Comparing long-term placements for young children in care: Does placement type really matter?

Dominic McSherry [a,*], Montserrat Fargas Malet [a], Kerrylee Weatherall [b]

[a] Centre for Evidence and Social Innovation (CESI), School of Social Sciences, Education and Social Work, Queen's University, Belfast, Northern Ireland BT7 1LP, United Kingdom
[b] Belfast Health and Social Care Trust, Children's Community Services Directorate, Belfast, Northern Ireland BT14 6AB, United Kingdom

ABSTRACT

This paper presents findings from the third phase of a longitudinal study, entitled Care Pathways and Outcomes, which has been tracking the placements and measuring outcomes for a population of children ($n = 374$) who were under the age of five and in care in Northern Ireland on the 31st March 2000. It explores how a sub-sample of these children at age nine to 14 years old were getting on in the placements provided for them, in comparative terms across five placement types: adoption; foster care; kinship foster care (with relatives); on Residence Order; and living with birth parents. This specifically focused on the development of attachment and self-concept from the perspective of the children, and behavioural and emotional function, and parenting stress, from the perspective of parents and carers. Findings showed no significant placement effect from the perspective of children, and a statistically weak, but descriptively compelling, effect from the perspective of parents. The findings challenge the notion of adoption as the gold standard in long-term placements, specifically from the perspective of children in terms of their parent/carer attachments and self-concept, and highlight what appears to be the central importance of placement longevity for delivering positive longer-term outcomes for these children, irrespective of placement type.

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1. Introduction

This paper presents findings from the third phase of a longitudinal study, entitled Care Pathways and Outcomes, which has been tracking the placements and measuring outcomes for a population of children ($n = 374$) who were under the age of five and in care in Northern Ireland on the 31st March 2000 (McSherry, Fargas Malet, & Weatherall, 2013). It explores how a sub-sample of these children at age nine to 14 years old were getting on in the placements provided for them, in comparative terms across five placement types: adoption; foster care; kinship foster care (with relatives); on Residence Order; and living with birth parents. This specifically focused on the development of attachment and self-concept from the perspective of the children, and behavioural and emotional function, and parenting stress, from the perspective of parents and carers.

1.1. Placing children in care - the Northern Irish context

When efforts to secure children's safety and wellbeing within their own families fail, the law in Northern Ireland makes provision for the responsible local government authority (i.e. a Health and Social Care Trust) to share parental responsibility with the parents

through a Care Order (*Children Order 1995, Article 50*). In these cases, children are placed in substitute care placements, including: kinship foster care (with relatives or friends), foster care, and residential care (primarily for teenagers). When reunification with the birth family is thought possible, children subject to Care Orders may be placed with their birth parents, pending satisfactory progress being made in terms of the Trust's concerns, with a consequent revocation of the Care Order. In some instances, kinship and foster carers may choose to apply to have the Care Order superseded by a Residence Order (*Children Order 1995, Article 8*), which effectively takes the child out of the care system and affords the carers shared parental responsibility with the birth parents. Children may also be adopted from care. Since the early 2000s, there has been a dramatic growth in the use of adoption for children in care in Northern Ireland (McSherry, Weatherall, Larkin, Fargas Malet, & Kelly, 2010). Under the *Adoption (NI) Order 1987*, parental responsibility transfers in the first instance to the Trust, and then subsequently to the adopters.

1.2. Outcomes for children in care

Children who are in care in the UK have been found to be: 10 times more likely to be excluded from school; 12 times more likely to leave school with no qualifications; four times more likely to be unemployed; 60 times more likely to join the ranks of the homeless; 50 times more likely to be sent to prison; and their own children are

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* Corresponding author.
E-mail address: doiminic.mcsherry@qub.ac.uk (D. McSherry).

66 times more likely to need public care than the children of those who have not been in care (DHSSPS, 2006; Mooney, Winter, & Connolly, 2016; Social Exclusion Unit, 2003; UK Joint Working Party on Foster Care, 1999). They are also more likely to have physical and mental health problems, and emotional and behavioural difficulties (Dixon, 2007; McCann, James, Wilson, & Dunn, 1996; McCarthy, Janeway, & Geddes, 2003; Meltzer, Corbin, Gatward, Goodman, & Ford, 2003; Ward, Jones, Lynch, & Skuse, 2002). High proportions of children in the care system have also been found to have low self-esteem and self-concept (Ackerman & Dozier, 2005; Gil & Bogart, 1982; Hicks & Nixon, 1989). Similar findings have been reported in the USA (Casey Family Services, 2005; Courtney & Barth, 1996; Courtney, Piliavin, Grogan, & Nesmith, 2001; Pecora et al., 2003).

