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Children's social services and care rates in Wales: A survey of the sector

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Summary

- Reducing the high rate of children in care in Wales is a priority for the Welsh Government.
- This report shares findings from a survey of 792 social workers and leaders in children's social care across Wales. The survey sought to understand better the factors influencing care rates and differences between local authorities (LAs) with increasing or decreasing rates.
- Most respondents feel care rates are too high in Wales and in their LA, driven in part by systemic issues. Respondents feel these could be mitigated through more early help.
- Practices within LAs, and the influence of judges and courts, are also considered to influence rates.
- Although most respondents feel that their LA and its leaders do their best to protect children, there is concern about "risk-averse practice" in LAs and the wider system. There was also inconsistent use of practice frameworks in LAs.
- There were many agreements between workers and leaders, but leaders are less likely to identify external factors as influencing rates; are more likely to be positive about children remaining with birth families; and are less positive about care as an option.
- Major differences between respondents from LAs with increasing versus decreasing rates relate to the practices of children's social care itself; their views of external pressures are similar.
- In LAs with decreasing rates, respondents are more likely to think the right children are in care, be positive about the rate of children in care in their LA, be confident about practice in their LA, have positive values about birth families, prefer to keep children at home, and report using an outcomes-focused approach.
- Findings show that many factors influence care rates, but there are key differences in LAs that have reduced rates, connected to the values of leaders and workers, how consistent those are, and how well they are reflected in LA practices.
- This suggests that influencing the values and practices of LAs could help address differences in care rates and ensure children and families in Wales receive consistent support.

Introduction

The First Minister Mark Drakeford has identified reducing care rates in Wales as a priority of the Welsh Government (Drakeford, 2018). To understand better the factors influencing care rates, the Welsh Government commissioned the Wales Centre for Public Policy and the Centre for Children's Social Care Research and Development (CASCADE) at Cardiff University to undertake a survey with the children's social care (CSC) workforce.

The survey seeks to understand what those working in the sector believe may be driving care rates and to analyse some of the differences between local authorities (LAs) with increasing or reducing rates of children in care. We were also interested in the views of leaders in the sector. To understand these views and their implications for differences in care rates, the survey aims to answer the following research questions:

1. What do those working within CSC see as the factors driving the increase in care rates?
2. What are the similarities and differences in the views, values and practice responses of leaders and workers?
3. What are the similarities and differences in the views, values or practices of workers and leaders in LAs with increasing care rates compared to those with decreasing care rates?

The survey also asked questions about the impact of the Coronavirus pandemic on practice. As these did not relate directly to care rates, this discussion is presented in a separate short report (Forrester et al., 2021).

In total, 792 respondents completed the survey in November-December 2020.[1] The appendices, published in a separate accompanying document (Appendices: Children's social services and care rates in Wales – A survey of the sector, Wales Centre for Public Policy), contain a link to the survey, the sample, methods and approach to data analysis, and response tables. These should be read alongside this report and are referred to throughout.

[1] See Appendix B for more details.

Care rates in Wales

The care rate in Wales increased by 87% between 2003 and 2020, with more than 1% of children currently in care. A particular concern has been the way that care rates have increased in Wales compared to England, with rates and the rate of increase substantially higher in Wales.[2]

Care rates in Wales may be high for several reasons. The factors influencing care rates are multiple and complicated, the evidence base is limited, and some operate on a UK-wide level. Policy divergence may also influence differences in rates across the UK (McGhee et al., 2017). Some additional factors to consider include:

- The increase in the early 2000s has been linked **to increased media, political and professional attention** following high-profile deaths such as that of Peter Connolly.[3] The increase in care rates in Wales was substantial and concentrated in the poorest neighbourhoods (Elliot, 2020).
- High rates are strongly connected to **deprivation** (Bywaters et al., 2020). LAs with high rates of deprivation have more children in care, with approximately half of the difference in care rates in Welsh LAs being explained by differences in rates of deprivation (Hodges, 2020b). While deprivation is a key issue, there is no evidence for large changes in deprivation that would explain the change in rates.
- Recognition of **new risks to children** (Care Crisis Review, 2018). Over recent decades we have recognised new forms of harm to children, and these may be contributing to greater numbers of children in care. These include heightened recognition of issues already identified, such as parental substance misuse or the impact of domestic abuse on children, as well as new forms of harm we were not aware of, such as child sexual or criminal exploitation.
- The impact of government cuts in benefits and services associated with **austerity** have also been suggested to contribute to recent increases, with more families under pressure and spending failing to keep pace with rising need (Care Crisis Review, 2018).

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[2] In 2019-20 the care rate was 109 per 10,000 in Wales, 77 per 10,000 in Northern Ireland, 67 per 10,000 in England and 139 per 10,000 in Scotland. In 2004 rates in Wales, Northern Ireland and England were similar, at around 60 per 10,000 (Scottish Government, 2021).

[3] Peter Connelly, or 'Baby P', was a 17-month-old English boy who died in London in 2007 after suffering injuries over an eight-month period, during which time he had been seen repeatedly by social workers, doctors, and police.

- There is also evidence that **practices within CSC** may contribute to care rates. This has been hypothesised to contribute to rising care rates, with more "risk-averse" practice (Care Crisis Review, 2018). Substantial variations between LAs cannot be explained by variations in the above factors and seem likely to be linked to differences in how CSC and related agencies work together. Hodges and Bristow (2019) suggest 25% of the variation between LAs may be due to this.

There are certainly substantial variations between LAs in Wales, and despite the overall increase in Wales there are several LAs where rates have fallen. We know very little about what may be causing these differences.

Are high care rates a cause for concern?

Research suggests that some outcomes for children improve once they are in care (Forrester, 2010). However, there is limited evidence on outcomes compared with children in need who remain at home, and evidence suggests that those remaining at home may do less well educationally (Rees Centre, 2019). For some children, care is the right option. The care population also covers a diverse group of children, with different care experiences and home circumstances; the ability to keep children safely at home will be greater for some groups than others. The rate of care is a "Goldilocks" measure – it should not be too high or too low, but establishing the "right" level is difficult (Cordis Bright, 2013).

Nonetheless, there is growing concern about the harms that care can cause to children, families and communities, and its potentially limited capacity to reverse the effect of previous harms experienced with birth families. There is evidence of long-term harm to parents once they have had children removed (Broadhurst et al, 2019; Family Justice Observatory, 2021). Children in care are themselves the most likely group in society to have their own children removed when they become parents (Roberts, 2019, 2021). Furthermore, most children have contact with their birth family into adulthood, with high proportions returning home. This suggests the importance of these enduring relationships – as well as the difficulty the state often has in attempts to replicate life-long support. Care is also a very expensive option, and there are legitimate concerns about whether it is always the most cost-effective way of helping children. Wales' high rates raise important questions for the country in relation to social justice, social policy, and practices within children's social services.

Variations between LAs

A feature of the care rates in Wales is that they vary substantially between LAs: a child in Torfaen is five times more likely to be in care than one in Carmarthenshire. While some of the differences between LAs are due to issues such as levels of

deprivation, even when this is allowed for there is substantial variation (Hodges, 2020a; see Appendix C, Fig. C1).

The changes in care rates have also been different between LAs. Since 2015 the increase in care rates in Wales has been 21%, but LAs have varied significantly in their rates of change. To illustrate the extremes, four LAs have seen increases of 40% or more while two have seen *decreases* of more than 20%. These differences are of particular interest from a policy perspective, as the variations are not accompanied by similarly dramatic changes in underlying factors, such as level of deprivation. Furthermore, national drivers – from media coverage to family policy – cannot explain such differences. Importantly, if some LAs are reducing the need for children to be in care, there may be lessons that other LAs can learn. How have they managed to do it? How are they different? The key focus of this study is therefore to identify what differences there may be between LAs with reducing care rates compared to those with increasing rates.

Overview of the study

The online survey was circulated to heads of service in November 2020, who shared it with their staff, and with the social care workforce via Social Care Wales. The survey can be found in Appendix A and includes a mix of closed and open-ended questions. Of the 792 respondents who completed the survey, 718 were workers and 74 were senior managers (approximately 18% of the CSC workforce). Of these, 584 were qualified social workers (approximately 34% of those working in CSC). The number of responses and the response rate – at nearly one-fifth of the CSC workforce and more than one-third of qualified social workers in the sector – was very encouraging. In general the survey was representative of the workforce and the sample was large enough to allow considerable confidence in the findings. The bulk of respondents worked directly with children and families, for instance in child in need or child protection teams, with those less directly involved still playing key roles, such as in fostering or adoption services.

The LA response rate ranged from 2.2–58.0%, meaning that some LAs are more represented than others in the findings.[4] Missing data ranged from 1–16%; as the survey progressed the amount of missing data increased, but there was no evidence of missing data being greater in certain demographic groups or LAs. The full breakdown of participant characteristics and the analysis of study sample representativeness can be found in Appendix B. In presenting the findings we

[4] The LA with a response rate of 2.2% was an outlier, and since it was not included in the comparative analyses it does not compromise the robustness of the findings (see Appendix B for further details).

summarise the approach taken, including which statistical tests were used. Full details of the methods and statistical analysis can be found in Appendix C.

Structure of the findings

This report sets out the findings from the survey in relation to our three research questions. We integrate responses to the closed and open-ended questions in each area to present respondents' views on the factors driving the increase in care rates; views on what could be done to reduce care rates; and finally, the results from comparative analyses of leaders versus workers and LAs with increasing rates versus decreasing rates.

Views on the factors driving the increase in care rates

Respondents' views on the factors driving the increase in care rates were collected through closed questions to generate numeric responses, and a single open-ended question. In addition, respondents were asked to specify the practice framework they used (if they used one) and were asked an open-ended question about what might be done to reduce rates. The results for these elements of the survey are presented in this section.[5]

The closed questions were grouped into five categories, covering views on:

1. Whether there are too many children in care (in Wales and in their LA).
2. Key factors believed to be influencing the increase in care rates.
3. The influence of agencies outside CSC.
4. CSC culture and organisation.
5. Leadership within CSC.

[5] Full tables of quantitative findings are provided in Appendix D. Note that, for the qualitative findings presented, the number presented does not simply equate to the number of respondents. As the building block for the analysis, the number for issues is both the number of times mentioned and the number of respondents, and therefore individuals will only be counted once per issue. For areas and themes, as individual respondents can mention multiple issues, an individual could be counted more than once under the same area or theme.

The open-ended question – "What factors do you think are responsible for the increase in care rates in Wales?" – produced 542 codable responses.[6] Multiple issues could be present in one response. The issues can be grouped at three levels:

I. **Issues** – the building blocks for the analysis, with similar ideas or thoughts identified by respondents coded together.

II. **Themes** – groups of related issues, grouped together because they provided similar causal explanations about the impact of the theme (i.e. how did these issues increase care rates?).

III. **Areas** – groups of themes according to three broad areas of interest:

   a. *Actual or perceived increases in risks and needs in families.*

   b. *The influence of different agencies on rates – how they provide help, identify risk, or interact with CSC.*

   c. *Organisational culture and practice within LAs.*

To make navigating the report easier:

- Issues are in ***bold with italics.***
- Themes are in **bold.**
- Areas are identified as headings.

All themes and issues raised are reported below, including those from only a small number of respondents.

Do respondents think care rates are too high?

Respondents were asked a closed question about whether they felt the overall rate of children in care in Wales and in their LA was too high or too low (Table 1). Of those that responded, most felt the rate of children in care in Wales and in their LA was too high or much too high (67.8%, n=473 and 56.7%, n=394 respectively). Respondents were more likely to think that the national figure was too high than in their own LA, with four in ten believing that the rate was "about right" in their authority (39.6%) and

[6] Non-codable responses (n=16) typically contained responses in which the respondent has no answer, or states that there are a variety of (unnamed) factors. Responses were coded by the issue they raised through iterative coding by one researcher, and then independently checked by a second.

more than one-quarter thinking the same for Wales as a whole (28.6%). Very few respondents thought too few children were in care in either Wales or their LA.

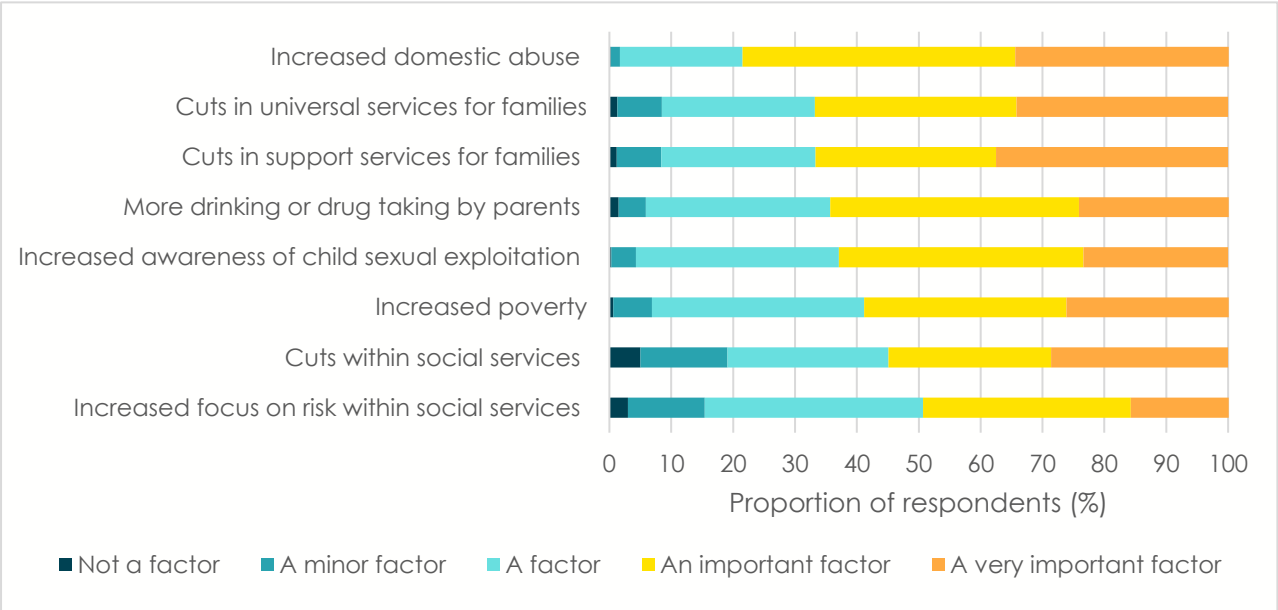
Table 1: Responses to question "Overall the rate of children in care is…"

	In Wales (N=697)		**In your LA** (N=695)	
	n	**%**	**n**	**%**
Much too high	49	7.0	41	5.9
Too high	424	60.8	353	50.8
About right	199	28.6	275	39.6
Too low	25	3.6	26	3.7
Much too low	0	0.0	0	0.0

The relative importance of different factors

When asked in a closed question about which factors most influenced the increase in care rates in Wales, respondents tended to agree that every offered option was a factor (Appendix D, Table D1 and Fig.1). For those who answered, the biggest drivers were thought to be increased domestic abuse (78.6%, n=536), and cuts in support services (66.7%, n=452) and in universal services for families (66.8%, n=453). Although most felt cuts within social services (54.9%, n=374) and an increased focus on risk within social services were also important (49.4%, n=335), around one-sixth thought they were either not a factor or a minor factor (19.1%, n= 130 and 15.4%, n=104 respectively).

Figure 1: The proportion of responses to factors influencing care rates



Actual or perceived increase in needs, risks and pressures on families

In responses to the open question about factors influencing rates, the biggest single area cited (497 times) was an actual or perceived increase in needs, risks and pressures on families. The two themes in this area were primarily about factors **increasing needs and risks in families** (382), though some related to **increased awareness of risks or harms** that may always have existed (115).

Increased needs, risks and pressures

Of the issues increasing needs in families, the most mentioned issue was ***increased pressure on families through social issues***, such as poverty or unemployment (185 respondents):

> **"Drugs. Poverty. Lack of futures for young people. Lack of meaningful employment in all areas of Wales due to 0hr contracts and nil job security when they do find jobs"**

These broader social factors were often also one element of a perceived ***increase in the number of families with complex problems*** (132 respondents), including increased referrals of multiple parental risk factors. These respondents also made links with difficulties in access to services and reported parents self-medicating with illicit substances owing to mental health needs:

> **"Austerity – families that were borderline struggling are now over the edge and their wider family less able to support them, financially or emotionally, and parents have reduced access to support with substance misuse or domestic violence issues so self-medication with alcohol, drugs has increased."**

Drug and alcohol use was identified by 48 respondents. Comments referred to the social acceptance of drugs and alcohol and *"a generation of people who have been severely affected by drugs and alcohol causing poor parenting".* The responses also suggested that it was the profile of drugs that is seen as particularly problematic, with the use of new drugs such as "spice". A small number (17 respondents) also suggested a ***reduction in social support networks*** and reduced sense of community might be a contributing factor.

Increased awareness of risks

A second theme relating to increased demand was **an increase in recognition of specific risks** (115). This covered five issues related to risks that either might not have been well understood in the past or might have been responded to differently before. One was a general sense of an ***increased understanding of risk and harm*** (28 respondents). These responses identified research knowledge, training, and assessment skills as contributory factors to an improved understanding of the impact of abuse, and were likely to relate this to domestic abuse.

The largest specific area of increased awareness was in relation to ***extra-familial harm*** (33 respondents), such as county lines, child criminal exploitation and child sexual exploitation (CSE).