When comparing how children in care progress relative to their non-care peers, the concept of 'outcome' is problematic. Statistics typically compare children who have been in care with the general population of children, rather than with children from similar backgrounds who have not been in care. Another issue is the fact that the care population is not a homogeneous group. There are children who enter care at a very young age and remain in stable long-term placements until adulthood and beyond, whilst some children only enter the care system as teenagers, perhaps as a result of deterioration in their behaviour that renders them beyond parental control. Thus, on a behavioural adjustment measure for example, the score for a recently entered teenager is less likely to be related to their experiences of the care system than it might be for a child who has been in care most of their life.

1.3. Adoption as a 'solution' to the 'problems' of care

Since the 1980s, domestic adoption of children from care has become a major long-term placement policy initiative across the different regions of the UK, a policy shared with the USA and Canada. However, it still remains a controversial long-term placement option, particularly because of the permanent severing of legal ties between children and their birth parents. Therefore, given the uncertainty that remains about the use of adoption for children in care, it is vital to discover if it makes a difference to the lives of these children, over and above what would be expected from a life spent in the care system, or leaving care and returning to live with birth parents.

The contemporary research base suggests that adoption delivers better outcomes than long-term foster care, with adoption providing higher levels of emotional security and sense of belonging (Triseliotis, 2002; Sinclair, Baker, Wilson, & Gibbs, 2005). In addition, adoptive placements are less likely to disrupt (Selwyn, Wijedasa, & Meakings, 2014). Yet, despite a body of research evidence suggesting that adoption is the de-facto gold standard in long-term placement for children in care, other research has challenged this assumption. Some researchers have argued that children growing up in long-term foster care have a strong sense of belonging to their foster family, similar to those who are adopted (Biehal, Ellison, Baker, & Sinclair, 2010; Schofield, 2002; Rushton, 2004).

This article focuses on whether placement type makes a difference across a range of outcomes, namely the children's attachment, self-concept, behaviour, and the parenting stress of their parents or carers. These measures do not provide a definitive account of longer-term outcomes for these children, and it is accepted that there may be a range of other outcomes measures that could potentially depict a different account to that being reflected in this article. However, it is our view that the aspects of life covered across the various dimensions of the four measures utilised in this study, do provide a strong indicator of comparative outcomes for children across different long-term placement types.

1.4. Children's attachments

Attachment, i.e. the ability to form secure and lasting relationships to a caregiver, is widely viewed as the bedrock upon which all future interpersonal relationships are founded (Aldgate & Jones, 2005; Belsky, Cassidy, & Baron-Cohen, 1994; Bowlby, 1951, 1969, 1973; Rutter, 1995). Security of attachment refers to the degree to which a child has internalised experiences based upon continuous exposure to significant others who are perceived as trustworthy, available, sensitive, and loving. The child requires a secure base to establish positive relationships, and this can be detrimentally affected by serial-attachment experiences, whilst frequent changes of caregivers may be painful and anxiety-provoking for the child (Thompson, 1998; Schofield & Beek, 2005).

The importance of stability for children in care, and the development of secure attachments, is a strong driving force behind efforts to have children adopted, so they do not 'drift' in care (Rowe & Lambert, 1973). However, others argue that care can actually provide children with the same degree of stability, and engender the same strength of attachment relationship with carers as might be expected in adoption, provided foster care is adequately resourced and carers and children properly supported (Biehal et al., 2010; Schofield, 2002). In fact, numerous research studies have found that the majority of children in care are able to form satisfactory attachment relationships with their new foster or adoptive parents (Rushton, 2003; Kaniuk, Steele, & Hodges, 2004; McSherry et al., 2013).

1.5. Children's self-concept

Children who have been abused or neglected, like many of those who enter the care system, are more likely to have poor self-esteem and self-concept because of feelings of incompetence and lack of support and encouragement from parents (Fischer & Ayoub, 1994; Harter, 1998; Kim & Cicchetti, 2009). High proportions of children in the care system have been found to have low self-esteem (Ackerman & Dozier, 2005), in part due to their early experiences of abuse and neglect (Asgeirsdottir, Gudjonsson, Sigurdsson, & Sigfusdottir, 2010; Chartier, Walker, & Naimark, 2009; Schofield, 2002), but also because of the 'negative stereotypes inflicted on them by society' (Martin & Jackson, 2002, p. 126). However, it has been argued that 'foster parents can have a positive and lasting effect on children's self-esteem' (Luke & Coyne, 2008, p. 403). In fact, some studies have revealed improvements in foster children's self-esteem and self-concept when their carers offered them acceptance, security, and sensitive parenting (Ackerman & Dozier, 2005; Schofield & Beek, 2005). As for adopted children, Juffer and van IJzendoorn (2007) found no difference in self-esteem between adoptees ($N = 10,977$) and non-adopted comparisons ($N = 33,862$) across 88 studies. This was equally true for international, domestic and transracial adoptees. Furthermore, Beckett et al. (2008) found that 'the ease with which children can talk about adoption does appear to be associated with higher self-esteem and the individual child's difficulties, as well as family composition' (p. 29).

1.6. Children's behaviour

The behaviour of children in care is often portrayed as problematic or challenging, mostly due to the range of difficult experiences they have endured from an early age. Extensive research has drawn attention to the prevalence of emotional and behavioural difficulties and mental health problems among children in care (Chartier et al., 2009; Dregan, Brown, & Armstrong, 2011; McCarthy et al., 2003; McSherry, Fargas Malet, McLaughlin, & Adams, 2015; Meltzer et al., 2003; Radford et al., 2011; Richards, Wood, & Ruiz-Calzada, 2006; Sempik, Ward, & Darker, 2008; Stein & Dumaret, 2011; Vostanis, 2010). It has been found that the incidence of these difficulties is higher among older than younger children (McSherry et al., 2015; Sempik et al., 2008), children who have experienced a greater number of placements (Pithouse, Lowe, &

Hill-Tout, 2004), and those who enter the care system later in life compared to those placed as infants (Richards et al., 2006). Significant majorities of children in foster care have been found to fall within the borderline or abnormal range on the SDQ Total Difficulties score based on parent/carer reports. This has been found to include as many as up to half (Dunne & Kettler, 2008; Egelund & Lausten, 2009) and as much as three-quarters (Milburn, Lynch, & Jackson, 2008) of the populations under investigation, suggesting that these difficulties may be having a significant impact on these children's lives.

Less is known about the prevalence of these difficulties for children who have been adopted from care. However, a growing body of research evidence suggests that some adoptive parents are facing significant relationship and behavioural difficulties, particularly during mid-to-late childhood and adolescence (Howe & Fearnley, 2003; O'Reilly, Bowlay-Williams, Svirydzenka, & Vostanis, 2016). Biehal et al. (2010) found that just over one-third of the children in their sample, who were either adopted or in stable long-term foster care, scored in the clinical range for behavioural and emotional difficulties, as measured by the SDQ, and that there were no significant differences between these two groups on this measure.

1.7. Parenting stress

It is widely accepted that some level of stress in parenthood is to be expected and is part and parcel of the 'costs and rewards of children' (Nomaguchi & Milkie, 2003). Parents or carers of children who have past experiences of the care system, or who remain within the care system, are faced with greater parental challenges than the norm. There is an expectation that when children come into care, their new care placement will 'provide compensatory experiences of care that enable their positive development' (Morgan & Baron, 2011; p. 21). Carers are also expected to manage relationships with birth family members, their own family tensions, the risk of placement disruption, the potential for complaints or allegations, and social work involvement (Wilson, Sinclair, & Gibbs, 2000). Several studies have found evidence of foster carers experiencing strain, anxiety and depression related to the stressors of the caregiving role stress (Lipscombe, Moyers, & Farmer, 2004; McSherry et al., 2013; Morgan & Baron, 2011; Schofield & Beek, 2005; Sinclair et al., 2005; Wilson, 2006). Kinship carers can have additional stressors (Whelan, 2003). Often, a child is placed in their care at a time of crisis and they have little or no time to prepare or to make the necessary lifestyle adjustments (Coakley, Cuddeback, Buehler, & Cox, 2007). Other stressors can include lack of financial resources; the ongoing, often fractious, relationship with the birth family; and its impact on the child, family members and family dynamics.

The parenting stress of adoptive parents is an under-researched area, but some studies have explored parental stress with adoptive parents who experience specific difficulties, such as parenting children with special needs, who have had institutional experiences, or those actively seeking support (Bird, Peterson, & Miller, 2002; Judge, 2004; McGlone, Santos, Kazama, Fong, & Mueller, 2002). In these studies, adopted children's behaviour is closely associated with their parents' stress levels, with parents of more troubled children experiencing higher levels of stress (Judge, 2003; McGlone et al., 2002). Additionally, the adoption of more than one child has been correlated with stress (Bird et al., 2002). Yet, in other studies, adoptive parents have reported relatively low levels of stress (Bird et al., 2002; Ceballo, Lansford, Abbey, & Stewart, 2004; Judge, 2003, 2004; Palacios & Sanchez-Sandoval, 2006).

1.8. Three waves of the care pathways and outcomes study

The first wave of this study (Multiple Placements: 2000–2003) focused on assessing the number of placements being provided to a population ($n = 374$) of young children in care over a two year period, and gathering baseline information to be used in survival analysis of the relationship between background factors and placement type. The second wave (the Carers' Perspective: 2003–2006) involved gathering the views of adoptive, foster, and birth parents for a sub-sample of the children in the study population ($n = 110$). Finally, the third wave (the Children's Perspective: 2006–2010) collected the direct views and experiences of a sub-sample ($n = 77$) of the young people (at that stage aged 9 to 14 years), who had been living in long-term placements (longer than three years), in addition to their parents and carers. The children were living in a range of placements: adoption, foster care, kinship foster care, on residence order, and living with birth parents (McSherry et al., 2013). This article reports on findings from the third wave, focusing on children's attachments, self-concept, behaviour, and the parents/carers' parenting stress.