More awareness of risks to teenagers (18 respondents) was related to this, with observations from a small number that the number of older young people coming into the care system has increased:

> **"I have noticed care proceedings being started on much older young people, and think this might be because we are more educated now in terms of risks of sexual and criminal exploitation, risks of the Internet and the parents not being able to safeguard their child."**

A small number of respondents identified ***multi-generational abuse*** (14 respondents) with particular reference to adverse childhood experiences (ACEs) and trauma perspectives. These people often felt the system had failed to take previous generations of children into care:

> **"Increase in children who are 3rd generation developmental trauma due to not intervening early enough with their parents and grandparents."**

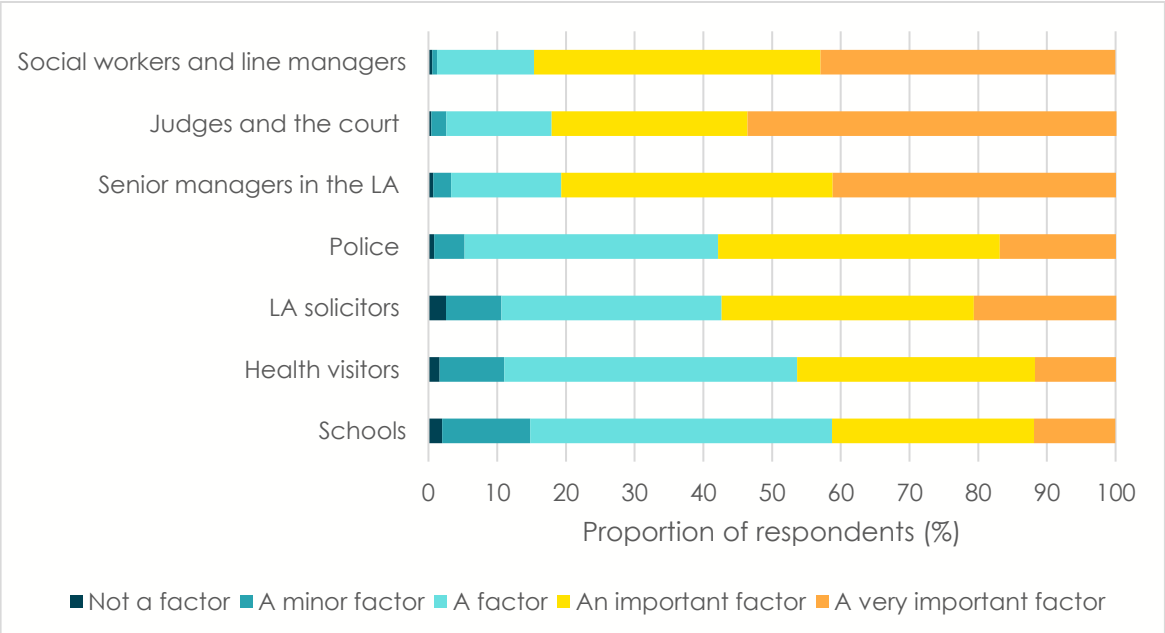
Finally, ***increased public reporting and scrutiny*** was identified (22 respondents). Responses described increased public awareness of risk factors such as CSE and domestic abuse, public confidence in reporting concerns, and increased vigilance and scrutiny.

What is the influence of different agencies on care rates?

How influential are different groups?

Respondents were asked in a closed question which agencies or groups most influenced the likelihood of children being in care in their area. They felt that influences came mainly from within the LA, with respondents identifying social workers (84.6%, n=594) and line managers/senior managers (80.7%, n=560) in their LA as either important or very important factors. The judges and courts were felt to have a similar level of influence with 82.2% (n=571) considering them important or very important factors (Appendix D, Table D2 & Fig.2).

Figure 2: Proportion of responses to influence of agencies or groups on care rate in respondents' LA



In what ways do other agencies influence rates?

The second key area identified in the open-ended responses was the role of other agencies (362 mentions). This can be divided into three broader themes: **cuts in services** (224), **increased pressure/referrals from other agencies** (64) and the specific **role of the courts and Cafcass**[7] (74).

Reduced help for families

Of the issues related to other agencies, ***cuts to community and support services*** were most commonly identified as responsible for the increase in care rates in Wales (179 respondents):

> **"100% I feel that cuts due to austerity have a direct link with children coming into care … There are not enough preventative services, and social workers themselves are too overstretched therefore unable to do the direct work with families."**

There was a particular emphasis on early support services in local communities, such as perceptions of *"government cuts to Flying Start"*.

A more specific issue was ***problems getting access to mental health support*** (22 respondents), with some describing it being a precipitating factor for parents to "choose" care. Finally, a related issue was the view that a ***lack of services to prevent care*** (23 respondents) was a factor in taking children into care, requiring more serious and intensive help.

Increased pressure on CSC from other agencies

Increased pressure from other agencies can be divided into two groups. Perceptions of ***improved professional identification and referral*** from multi-agency partners were reported by 43 respondents. The narrative talked of *"families being more visible through partnership-working"* and many responses referred to ACEs or domestic abuse, suggesting that training in ACEs has had an impact:

> **"Increase in multi-agency working and improvement in skills and knowledge, more is known about DV [domestic violence] and impact on children"**

[7] Cafcass Cymru is the Children and Family Court Advisory and Support Service in Wales.

21 respondents identified ***pressure from agencies*.** This included partner agencies being described as inflating concerns, being risk averse and pressuring social workers to escalate:

> **"[…] disenfranchised back covering workforce (including health visitors, teachers etc.) who are scared to get it wrong (at the very least being shot down in court is a humiliating experience which will impact your practice) and we are left with a system which does not manage risk confidently, nor work with purpose to address it."**

The role of courts and Cafcass

The role of courts and Cafcass were mentioned 74 times. The most common concerns were about how the legal system currently operates and a perceived ***micro-management and risk-averse approach*** to public law cases (48 respondents):

> **"Cafcass and the courts being risk averse. Regional judges, social workers and LA solicitors being fearful of criticism from the courts for not having put in court applications early enough, children remaining at home with their parents under a care order, lack of trust from the courts for LAs to manage plans and courts and Cafcass wanting to micro manage."**

Responses included comments of being criticised for "late" decision-making or not being respected:

> **"Courts are risk averse, LA social workers are not respected by the courts and often despite them having worked most intensely their view feels like it is the least valued."**

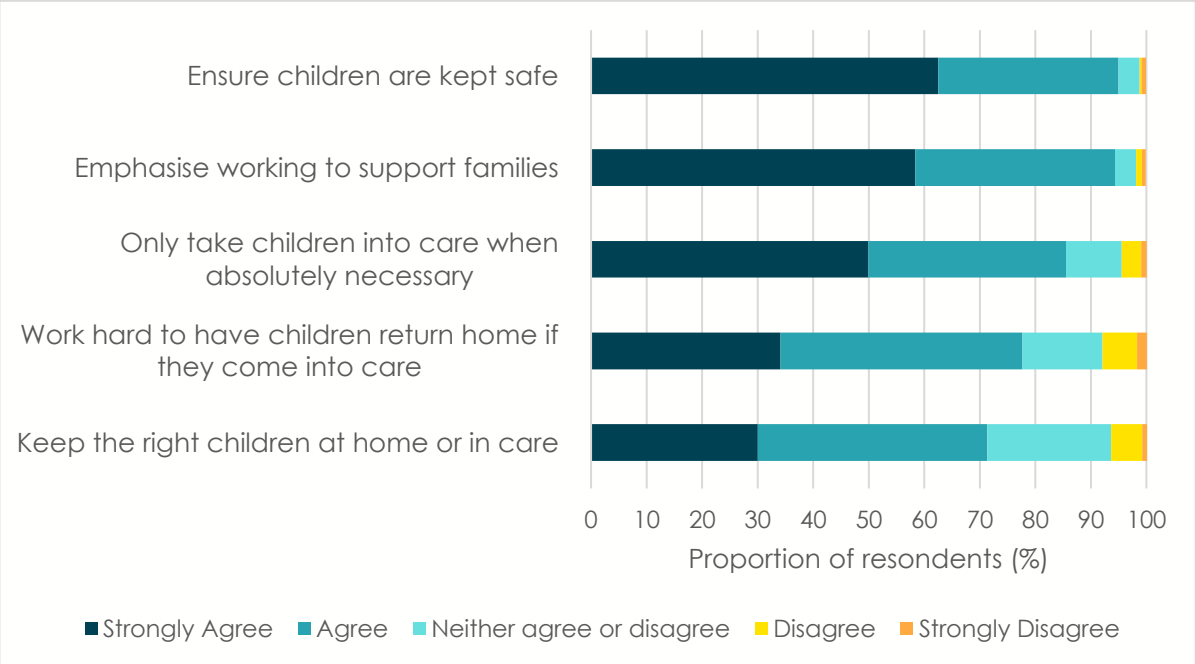
In addition, several specific issues were mentioned. These included the ***granting of higher orders*** by the Court, overruling the LA (11 respondents); a court preference for issuing or maintaining a ***care order whilst the child remains in the family home*** (9 respondents) and problems with ***kinship care regulations*** (6 respondents).

What do respondents think of their LA's organisational culture and leadership?

Respondents were generally positive about their LA when asked in a closed question. Most who answered strongly agreed or agreed that their LA ensured children were kept safe (95.0%, n=649), emphasised working to support families