2. Methodology

2.1. Design

The third wave of the study focused on the same population of children that had been followed in the first and second waves. Social service placement data was obtained and this provided placement data for the full study population on 31 March 2007. Most of the children had been in their placements for many years at that stage. This was considered an ideal opportunity to address the key research question as to whether or not there were differences in outcomes between children who had been provided with different long-term placements. As such, an attempt was made to recruit children and parents/carers from the five placement types, focusing specifically on those children who had remained in long-term placements (longer than three years). A sub-sample of 135 (36% of study population) children were selected for recruitment, with a view to interviewing 70–75 children, approximately 11–15 in each placement type. This was to ensure a balance between the collection of quantitative and qualitative data, thus avoiding qualitative data saturation, whilst at the same time ensuring that the comparison groups were sufficiently large enough to enable appropriate inferential statistical analysis.

2.2. Recruitment

An initial letter asking parents/carers if they would be willing to receive an invitation pack for the study was written by the research team and sent by the relevant local authority to be forwarded to the families selected for recruitment. A passive consent approach was initially used, and the letter informed parents/carers that they should ring a specified representative in the authority if they did not consent to the research team receiving their contact details. Families who had not opted out were sent an invitation pack with information about the study and what would be involved if they agreed to take part. If they did agree to participate, parents/carers were asked to call a free phone number within a two-week period so that a first interview could be scheduled. Where parents/carers did not contact the research team within the two-week period, direct calls were made to enquire as to whether or not they had received the invitation pack and if they were willing to participate in the study.

2.3. Data collection

Data were collected using quantitative and qualitative methods with the children and their parents/carers. This paper will focus exclusively on the quantitative data. Interviews took place in the family home. Parents/carers completed the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) and the Parenting Stress Index-Short Form (PSI/SF) (Abidin, 1990). Children completed the Piers-Harris Self-Concept Scale 2 (Piers & Herzberg, 2002), and the Inventory of Parent and Peer Attachment – Revised

(IPPA-R) for children (Gullone & Robinson, 2005). The children completed the IPPA-R by playing a board game, and the Piers-Harris using a post-box game. Both these games were developed by the research team (McSherry et al., 2013).

2.4. Instruments

2.4.1. The Inventory of Parent and Peer Attachment – Revised version for children (IPPA-R) (Gullone & Robinson, 2005)

The original IPPA (Armsden & Greenberg, 1987) was developed to measure the positive and negative affective and cognitive dimensions of adolescents' relationships with their parents and close friends and how well these figures serve as sources of psychological security. The IPPA-R is appropriate for use with children aged between 9 and 15 years. Gullone and Robinson (2005) provide support for the reliability and validity of the revised measure. It contains two scales: 28 items assessing parent attachment and 25 items assessing peer attachment. Whilst completing the parent section of the measure, the children were reminded that these questions were focused on the parents or carers with whom they currently lived.

Respondents are required to rate the degree to which each item is true for them on a three-point scale: "always true", "sometimes true", or "never true". The items in each of the two scales cluster into three factors: *Trust* – the degree of mutual understanding and respect in the attachment relationship; *Communication* – the extent and quality of spoken communication; and *Alienation* – feelings of anger and interpersonal alienation. Although the measures does include items on peer attached, for reasons of brevity this article focuses solely on parent/carer attachment.

2.4.2. The Piers-Harris Self-Concept Scale 2 (PH-2) (Piers & Herzberg, 2002)

This standardised self-report questionnaire, which is a modification of the 1984 Piers-Harris Children's Self-concept Scale, examines self-concept in children aged 7–18. It is based on the child's own perceptions about themselves rather than the observations of parents or teachers. It is composed of 60 items and yields a general measure of the respondent's overall self-concept, but also includes six domain scales: *Physical Appearance and Attributes* – measures a child's appraisal of her/his physical appearance, as well as attributes, such as leadership and the ability to express; *Intellectual and School Status* – represents the child's self-assessment of intellectual abilities and academic performance, general satisfaction with school and future expectations about achievement; *Happiness and Satisfaction* – assesses general feelings of happiness and satisfaction with life; *Freedom from Anxiety* – assesses anxiety and dysphoric mood; *Behavioural Adjustment* – represents the child's admission or denial of problematic behaviour in home or school settings; and *Popularity* – represents a child's evaluation of his/her social functioning, including perceived popularity, the ability to make friends, and inclusion in activities such as games and sports. In addition, two validity scales identify biased responding and the tendency to answer randomly. Children complete the 60-item scale by responding yes or no to the statements. It is widely used and has good reliability and validity (Jeske, 1985; Piers, 1984; Piers & Herzberg, 2002).