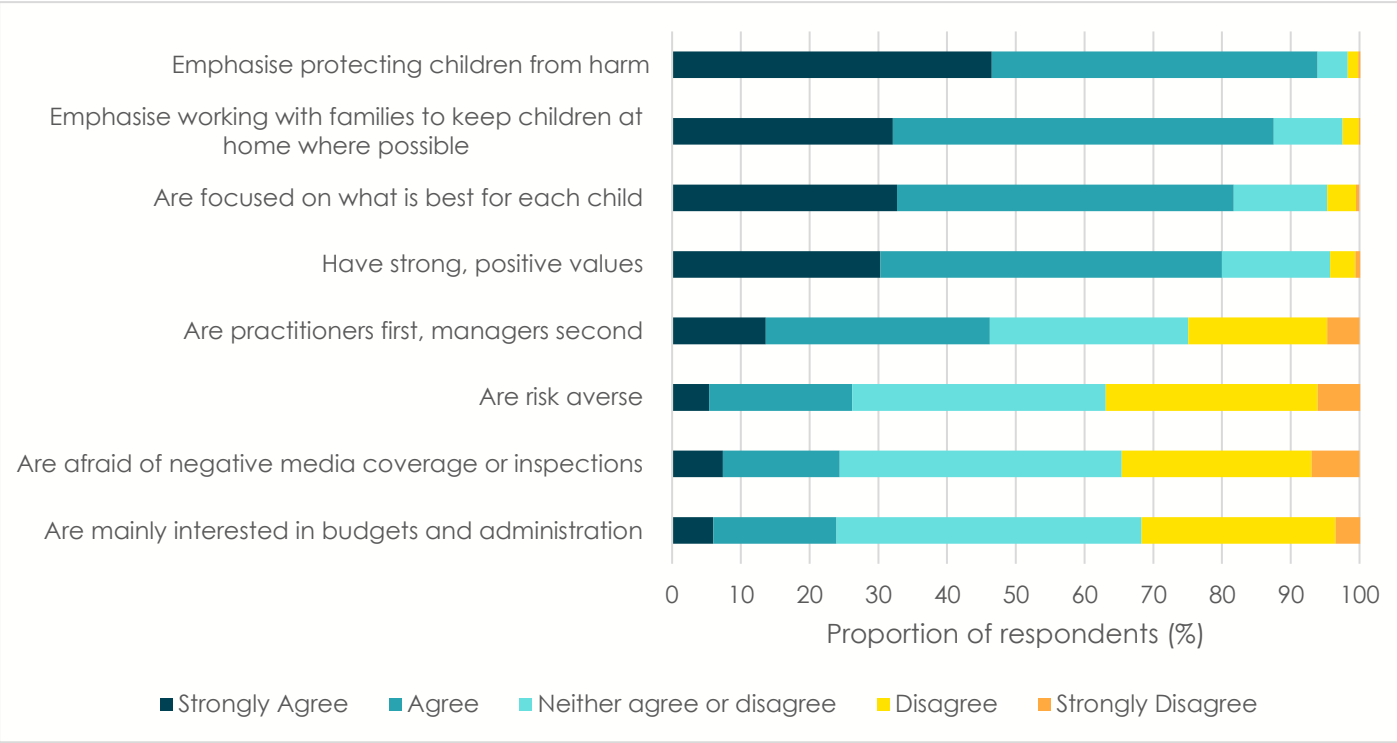
(94.4%, n=645), and only took children into care when absolutely necessary (85.5%, n=583). They were somewhat less sure about whether their LA kept the right children at home or in care, with 22.3% (n= 152) neither agreeing or disagreeing with this statement and 6.5% (n= 44) disagreeing or strongly disagreeing (Appendix D, Table D3 & Fig.3). This was perhaps linked to a lower level of certainty that they worked hard to return children home once they entered care: almost one-sixth of respondents were unsure about this (14.4%, n=98).

Figure 3: Proportion of respondents' views about their LA



Workers were asked questions about leaders in their LA (Appendix D, Table D4 & Fig. 4). Most strongly agreed or agreed that their LA leaders emphasised protecting children from harm (93.9%, n= 582), working with families to keep children at home (87.5%, n= 543), are focused on what is best for each child (81.7%, n= 505), and have strong, positive values (80.0%, n= 494). However, some respondents felt LA leaders could be risk averse (26.2%, n= 161) and afraid of negative media/ inspections (24.4%, n= 151).

Figure 4: Proportion of responses on workers' views about the leaders in their LA



In answers to the open-ended question, the third main area influencing the increase in care rates was organisational and cultural factors within CSC (152 mentions). There were two broad themes: **changes in practice** (112) and **factors influencing practice** (140).

Changes in practice

The most common description of changed practice was development of a ***risk-averse practice culture*** (68 respondents). The perception was generally that this risk aversion pervaded the whole organisation – practitioners, managers, and legal advisors:

> **"LAs and other organisations being much more risk averse. Everyone would rather err on the side of caution."**

This was often also linked to fear of criticism from the courts:

> **"A culture of being risk averse; fear of getting it wrong and using care orders to assure ourselves children are safe when of course it is not the order that keeps a child safe in isolation; criticism from judges and guardians making social workers feel damned if they do and damned if they don't."**

Lowering of thresholds, particularly for care proceedings, was raised by 23 respondents.

Linked to this, ten respondents identified what might be called a ***removal culture*** in CSC. One respondent reported their manager saying that "her mantra" was first to remove the child and then seek to resolve whatever situation prompted intervention. The same respondent said that "sadly this sort of thinking is common."

This links to the final issue in changed practices, which was ***case drift*** for children once they are in the care system. Eleven respondents reported that social work practice lacked focus on an *"exit strategy"* or on progressing assessments towards permanence for children once a child was in care.

Factors influencing practice

The responses that focused on **factors that influenced practice** could be divided into five issues. Fear of ***media criticism*** that had led to a risk-averse culture was mentioned by 22 respondents:

> **"The media has played a large part in putting the blame on social services when children are abused at home or in care. This has ultimately resulted in a risk-averse approach to dealing with reports of abuse where taking children into care is seen as the safest action."**

Management issues were identified by 24 respondents, with responses linking issues of poor supervision and a blame culture to risk-averse practice:

> **"More inexperienced social work managers being promoted into posts who are risk averse and life experience poor."**

Staffing issues were raised as a perceived factor contributing to the increase in care rates (36 respondents) and predominantly referred to poor staff retention and inexperienced or de-skilled practitioners. ***Time and workforce pressures,*** such as not having time to work with families owing to excessive caseloads, were identified by 24 respondents.

The final issue was closely related. ***Practice under pressure*** (24 respondents) captured challenges of working under time and organisational pressure, with a particular focus on bureaucracy:

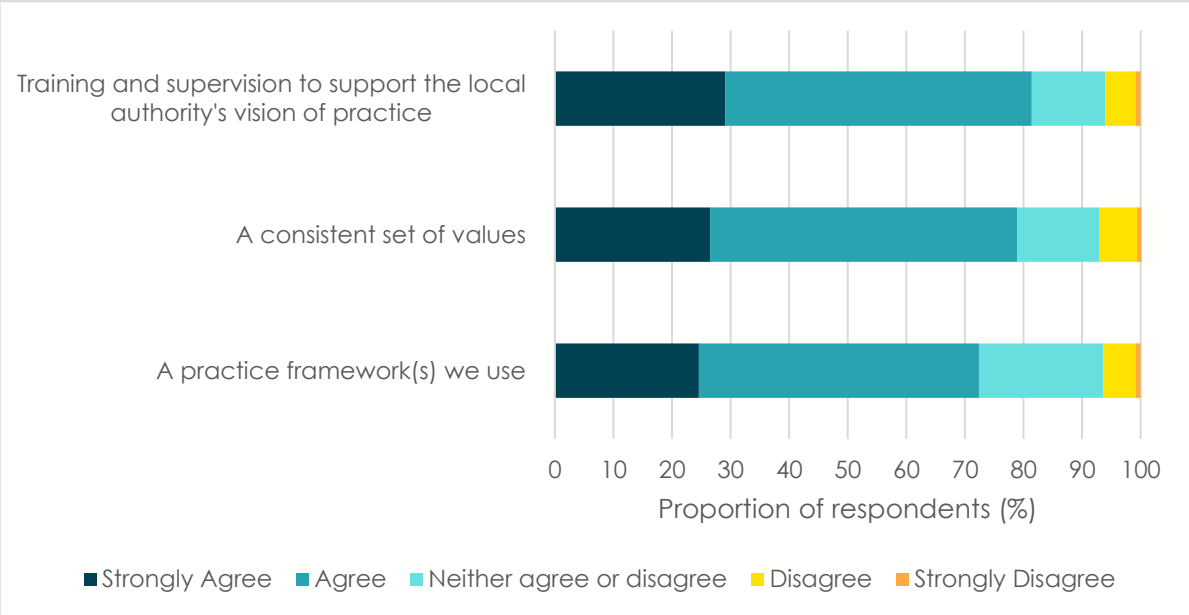
> **"We seem to think that paperwork protects children rather than positive relationships with families and as such have de-skilled our workers in therapeutic/face to face intervention, and made them good at writing about risk."**

The role of practice frameworks

Practice frameworks have become increasingly popular in recent years in the UK. They include both whole-system approaches such as Signs of Safety or Restorative Practice and models of practice applied within specific teams or services. It is also possible for an individual to have a specific framework they use. However, in general, the way that practice frameworks are understood is as a whole-system commitment to particular ways of working.

In response to the closed question on practice frameworks,[8] respondents generally agreed (Fig. 5 & Appendix D, Table D5) that their LA has a practice framework they use (72.4%, n= 486), appropriate training and supervision (81.4%, n= 554) and a consistent set of values (78.9%, n= 533).

Figure 5: Proportion of responses on views about their LA practice



Responses to the open-ended question (459 responses from 360 respondents)[9] suggest a more complicated picture.[10] Many of the approaches cited are not practice frameworks but are instead about the legislation underpinning services or "early intervention". Many appeared focused specifically on assessment, rather than a broader vision of practice. We expected respondents from the same LA to give

[8] The open and closed questions about practice frameworks were developed in part through discussion with the stakeholder group and in light of previous research identifying them as a key element of good practice (Cordis Bright, 2013).
[9] Many mentioned more than one practice framework.
[10] Responses were categorised by an experienced social worker, so that similar frameworks were grouped together. This was double-checked by the first author (for instance, various 'strength-based' approaches were put together).

similar responses, but this was only true for two named frameworks: Signs of Safety and what we refer to in this report as the “Outcomes Framework”. Signs of Safety is a commonly used framework applying solution-focused approaches to child protection. Training in an outcomes-focused approached was developed across Wales to support the implementation of the Social Services and Well-Being Act (2014), and some LAs have developed this into a holistic framework for practice, which we term the “Outcomes Framework”. The Outcomes Framework is a framework for practice, meetings and assessment and an attempt to develop a practice framework based on the principles of the Act. Even for these frameworks it was only in a few of the LAs where they were identified that the majority of respondents mentioned them.

The degree to which practice frameworks are used is worthy of further exploration. Our evidence suggests their use seems patchy. However, we were able to analyse the use of Signs of Safety and the Outcomes Framework in the comparison of LAs with increasing and decreasing care rates (see below).

What did respondents think could be done to reduce care rates?

This was addressed through an open-ended question which produced 540 codable responses.[11] Most of these related to just one (230) or two (181) issues, but a minority of longer responses touched on multiple issues, with the largest number being 8.

Responses were coded into 21 issues; the frequency of responses for each of these ranged from 5 (social workers should be community-based) to 301 (better preventative/early intervention services). The issues were organised into five broad themes:

1. **Primary prevention (140)**
   Societal changes or improved universal services

2. **Secondary prevention (326)**
   Increased services to help people and/or prevent the need for CSC

[11] There were 556 free-text responses to this question in total. Of these, 540 responses could be coded. The 16 non-codable responses divided equally between statements that current practice in relation to care or support was already adequate or responses such as “no”.

3 **Improved working in other agencies (127)**
To prevent the need for referral or improve interagency working

4 **Improvements within CSC (218)**
Suggested ways in which services or assessments might be bettered

5 **Specific services for families at high risk (235)**
Improved services for children and families at high risk of a child entering care

Primary prevention: societal changes or improved universal services

Emphasis was often placed on the need for a holistic approach, rather than simply tackling services within the remit of CSC:

> **"Children live in families, taking an approach that just focuses on parenting without addressing the conditions that create environments where parents cannot parent safely will never address the continued increase in children needing to be looked after."**

Universal, community-based support (84 respondents) covered universal services and the promotion of non-professional community-based networks to support families in need. The emphasis was on "*wider availability and access to community resources"* and "*building stronger and closer communities by emphasising the need to care for one another".* A closely related issue was ***community investment*** to build stronger communities and tackle poverty (56 respondents), for instance: *"more government money and resources in poorer poverty-stricken areas such as [ours]"*.

Secondary prevention: increased services to help people/reduce the need for CSC

Services to help families who have problems so that they do not need the involvement of CSC was the most common response.

Better preventative and early intervention services was the most common issue across the responses (301 respondents). However, the nature of the help suggested was often not outlined in much detail, for instance:

> **"More investment in preventative services, catch families earlier to reduce risk and escalation of statutory intervention."**

No single type of service was identified as being particularly useful. In contrast, it seemed that the important thing from the respondents' perspectives was the array of services:

> **"[…] resources in the community to support work, e.g. financial advice & planning, access to mental health services, varied types of support around domestic violence, substance misuse, psychological support".**

Improved working in other agencies

Improving the way other agencies worked, or the way different agencies worked together, was a common theme. The most common issue identified was the call for closer working arrangements with safeguarding partners and a ***whole system commitment*** in responding to children and families in need and at risk (56 respondents). The responses consistently talked of *"the onus"* being on the social worker and advocated a balancing of responsibilities so that multi-agency partners share *"the burden"* of high-risk families, delivering a *"joined-up approach"* where *"all professionals take responsibility to reduce the demands on SSD (Social Services Departments)".* A slightly different focus in this area was making the system less collectively *"risk averse"*.

A related issue was creating ***greater alignment between courts and social services*** (24 respondents) with most of these responses asking for a "*less punitive judiciary"* sometimes as part of a more general need to reduce the focus on risk:

> **"Practice is pushed in a risk adverse way by the entire system (courts, society, Cafcass etc.) and the interactions in the system make it this way. This is not one profession or one organisation pushing this. We have a culture where we have to justify what we do at all levels (Welsh Government downwards) and demands of this are significant. This translates to practice with families that is prescriptive 'to' not 'with' and this impacts on work with families at risk."**

Other responses acknowledged a current misalignment and referred to "*the government and court not being on the same page",* and called for things such as a *"policy and law review"* or *"training for the judiciary"* or to *"encourage judiciary and Guardians to engage fully with the principles of the Act."*

Improving access to partner agency services was identified by 39 respondents. Of these, ***improved mental health services*** for both adults and children was the most common (35 respondents). Comments referred both to timelier access and there being a wider array of services on offer to meet identified needs. ***Improved access***

to other adult services**,** such as drug and alcohol services and domestic violence perpetrator programmes, was raised by 12 respondents.

Improvements in CSC

The responses relating to actions to improve CSC's response to families identified as in need or at risk were more detailed than the others – perhaps because this issue benefited from the insider perspective of the respondents. A key issue was ***moving away from a risk-averse culture*** (42 respondents) towards being confident in holding and managing risk:

> **"A shift in culture to being more risk positive and intervening early will be key. If we can support families to make changes, while being comfortable to sit with some risk, we can prevent children coming into local authority care."**

A particular feature was a proposal for less oppressive processes emanating from a senior organisational level:

> **"Organisational change that allows all staff to participate in regular reflective practice sessions. Shift in culture from being risk averse, fear and blaming including Court processes."**

A smaller group of respondents advocated ***more consistency in decision-making*** (20 respondents). Another issue was ***improving social worker practice with families*** (42 respondents)**,** for instance by more *"work in an outcome focused manner where we support more and develop relationships with parents before we remove children from their care"***.**

More staff and staff retention (47 respondents) was also identified as an action to reduce care rates and a closely related issue was action to ***address social worker caseloads*** (50 respondents). Among these responses, increased time with families was almost universally emphasised and was seen as shifting the practice approach from reactive to proactive:

> **"Decrease social worker case loads and decrease admin burden – let us be social workers instead of administrators."**

Better supervision was also highlighted by respondents within this theme (12 respondents). Most of the responses promoted "*meaningful and reflective supervision sessions"*.

Services for families at high risk

Many respondents (235) drew attention to the need for more services and support to be available to those assessed as being on the "edge of care". The most common suggestion was ***intensive home-based support*** (140 respondents). Respondents talked about "*bespoke services"* and predominantly referred to them as "*home-based*" and intensive, designed to "*fit the needs of the families not the other way around".* Accessibility of services and support was identified as a particularly important aspect of edge of care support and this related to the avoidance of waiting lists and being able to put in place a service which runs outside normal office hours:

> **"Intensive wrap around support 24/7 – there are gaps in services outside of office hours but trigger points can be any time for a family and there needs to be service provision to meet these needs."**

The other aspect deemed important was that support offered to families at this level of risk needs to be intensive, therapeutic and supportive. The overall sense was that there is a need for committed action underpinned by a desire for children to remain at home if this could be achieved safely and was considered in the child's best interests. The focus should be on services "*specifically designed to reduce the risk of children becoming looked after".*

Other issues raised included ***neglect cases*** (15 respondents), and a need for sustained intervention and potentially that expectations (of CSC and wider agencies) should be reset to acknowledge that, for some families, a good enough standard of care for children could only be maintained at home with long-term support:

> **"Some families are unable to sustain positive changes without social work intervention. The current systems work on putting in support for 8 or 12 weeks, or monitoring via the Child Protection Conference route and then within a year issuing proceedings if there has been no change. … I think we need a new approach that accepts long-term support that may last for years ... Our approach is normally to rush in, make a judgment call and remove, or just as bad, see a brief improvement, close the case, only for it to keep coming back. Inevitably, the effect of persistent neglect has a much more damaging effect overall and mostly the children in these families end up getting removed."**

A smaller number of respondents (21) identified ***improved planning for children in care*** to increase reunification and avoid case drift. They suggested a need to reset a mode of practice in which "*capacity is being drawn to new entrants"*. Some also considered that ***more could be done with longer term care cases*** (37 respondents) with a view to more returning home – for instance, being aware that

"the majority of children are likely to be heading home when they turn 18". A related set of suggestions was to increase the availability of respite options to avoid permanent care, and this seemed to relate both to children with complex additional needs and those where parenting or the capacity to manage complex teenage behaviours resulted in a high risk of care.

Other responses thought more could be done to ***support the wider family*** (22 respondents), with several referring to how budgets are currently spent. As one respondent noted, "*LAs can spend tens of thousands on residential placements, but make you jump through lots of hoops to get a small amount to support children at home",* and suggested that the purchase of relatively small items like "*buying bunkbeds"* may be enough to reduce the need for children to be taken into care.

Comparative analyses

Variables for comparative analyses

As noted in the introduction, we wanted to compare the views of leaders and workers as well as compare LAs with increasing and reducing care rates. For both analyses we considered three sets of variables:

1) The responses to the survey questions discussed above.
2) The responses to a series of questions designed to explore values, attitudes and response to risk.
3) The responses to two case studies.

Survey questions: a factor analysis

To compare groups of respondents it was necessary to simplify and reduce the number of questions analysed, to avoid questions that had very similar answers making it difficult to identify real relationships. Here we provide a non-specialist overview of the approach we took.[12]

To simplify the data, we carried out a factor analysis. Factor analysis identifies strongly related variables which are linked to an underlying factor, and then provides a measure for this factor. It is a powerful way of simplifying survey responses. A factor must have at least three variables which are strongly correlated to be included

[12] More detail and some of the analyses underlying this are provided in Appendix C.

in the model (Rahn, 2021). A decision then needs to be made about whether they also make sense conceptually. If they do then this can be considered a “factor”.