Interpretation of scores on the Piers-Harris total self-concept measure are in the following range: very low (≤2% of population); low (3–14%); low average (15–28%); average (29–71%); high average (72–83%); high (84–97%); and very high (≥98%). Whilst on the different domains of the measure, the range is as follows: very low (≤2%); low (3–14%); low average (15–28%); average (29–71%); and above average (≤72%). Given the size of the comparison groups in this study, it was considered more appropriate for the presentation of results to re-categorise the total self-concept range from seven to three dimensions. These are: low (combining very low, low and low average scores, ≤2–28%); average (representing the original average range, 29–71%); and high (combining high average, high and very high scores, 72–≥98%). Similarly, the domains range was

re-categorised from five to three dimensions. These are: low (combining very low, low and low average, ≤2–28%); average (representing the original average range, 29–71%); and high (representing the original above average range, ≥72%).

2.4.3. The Strengths and Difficulties Questionnaire – SDQ (Goodman, 1997)

This is a commonly used behavioural screening questionnaire for assessing psychological morbidity in children and adolescents, as perceived by their parents/carers. It is composed of 25 items divided into five scales of five items each, including: *Emotional Symptoms*; *Conduct Problems*; *Hyperactivity/Inattention*; *Peer Relationship Problems*; and *Prosocial Behaviour*. A total difficulties score is based on the combined scores of each of the scales, with the exception of the prosocial scale. Scores can be classified as normal, borderline or abnormal. Approximately 10% of a community sample scores within the abnormal range on any given domain, with a further 10% in the borderline range. The SDQ has adequate discriminant and predictive validity (Goodman, 1997; Goodman & Scott, 1999). It correlates highly with the Rutter Questionnaires (Goodman, 1997) and with the Child Behaviour Checklist, although it has been considered more sensitive in detecting inattention and hyperactivity, and equally effective in detecting internalising and externalising problems (Goodman & Scott, 1999). The reliability and validity of the SDQ make it a useful brief measure of the adjustment and psychopathology of children and adolescents (Goodman, 2001).

2.4.4. The Parenting Stress Index – Short form – PSI/SF (Abidin, 1990)

This is a measure for stress in the parent–child relationship. It contains 36 items divided into four sub-scales: *Defensive Responding* – assesses the extent to which the respondent attempts to minimise indications of problems or stress in the parent–child relationship and to present a favourable impression of themselves; *Parental Distress* – determines the distress an individual is experiencing in his or her role as a parent, as a function of personal factors related to parenting, such as impaired sense of parenting competence; stresses associated with the restrictions placed on other life roles; conflict with the child's other parent; lack of social supports; and presence of depression; *Parent–Child Dysfunctional Interaction* – represents parent/carer perception that their child does not meet their expectations and that the parent-child interaction is not rewarding; and *Difficult Child* – indicates parent/carer perceptions of child difficulty based on child characteristics including temperament, defiance, compliance and degree to which the child's behaviour is demanding. The measure provides a total stress score in addition to a score for each of the sub-scales. The normal range of scores is within the 15th to the 80th percentiles. Abnormally high scores are considered to be those at or above the 85th percentile. The PSI/SF was administered by a researcher. Each item was read out to the participants who then indicated their preferred response, which could be either strongly agree, agree, not sure, disagree, or strongly disagree.

2.5. Sample

Of the 135 children selected for recruitment, 77 were recruited to the study across the five placement types (See Table 1). However, seven of these children only participated in the qualitative aspect of the study, due to a number of placement breakdowns during the data collection phase, a child being deemed developmentally incapable of completing the quantitative data collection activities, and a parent not wanting the researchers to speak directly to the child, but being happy to contribute a parental perspective. Hence, the data presented in the Results section was gathered from 70 children (IPPA-R and Piers-Harris), and 72 parents/carers (SDQ and PSI-Short Form).

All interviews were conducted between March 2009 and January 2010, when the children were aged between 9 and 14 years old. A profile of the children at the time of interview, across the five placements, is presented in Table 2. As shown, most children had been in their

Table 1
Families recruited for interview.

Placement	Selected for recruitment	Recruited	% of recruitment	% of population
Adoption	30	18	60	13
Foster care	24	19	79	25
Kinship care	30	13	43	43
Residence order	21	15	71	71
Birth parent/s	30	12	40	40
Total	**135**	**77**	**57**	**21**

placements for many years. Those children in adoptive placements and on residence order entered their placement on average at a younger age than those in foster care, kinship foster care, and living with birth parents, and consequently had spent a longer period of time in their placements.