This process led to the identification of four factors within our closed questions (see Appendix D, Table D6 for factor loadings), and to the creation of a “score” ranging from 1–5 for each:

1. **Confidence in LA**: A higher score means that respondents are more confident that their LA keeps children safe and, where possible, at home.
2. **Cuts to services**: A higher score means that respondents place more emphasis on cuts to services affecting whether a child goes into care.
3. **Support for practice:** A higher score means that respondents are more likely to believe that their LA has working practices in place to support the LA's vision of practice.
4. **Influence of community agencies**: A higher score means that workers place more emphasis on community agencies such as police, schools and health services as factors influencing the rate of children in care in their area.

In addition, there were three pairs of questions that were strongly correlated with one another and seemed to be conceptually related, but could not be tested statistically as factors as they only related to two questions. We therefore created a new variable that was the mean of responses for each of the three pairs. For ease of presentation we refer to these as factors:

5. **The influence of courts:** A higher score means that respondents place more emphasis on the influence of courts and LA solicitors on care rates.
6. **The influence of workers and managers**: A higher score means that respondents place more emphasis on workers and managers as influencing care rates.
7. **Parental factors:** A higher score means that respondents are more likely to identify parental alcohol, drugs or domestic abuse as increasing care rates.

Values, attitudes and response to risk

In addition to the views of respondents we considered two new issues: responses to case studies to explore practice responses to high-risk situations, and respondents’ values in relation to care and family.

Case study vignettes

We wanted to explore whether there are differences in practice between LAs in terms of culture, attitudes and values. This is a difficult issue to research, and we could not identify any existing measures to do so. We therefore developed two case study vignettes which were designed to explore this area. These were based on genuine cases and piloted with social workers in England to identify two vignettes that produced a range of responses (see Appendix C for more information on their development). We expected to find different responses in LAs with increasing or reducing care rates. We also explored whether workers and leaders responded differently. For real children and families, decision-making is a complicated process usually involving many people, but we wanted to explore whether differences could be identified at the level of individual workers and leaders.

The case studies were followed by closed questions that attempted to measure social work practice decisions. The questions were adapted for leaders, who were asked both what they would do and what they thought workers in their authority would do. A risk score was calculated based on their answers, which ranged from 1 to 3, with 3 being the most “risk focused” (i.e., most likely to remove the child from home) and 1 being “family focused”. It is important to note that there is no right or wrong answer for the case studies; they solely attempt to identify differences in level of family or risk focus.

Box 1: Case study 1 – Anna, aged 6.

Anna lives with her mother, June, and father, Ian. Ian was convicted of sexual offences against a 12-year-old girl in 1996 and in 2013 of persistent soliciting of women in an inner-city area. June was in a relationship with him in 2013 and does not believe he tried to solicit sex workers. She also states that despite his conviction for sexually assaulting a 12-year-old, he does not present a risk to children.

Ian owns a collection of knives. He has been heard by neighbours saying that he has access to a gun and if social services remove his daughter, he will cause “carnage”.

When you meet with Anna, she says she does not want to see her father and that he is "bad". She also drew a picture of her mother and father and put a big cross through her father.

In response to Case study 1 (Table 2), most respondents chose to immediately "Work with family on a child protection basis with the intention of getting them to understand your concerns" (62.1%, n= 488), and over the next six months to either "work with the family in the community" (43.2%, n= 339) or "Work with the family while Anna is in alternative care with a view to returning her home" (40.6%, n= 319). The average risk score for case study one was 1.7 (SD= 0.8).

Box 2: Case study 2 – Dawn, aged 14

Dawn went to live with her mother, Joanne, six months ago when her father died. Joanne has a history of mental illness and substance abuse. At the time of moving she presented as stable and able to care for Dawn. However, Joanne struggles to maintain boundaries and avoids conflict with Dawn.

During Covid-19, Joanne and Dawn disengaged from all services, neighbours complained that the home was being used for drug parties, and professionals reported that Dawn was known to hang out with known drug dealers and on the streets with homeless individuals.

Joanne has never reported Dawn missing and becomes angry when professionals raise concerns. Whilst there are no police reports or referrals, there is a great deal of professional anxiety and anticipation that harm will be caused to Dawn.

In response to Case study 2 (Table 2), most participants chose to immediately "Start protective action while trying to engage Joanne in protecting Dawn" (51.0%, n= 382), and over the next six months to "Work with Dawn and Joanne in the community" (75.3%, n= 563). The average risk score for case study two was 1.8 (SD=0.5). The combined mean risk score for both case studies was 1.8 (SD=0.5).

Table 2: Responses to case studies

	n	%
Case study 1: Which of the following do you think you/SW in your LA would do immediately? (n=786)		
Work with family on a child protection basis with the intention of getting them to understand your concerns	488	62.1
Start care proceedings to remove Anna while risks are being fully assessed	298	37.9
Case study 1: Which of the following do you think you/SW in your LA would be most likely to do over the next 6 months? (n=785)		
Work with the family in the community	339	43.2
Work with the family while Anna is in alternative care with a view to returning her home	319	40.6
Explore long term-alternatives for Anna	127	16.2
Case study 2: Which of the following do you think you/SW in your LA would do immediately? (n=749)		
Continue to try to engage Dawn and Joanne	169	22.6
While working with Dawn and Joanne, consider whether care proceedings are needed	198	26.4
Start protective action while trying to engage Joanne in protecting Dawn	382	51.0
Case study 2: Which of the following do you think you/SW in your LA would be most likely to do over the next 6 months? (n=748)		
Work with Dawn and Joanne in the community	563	75.3
Place Dawn in care for her protection while working for her to return home	138	18.5
Explore long-term alternative care	47	6.3

The case studies were an exploratory measure developed for this study. While there was adequate internal reliability (so that for instance people who scored high on

Case study 1 were likely to score high for Case study 2), Case study 2 had stronger discriminant validity (i.e. it was more strongly associated with differences between leaders and workers and between LAs). We therefore primarily used Case study 2 in comparative analyses, but provided data on both Case study 1 and the average of the two, as appropriate (see Appendix C for a fuller discussion of reliability and validity of the case studies).

Value subscales

For the values, we used subscales from the work of Davidson-Arad and Benbenishty (2010). Three subscales were selected, reflecting values in relation to:

1. The importance of birth families and harms of removal (n=708).
2. Positive views of foster care (n=703).
3. Reunification and minimising time in care (n=705).

Scores ranged from 1–5, with a higher score meaning respondents agreed more strongly with the value. The mean score for subscale 1 was 3.1 (SD=0.6), subscale 2 was 2.3 (SD=0.5), and for subscale 3[13] was 3.0 (SD=0.7). However, the purpose of this element of the study is purely comparative – to see whether there are differences between LAs or between workers and leaders in their values.

Comparing the responses of leaders and workers

We explored differences between leaders and workers in relation to 14 variables:

- The seven factors relating to views on care rates.
- Three values subscales.
- Responses to each of the case studies.
- Demographics: age, whether they were a qualified social worker.

Table 3 presents the bivariate results of a t-test to identify significant variables.

[13] Subscale 3 has a Cronbach Alpha coefficient of 0.5, which is adequate though relatively low internal consistency, and still a usable measure. See Appendix C for other coefficients.

Table 3: Difference in means between leaders and workers responses

	Leaders		Workers			Difference in means between groups	
	Mean	**SD**	**Mean**	**SD**	**df**	**p**	**t**
Significant differences							
Against removing a child at risk from home (subscale 1)	3.5	0.5	3.0	0.6	706	<.001	-6.1
Favour reunification (Subscale 3)	3.5	0.6	3.0	0.6	703	<.001	-6.8
Case study 1 risk score	1.6	0.7	1.8	0.8	784	0.033	2.1
Case study 2 risk score	1.6	0.6	1.8	0.5	747	0.004	2.9
Cuts to services (Factor 2)	3.5	1.0	3.9	0.9	705	0.004	2.9
Influence of community agencies (Factor 4)	3.1	0.8	3.5	0.8	705	0.002	3.1
The influence of courts (Factor 5)	3.8	0.8	4.0	0.8	689	0.026	2.2
Non-significant differences							
Positive views foster care (Subscale 2)	2.2	0.4	2.3	0.5	701	0.255	1.1
LA attitude to risk (Factor 1)	4.4	0.7	4.2	0.6	705	0.133	-1.5
Support for practice (Factor 3)	4.1	0.8	4.0	0.6	705	0.203	-1.3
The influence of workers and manager (Factor 6)	4.0	0.9	4.2	0.7	692	0.051	2.0
Parental factors (Factor 7)	4.1	0.7	4.0	0.7	679	0.254	-1.1

*All factors and value subscales are on a scale of 1-5, with a higher score, meaning the respondent agreed more strongly with the issue. The case studies are scored between 1–3, with a higher score meaning the respondent answered in a more risk-averse way.

To further test for differences between responses from leaders and workers, a logistic regression model was used. Regression analysis allows the interaction

between variables to be analysed and identifies variables that remain significant once this has been done.[14] Owing to leaders generally being older than workers, age was not controlled for in the regression model because of collinearity with other independent variables. Whether respondents were qualified social workers was included initially, but controlling for this factor made very little difference to the model and it was therefore excluded.