2.6. Analysis

One-way Analysis of Variance (ANOVA) enabled a comparison of the extent of variation in mean scores between the different placement groups across the range of measures applied with parents/carers and children. In terms of post-hoc analysis between the different groups, Tukey's HSD (honestly significant difference) test was applied. Most researchers tend to assess the power of their statistical tests using $\pi = 0.80$ (alpha = 0.05, two-tailed) as a standard for adequacy. The SAS Institute (2003) advised that 'to achieve a minimum of 80 per cent power (in a one-way ANOVA), 11 units per groups would be needed'.

Within this study, 70 children across the five placement groups completed the Piers-Harris and the IPPA-R measures. These were: 16 in foster care, 17 adopted, 14 on residence order, 12 in kinship foster care, and 11 living with birth parents. Furthermore, 72 parents/carers across the five placement groups completed the Parenting Stress Index (PSI) and Strengths and Difficulties Questionnaire (SDQ). These were: foster carers for 16 children, adoptive parents for 18 children, residence order carers for 14 children, kinship foster carers for 12 children, and birth parents of 12 children. These figures meet the unit-threshold specified by the SAS Institute (2003) for 80 per cent power.

2.7. Ethical considerations

Two separate ethical applications were made to the Office for Research Ethics Committees in Northern Ireland (ORECNI) in relation to this phase of the study. The first was made regarding gaining access to the placement data that was required to specify the placement profile for the population, which, in turn, allowed for the identification of the interview sub-sample. The second focused on the methodology for the interviews with children and their parents/carers. Both applications received favourable opinions.

Parents/carers consented for themselves and their children to take part. However, during each visit, written consent was sought from parents/carers and the children themselves. Each person was required to sign a consent form (one for parents/carers and one for children). It

Table 2
Profile of interviewed children (years and months).

Placement	Average age entered current placement	Average time in current placement
Adoption	1 yr 8 mts	10 yrs 1 mt
Foster care	4 yrs	8 yrs 5 mts
Kinship care	3 yrs 5 mts	8 yrs 11 mts
Residence order	1 yr 5 mts	10 yrs 3 mts
Birth parents	4 yrs 6 mts	8 yrs 3 mts

was envisaged that if children became upset during data collection, the interview would stop and children would be given the option to continue, to re-schedule the interview for another day, or to withdraw from the study. However, this situation never emerged.

3. Results

3.1. Children's attachments

In addition to allowing for the depiction of overall parent and peer attachment scores, Armsden and Greenberg (1987) established a system for categorising scores on the IPPA as indicative of either low or high security. This was based upon a re-categorisation of scores across the *Trust*, *Communication* and *Alienation* domains as low, medium or high scores. These categories were created by dividing the range of the children's scores into three equal segments. Certain combinations of these scores across the different domains were considered to be indicative of either low or high security of attachment. This categorisation system was applied in the current study, and it was found that five children had scores that indicated low security of attachment with parents/carers: one adopted child; one child living with birth parents; one foster child; and two children on residence order. No children in the kinship care group received a low security of attachment on the IPPA-R. This indicated that the vast majority of children in the sample were securely attached to their parents/carers.

There was no significant variation in mean score between the five placement groups on any of the dimensions of the IPPA-R for parent/carer attachment. Additionally, there were no significant mean differences between any of the five care placement groups on any of the dimensions. However, the distribution of low, medium and high scores across the different domains did depict a pattern that was deemed worthy of comment, and this is displayed in Table 3.

As Table 3 illustrates, the vast majority of children scored highly in terms of *Attachment to Parent/Carer*, irrespective of placement type. Only a small percentage in each of the groups had a low score. Regarding the parent/carer *Trust* dimension, the vast majority of children in each of the placement groups scored highly for parent/carer, with the adoption group showing the lowest proportion of children scoring highly. In terms of the *Communication* sub-scale, with the exception of the residence order group, over half the children across the placement groups scored highly, with the proportion being greatest in the foster care group, and a low proportion had low scores. Finally, in relation to the *Alienation* dimension, the vast majority of children in each group had low scores (indicating positive relationships with parents/carers), with the birth parent group having the smallest proportion. Table 3 also illustrates that the pattern of distribution of low, medium and high scores was very similar across the five placement groups.

3.2. Children's self-concept

There was no significant variation in mean scores between the five placement groups on any dimension of the Piers-Harris, including *Total Self-Concept*. Additionally, there were no significant mean differences between any of the five placement groups on any of the dimensions. Although no significant differences were found, as was the case in relation to parent/carer attachment, the distribution of scores across the different domains did depict a pattern that was deemed worthy of consideration, and this is displayed in Tables 4a and 4b (which split the dimensions of the measure purely for presentational purposes).