The following variables remained significant: **Leaders were more likely than workers to:**

- **Be against removing a child at risk from home** (subscale 1),
- **Be in favour of reunification and optimal duration of care** (subscale 3),
- **Place less emphasis on external cuts to services as factors influencing increasing rates of children in care in Wales** (factor 2),
- **Place less emphasis on community agencies such as police, schools and health services as factors influencing the rate of children in care in their area** (factor 4),
- **Be less likely to believe that the courts and LA solicitors influenced whether a child went into care in their area** (factor 5).

The response to case studies ceased being statistically significant because it was strongly related to values.

Comparing the responses of LAs with increasing or reducing care rates

Which LAs did we compare?

In order to identify differences, responses from LAs with decreasing rates of care were compared to responses from LAs with increasing rates of care. LAs were identified as "decreasing" if they had reduced the rate of children in care by 10% or more over the last five years. LAs were identified as "increasing" if the rate of care had increased by more than the Welsh average (21%) over the last five years. In addition, to exclude the possibility of "natural" variation (i.e. a LA with high rates reducing from a very high starting point or the opposite), we excluded any LA which,

[14] Full details are provided in Appendix D, Table D7.

despite the increase, had a lower care rate than might be expected once deprivation was allowed for (we explain in Appendix C how we allowed for deprivation). This excluded one LA which had a high rise but still had a comparatively low care rate (Pembrokeshire). This methodology produced two groups, as set out in Table 4.

Table 4: LAs with increasing and decreasing rates of care selected for comparison

LA	% change over the last 5 years
Decreasing care rates	
Carmarthenshire	-31.8
Neath Port Talbot	-27.4
Increasing care rates*	
Isle of Anglesey	35.0
Gwynedd	29.6
Wrexham	41.7
Powys	40.6
Vale of Glamorgan	22.3
Cardiff	30.7
Merthyr Tydfil	29.4
Caerphilly	40.8
Torfaen	36.9
Monmouthshire	42.1

*one LA excluded owing to 15% lower than predicted care rate

What differences were there between these two groups?

We then explored differences between the two groups of LAs in relation to the same 14 variables used to compare leaders and workers, namely:

- The seven factors representing respondents' views.
- Three values subscales.
- Responses to each case study.
- Demographics: age, whether they were a qualified social worker.

Table 5 presents the bivariate results of a t-test to identify significant variables.

Table 5: Difference in means between LAs with increasing vs decreasing rates of care

	Increasing care rates		Decreasing care rates		Difference in means between groups		
	Mean*	**SD**	**Mean***	**SD**	**df**	**p**	**t**
Significant differences							
Against removing a child at risk from home (subscale 1)	3.0	0.6	3.3	0.5	434	0.001	3.4
Case study 2 risk score	1.8	0.5	1.6	0.6	456	0.002	-3.2
LA attitude to risk (Factor 1)	4.2	0.6	4.5	0.4	433	0.001	3.2
Support for practice (Factor 3)	4.0	0.6	4.2	0.5	433	0.008	2.7
Non-significant differences							
Positive views foster care (Subscale 2)	2.3	0.5	2.3	0.5	428	0.969	-0.04
Favour reunification (Subscale 3)	3.0	0.6	3.0	0.7	432	0.735	0.3
Case study 1 risk score	1.8	0.8	1.7	0.8	477	0.080	-1.8
Cuts to services (Factor 2)	3.9	0.9	3.7	0.9	433	0.814	-1.3
Influence of community agencies (Factor 4)	3.5	0.8	3.3	0.9	433	0.054	-1.9
The influence of courts (Factor 5)	4.0	0.8	3.9	1.0	421	0.426	-0.8
The influence of workers and manager (Factor 6)	4.2	0.7	4.3	0.9	422	0.243	1.2
Parental factors (Factor 7)	4.0	0.7	3.9	0.7	415	0.797	-0.3

*All factors and value subscales are on a scale of 1-5, with a higher score meaning the respondent agreed more strongly with the issue. The case studies are scored between 1-3, with a higher score meaning the respondent answered in a more risk-averse way.

We then carried out a logistic regression analysis.[15] The following variables remained significant. Respondents from **LAs with increasing care rates were:**

- **Less likely to be against removing a child at risk from home** (subscale 1).
- **More risk averse** (case study 2 risk score).
- **Less confident that their LA keeps children safe and where possible, at home** (factor 1)**.**
- **Less likely to feel that their LA had the procedures in place to support the LA's vision of practice** (factor 3).

The demographic characteristics – age and whether they were a qualified social worker – were initially controlled in the model, but these made very little difference and were therefore excluded.

Differences in practice framework use

In addition to comparing LAs using these variables, we examined whether there were any significant differences in relation to practice frameworks; specifically, the reported use of Signs of Safety or the Outcomes Framework. This required a different type of test. Chi-squared tests look for differences in proportions between two categorical variables to see the difference is significant or not. Chi-squared tests (see Table 6) showed that 31.4% (n=22) of respondents from LAs with decreasing care rates stated they used the Outcomes Framework compared to 2.9% (n=12) in LAs with increasing rates and this difference was significant.[16] There were no significant differences in groups for Signs of Safety, with 15.3% (n=63) stating they use it in the increasing group and 17.1% (n=12) stating they use it in the decreasing group.[17]

Table 6: Proportion of respondents stating they used the Outcomes Framework or Signs of Safety

	Signs of Safety		Outcomes Framework	
	n	**%**	**n**	**%**
Increasing	63	15.3	12	2.9
Decreasing	12	17.1	22	31.4

[15] Full details are provided in Appendix D, Table D8.
[16] ($X^2(1, N=473) = 72.4, p<0.001$).
[17] ($X^2(1, N=473) = 0.1, p=.750$).

The high use of the Outcomes Framework was strongly associated with one of the two LAs in the decreasing care rates group.

Differences between leaders and workers

It was also possible to compare some elements of the analysis of leader/worker differences between LAs with decreasing and increasing care rates – though considerable caution is required in interpreting findings as there were only eight leaders in the LAs that were reducing care. Nonetheless, t-tests indicate that there is significantly greater agreement in values between workers and leaders in LAs with decreasing rates compared to those with increasing rates.[18]

Key findings

The study set out to answer three research questions:

1. What do those working within CSC see as the factors driving the increase in care rates?
2. What are the similarities and differences in the views, values and practice responses of leaders and workers?
3. What are the similarities and differences in the views, values or practices of workers and leaders in LAs with increasing care rates compared to those with decreasing care rates?

1: The views of the CSC workforce on factors driving care rates

We are reporting on the perceptions of the workforce in CSC, from which a strong picture of the system emerges. This means that, for example, on the factors driving increasing rates or the potential actions to reduce these, we are presenting one perspective among many in what is a complex system involving multiple agencies. The value of this perspective should not be underestimated, but nor should it be taken as impartial or objective.

[18] For subscale 1 (decreasing: t(60)= -1.6, p=.116; increasing: t(372)= -3.4, p= .001) and subscale 3 (decreasing: t(60)= -2.5, p=.017; increasing: t(370)= -3.7, p <.001).

There was a **high level of agreement that care rates are too high**. Respondents felt this was true for both the country as a whole and for their LA, and this view was even more strongly held in LAs with increasing rates of children in care.

A finding which might seem at odds with this is that most respondents (70%) also agreed that the "right" children are at home or in care. We suggest five factors could explain this apparent difference:

1. First, it is possible to believe that generally the right decisions are made, but that sometimes a child is in care who need not be and that cumulatively this makes the rate too high.
2. While individual decisions may be right, sometimes systemic or structural issues might be driving the increase in rates.
3. It can be difficult for respondents to assess current rates without having access to the data and being able to compare them to historic rates or rates elsewhere.
4. Respondents may also be influenced by social desirability bias – for instance, suggesting rates are too low could indicate they feel more children should come into care, which could be perceived negatively.
5. Finally, when asked what could help to reduce the number of children in care, respondents focused on the admission point rather than the length of stay or exit from care. Benbenishty et al.'s (2015) international study found that while social workers may be reluctant to receive children into care, they are also reluctant to send them home.

For **those working in CSC, the drivers of the increasing rates are multifaceted,** encompassing both what is happening for the families that they work with and the public service response to this:

- Respondents report **increased needs in families**, driven by societal issues (e.g. poverty and unemployment) and an increase in families with complex needs. Alongside this, they report an increased awareness of risks, and therefore an increase in those being identified as at risk.
- In part, respondents link the increase in need to the **lack of appropriate support from public services** (e.g. challenges accessing mental health services, or cuts in services to support families). This was connected to a sense of **inconsistency in how different agencies manage and respond to risk**.
- While all agencies were perceived to have an influence on rates, **judges and the courts** stood out as an important factor:

    - For some, it was specific practices, such as placing with parents or in the wider family under a care order.
    - For others it was more systemic – for instance, the introduction of timescales may have had the unintended effect of reducing the opportunity to give parents time to change and may therefore be limiting chances to return children home.
    - Some responses suggest a poor relationship between CSC and the courts; for example, courts being perceived to be critical of failures to bring children to court quickly enough, or respondents characterising the courts as a hostile environment.
- Finally, the **ways in which workers and managers within CSC make decisions and work with families was identified as a key influence**, and was also one of the areas most often identified for changes in the open-ended responses:
    - Overall, there was a picture across Wales of respondents feeling that their LA and its leaders were doing their best to help families and protect children.
    - Despite this, the central issue within CSC seemed to be the development of a **"culture of risk-averse practice"**. The perceived drivers for this were varied, including staff shortages, a focus on paperwork, and the influence of the media and the courts.
    - While most respondents said they used a practice framework, when asked to describe it there seemed a great deal of variation. Often what was described was not a framework and within LAs there was usually not much agreement between respondents about the practice frameworks being used – which suggests that often **no consistent framework was being used across the LA**.