In relation to *Total Self-Concept* scores, the largest proportion of children with scores indicating high self-concept was in the kinship care group, whilst the residence order group had the highest proportion of children with scores indicating low self-concept. In terms of *Behavioural Adjustment*, there was a difference between the kinship care and birth parent/s groups, with only 10% in the birth parent/s group having a high score, compared with 66% in the kinship foster care group.

Table 3

Placements by IPPA-R Attachment to Parent/Carer and subscales Trust, Communication and Alienation on the low/medium/high score range (%).

	Attachment to parent/carer			Trust			Communication			Alienation		
	Low	Med	High	Low	Med	High	Low	Med	High	High	Med	Low
Adoption	6	24	70	4	18	76	6	41	53	0	18	82
Foster care	0	31	69	0	12	88	6	31	63	6	19	75
Kinship care	0	25	75	8	0	92	0	42	58	0	17	83
Residence order	14	21	64	7	7	86	7	57	36	8	21	71
Birth parents	9	18	73	9	0	91	0	45	55	9	27	64

However, most of the children in the birth parent/s group had scores within the average range. The patterns were very similar for the foster care and residence order groups, with both having relatively high proportions of children scoring low and relatively small proportions scoring highly.

The pattern of distribution of low, average and high scores on *Intellectual and School Status* was similar for the adoption, residence order, foster care, and birth parent/s groups, with a relatively even distribution of low, average and high score (with the adopted group having a larger proportion of average scores). However, the pattern of distribution of scores for the kinship care group was slightly different, with no children having low scores on this dimension, and a relatively large percentage (58%) having high scores.

There was some variation among the groups in terms of the distribution of low, average, and high scores on *Physical Appearance and Attributes*. For the kinship care group, no child had scores that indicated a low score on this dimension, but only a small proportion had high scores. In contrast, the birth parent/s group had a small proportion of children scoring low, but 50% of the group scoring highly. The adoption, foster care, and residence order groups had a reasonably similar pattern of distribution of low, average, and high scores, with a larger proportion of high scores in the foster care group, and a larger proportion of low scores in the adoption group.

The pattern of distribution of scores on the *Freedom from Anxiety* dimension were very similar for the adoption, kinship care and birth parent/s groups, with a relatively even split between average and high scores. The foster care group had the highest proportion of children scoring highly on this dimension. As for the *Popularity* dimension, the pattern of distribution of scores were quite similar for the adoption, foster care, kinship care, and birth parent/s groups, with relatively even splits between average and high scores. However, for the residence order group, only small proportions of children had high and low scores, and a large proportion had average scores on this dimension. Regarding the *Happiness and Contentment* scores, the adoption, foster care, kinship care, and birth parent/s groups had a reasonably even distribution of average and high scores. In contrast, only a small proportion of the children in the residence order placement group had high scores on this dimension, with the vast proportion having average scores.

3.3. Children's behaviour

There were no significant variations in mean scores or significant mean differences between the five placement groups on any dimension of the SDQ. However, as was the case in relation to the two measures used with the children, the pattern of distribution of scores was deemed worthy of comment, and is depicted in Table 5.

As shown in Table 5, the proportion of children in some of the groups in this study that scored above the clinical threshold for *Total Difficulties* was high, particularly those living with birth parents (50%) and in foster care (44%). In contrast, smaller percentages of children in the adoption (28%), kinship care (25%) and residence order (14%) groups scored above the threshold. Similar to the results for the *Total Difficulties*, nearly half the children in the foster care and birth parents groups scored within the abnormal range for *Emotional Symptoms*. In terms of *Conduct Problems*, the contrast between the groups was less stark than before, with the proportion of children scoring above the threshold ranging between 21 and 50%. In relation to mean scores, the birth parent and kinship care groups had the highest proportion of children in the abnormal range, whilst the residence order group had the lowest proportion.

In terms of *Peer Relationship Problems*, the proportion of children scoring above the threshold was relatively low in the kinship care and residence order groups, with the adoption and foster care groups showing the highest proportions. Most children across all the groups scored in the normal range regarding *Prosocial Behaviour*, with only small proportions of children in foster care and kinship care having abnormal scores. Finally, regarding *Hyperactivity*, a third of children within most of the groups (adoption, kinship care and birth parents) had scores in the abnormal range, with a smaller proportion of children on residence order having similar scores. However, the largest proportion of children in the abnormal range on *Hyperactivity* was in the foster care group.

3.4. Parent/carer stress

There was no significant variation in mean scores between the five placement groups on PSI total stress, and the PSI difficult child and parent–child dysfunctional interaction subscales. Additionally, there were no significant mean differences between any of the five placement groups for these same subscales. However, significant differences were found for parental distress, including:

- a significant variation in parental distress mean scores across the five placement groups, $p < 0.05$;
- significant differences between the birth parent group and the adoption, $p < 0.05$, kinship care, $p < 0.05$, and foster care, $p < 0.05$, groups.