Many of these factors were echoed in the **views on what should be done to reduce care rates**, with respondents identifying:

- A need for an **increased focus on early intervention and prevention**, both primary and secondary, and targeted support for families.
- A focus on **improving the workings of CSC**, from culture and practice to issues around workforce and management.

It is important to consider the nature of self-report data. Our data is comparatively strong where respondents are reporting on their own views and values. For instance, we can be fairly confident that most felt that care rates are too high in Wales and that we have captured key elements of their values. Their views may be less valid in

trying to explain underlying causes. For example, understanding what practitioners think may be driving changes in care rates is of interest in its own right, but ultimately the views given are just one perspective among many in what is a complex system that involves multiple agencies. More specifically, practitioners may be well placed to understand why children come into care based on their direct experiences, but less well placed to understand why care rates have increased or why they vary between LAs.

2: Comparison of leaders and workers

There were many agreements between workers and leaders, with both similarly positive about practice and support for practice within their LAs.

Differences were found in three main areas**:**

1) **Leaders were less likely to identify external factors as influencing care rates**. Thus, they saw cuts to support services, the impact of other agencies and the influence of courts as less important than workers did.
2) **Leaders were significantly more positive about children remaining in their birth family and less positive about care as an option** than workers.
3) **Leaders responded to case studies in a less risk-averse way**. They were more likely to believe children could be worked with at home and less likely to suggest removal.

3: Comparing LAs with increasing and decreasing care rates

Compared to those from LAs with increasing rates, respondents from LAs with **decreasing rates** were:

- More confident that their LA keeps children safe and, where possible, at home.
- Less likely to feel their LA has too many children in care.
- Have values that were more positive about birth families.
- Less risk averse in response to case studies.
- More likely to feel that their LA had the procedures in place to support the LA's vision of practice.

- More likely to use the Outcomes Framework.

There were also greater differences in the values of workers and leaders. In LAs with increasing rates, workers were less positive about birth families and more likely to be risk averse in response to case studies than leaders.

These major differences all relate to the workings of CSC itself. This confirms the sense that the differences in changes in care rates between LAs are likely to be due, at least in part, to differences in the practices of CSC. It also suggests that the other factors identified by respondents as influencing rates (e.g. increased need), may be issues for the country as a whole, but are unlikely to explain differences in changes in rates between LAs.

What are the implications of these findings?

The responses from LAs with decreasing care rates paint an encouraging picture. Those with decreasing care rates were more satisfied with practice in their LA. It could be argued that the trend of decreasing care rates leaves children at unacceptable levels of risk. This does not appear to be the view of those working in the services – they are *more positive* about the decisions being made. They were also more positive about the support they receive, such as in training and supervision.

There appears to be a difference in values and approaches to risk between LAs with increasing and decreasing rates. In LAs with decreasing care rates the values of workers were more positive about birth families. This was closely related to these workers being less likely to remove a child.[19] In addition, the values of leaders and workers were more closely aligned in these LAs. While numbers are comparatively small, our interpretation of this is that in services with increasing care rates there is a disconnect between the values and decision-making practices of leaders and those of workers. A challenge for leaders in LAs with increasing care rates may be finding ways to better align the views and approaches of their workers with their own values and beliefs about practice.

The survey findings do not offer ways to achieve this. However, the findings in relation to practice frameworks suggest an important element may be the use of frameworks. Using Signs of Safety did not seem to make a difference to whether rates were increasing or reducing. But there were differences in those who used the Outcomes Framework. More work is needed to understand this, but it does suggest that a coherent approach to using the Outcomes Framework may help LAs to reduce

[19] This was found for case study two (Dawn's story). There was also a tendency in this direction for case study one (Anna's story) but it did not achieve statistical significance, though the combination of the two case studies was significant.

care rates, and more generally that a combination of change in LA culture with the use of helpful tools of practice may make a difference.

Strengths and limitations of the research

Collecting data through a relatively brief online survey allowed us to obtain views from a large number of people in the CSC workforce. The number of respondents makes this one of the largest surveys of people working in social care undertaken in the UK, and it provides a breadth of responses that covers the whole of Wales as well as allowing us to compare leaders and workers. We are enormously grateful to the many workers who took time out of their busy schedules to share their views and to the heads of services who supported the study and encouraged their workers to complete it.

Yet the ability of the survey to obtain a large number of responses is related to one of its main limitations. Many of the responses were pre-coded and there was limited scope for more in-depth analysis of the open-ended questions. Furthermore, most of our measures were exploratory; there are not standardised measures for many of the issues we were interested in. For instance, this is the first time that responses to case studies have been used in this way (as far as we are aware). We therefore had to develop case study vignettes. These were partially successful in identifying differences in decision-making, but would benefit from further research to establish validity.

There are also challenges in knowing which comparison groups or outcome measures to choose for our analysis. Two issues are particularly important. First, our measures are probably only moderately or weakly good at capturing the concept they try to measure, because there is no easy way to measure many of these things. Second, there are likely to be many variables influencing care rates. Therefore, unpicking the specific contribution of, for instance, staff values is difficult because many other factors will be influencing care rates. The challenge is identifying true signals amidst the cacophony of other noises.

It is also important to emphasise that this analysis does not provide strong evidence on why care rates have been rising in recent years. The findings tell us what professionals think is influencing the rise in rates. The data is stronger on variations between LAs with reducing or increasing rates, as we can directly compare respondents from these groups.

Conclusions

There are many factors influencing care rates, and they interact in complicated ways that we do not understand well (Care Crisis Review, 2018). Factors also operate at different levels, in terms of Wales, the wider UK, and differences between Welsh LAs. Respondents to our survey reflect this complexity, identifying multiple factors possibly influencing rates and many potential ways to respond to the issue. Respondents conveyed a picture of a sector experiencing many external pressures on professionals and families. While many of these pressures have been identified in previous work, including the Care Crisis Review (2018), the practices of social workers and leaders within CSC, and their experiences of courts and Cafcass, have received little research attention.

Our findings highlight that courts were seen to have a tendency to reinforce risk-averse practice through criticism of social workers and a focus on agencies failing to protect children. Given these findings, it is encouraging that Family Drug and Alcohol Courts are being trialled in Wales. This approach is intended to take a more “problem solving” approach to court processes, and provide a different and potentially more constructive role for court involvement with families (Zhang et al., 2018; Meindl et al., 2019). We also note the helpful suggestions of the recent Public Law Working Group (2020) to address the increased rate of care proceedings.

We also found important similarities and differences between LAs with decreasing care rates compared to those with increases. The ratings and descriptions of external pressures on families and services were very similar, while there were significant differences in factors that were related to the internal workings of CSC. This included satisfaction with elements of the service and the values and practice decisions of respondents. This suggests that although all LAs experience multiple pressures that might lead children to be in care, they respond to them in different ways. Some LAs seem able to mitigate the various factors that drive increasing care rates.

LAs with decreasing rates showed a combination of better respondent satisfaction with LA decisions and support for practices such as training and supervision, more family focused values, and responses to case studies that were less likely to take children into care. As noted earlier, respondents in these LAs were more confident that the right children were being left at home. There was no indication that they felt children were being left in dangerous situations.

Furthermore, in those LAs with decreasing rates there was greater alignment of the values of workers and leaders about keeping children at home and whether care was a positive choice. This is important, because reducing care rates can sometimes be

seen as a technical problem that can be addressed, for instance, by implementing a particular evidence-informed intervention. Our findings remind us that decisions about children being in care are first about the values of workers and organisations. This is evidenced in the strong relationships we identified between values and decision-making in relation to the case studies.

However, it also highlights two areas where we suggest further evidence is needed:

1. **A better understanding of differences in the practices in LAs with decreasing compared to increasing care rates**. We identified differences in decision-making at the point of potential entry into care, which hint at more extensive differences. Decision-making takes place at myriad points, and we know little about how this or other elements of practice, such as direct work with families, may vary between LAs. Understanding this would require a more in-depth study that does not only rely on self-reported views and behaviours.
2. **How best to achieve changes in values and practices**. Our findings suggest that values and practices influence care rates. More closely aligned values and decision-making practices between leaders and workers, and a more coherent approach to using practice frameworks, may make a positive difference to reducing care rates. However, more work is needed to understand how and why these could make a difference.

This study does not provide simple solutions to the complex issue of how to reduce the need for children to be in care. We cannot quantify the differences in values into differences in care rates, and there are more questions than answers about how some LAs create values and practices focused on keeping children in their families more than others. Yet we did find differences within CSC that suggest that some of the very marked variations in care rates between LAs are related to the values and practices within LAs.

A key issue arising from this is about equity. We know that a child in Torfaen is five times more likely to be in care than one in Carmarthenshire, and this is just the extreme example of more general variation in rates between LAs. Our findings suggest that some of this difference is about different values and practices within LAs. This raises important questions about whether children and families are receiving consistent decisions and help across Wales.

While our study found a strong sense that the sector thinks care rates are too high, we cannot provide an answer to what might be done about this. Instead, we focus on some key questions. These include: whether we can discover more about how some LAs manage to reduce care rates despite the real and substantial challenges

experienced across the country; how LAs can learn from one another to ensure consistency and quality in services; and how leaders and others can help create change within CSC where that is needed.

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