Although significant differences were only found on the parental distress dimension, the pattern of distribution of scores across the five

Table 4a

Placements by Piers Harris total self-concept and three subscales on the low/average/high score range (%).

	Total self-concept			Behavioural adjustment			Intellectual and school status			Physical appearance		
	Low	Av	High	Low	Av	High	Low	Av	High	Low	Av	High
Adoption	12	41	47	12	47	41	23	59	18	35	47	18
Foster care	19	50	31	37	44	19	38	38	24	12	50	38
Kinship care	0	42	58	17	17	66	0	42	58	0	75	25
Residence order	36	36	28	43	36	21	35	29	36	28	43	29
Birth parents	10	40	50	20	70	10	30	40	30	20	30	50

Table 4b
Placements by three Piers-Harris sub-scales on the low/average/high score range (%).

	Freedom from anxiety			Popularity			Happiness and contentment		
	Low	Av	High	Low	Av	High	Low	Av	High
Adoption	5	47	47	12	41	47	5	47	47
Foster care	19	19	62	7	31	62	0	37	63
Kinship care	0	50	50	0	42	58	0	42	58
Residence order	29	29	42	21	57	22	0	71	29
Birth parents	0	60	40	0	60	40	10	30	60

placement groups on all dimension of the PSI were considered worthy of consideration, and these patterns are depicted in Table 6.

As shown in Table 6, high proportions of parents/carers across the five placement groups were experiencing clinical levels of parenting stress. Although differences on *Total Stress* were not significant, scores are relatively high for birth parents (50%), foster carers (44%) and kinship carers (33%). Similarly, large proportions of parents/carers were experiencing clinical high levels of parenting stress as a result of the child being difficult to manage. However, the proportion of residence order carers scoring above the clinical range for *Difficult Child* (21%) was half that in the kinship carer and birth parent groups (42%). In terms of *Parent-Child Dysfunctional Interaction*, the proportions of parents/carers scoring in the high/clinical range were not as large on this sub-scale in comparison to the previous subscales discussed, but still highest in the foster care (19%) and birth parents (33%) groups. Finally, the scores across the groups for *Parental Distress* were generally low apart from the birth parent group, with half the parents in that group registering scores in the high/clinical range, whilst no adoptive parents had a clinically high parental distress score.

4. Discussion

4.1. Children's attachments

Most of the children in this study, irrespective of placement group, received high security of attachment ratings to their parents/carers, and the pattern of distribution was very similar across the placement groups. This suggests that attachment relationship for these children were operating independently of placement type. Triseliotis (2002) commented that adoption provides higher levels of emotional security and a stronger sense of belonging than long-term foster care, whilst Sinclair et al. (2005) found that adopted children did better than children in long-term foster care on most outcome variables. The findings of this study do not concur with this view in relation to the development of attachment with parents/carers, so what might explain this seemingly surprising finding? It could be argued that the results are surprising because this type of comparative longitudinal research is very uncommon. Rushton (2004) noted the lack of research in this area and the need to compare adoption with other long-term placement options. Over the last decade, the comparative research base has not been extended to any significant degree. Consequently, the research findings presented in this paper offer the first longitudinal comparison of a range of long-term placements for young children in care.

The key aspect that these placements had in common, across the five placement types, was their lengthy duration. Most of the children had remained in these placements from a very young age (see Table 2 in the Methodology section), and as was evidenced during the interviews with children and their parents/carers (McSherry et al., 2013), this had enabled the formation of new and lasting attachments to their new parents/carers, irrespective of the social or legal definition associated with the placement itself.

4.2. Children's self-concept

The findings indicated that most of the children, irrespective of placement group, scored within the average or high range, across all dimensions. In terms of the development of their self-concept, these children were doing as well as, and in some instances better than, their non-care peers (on the basis of their comparative performance on this standardised test). This may be a profile that, in terms of the current research base, would have been expected for the adopted group, but perhaps not either of the care groups (foster and kinship), or the birth parents group, where concerns have been raised regarding the capacity of this type of placement to meet the developmental needs of children (Biehal, 2006; Fargas et al., 2014; Farmer, Sturgess, O'Neill, & Wijedasa, 2011; Thoburn, Robinson, & Anderson, 2012). So, how can this be explained?

Again, it may be that longevity is at the core of these generally positive outcomes. Research suggests that children who receive affection, acceptance, safety, and assistance from their parents/carers, are more likely to show high levels of self-esteem and self-concept (DeHart, Pelham, & Tennen, 2006; Kim & Cicchetti, 2003). All the children who were interviewed for the current study were in stable long-term placements since infancy. The interview data indicated that these relationships were mostly underpinned by mutual love and affection. It would appear, therefore, that the support, encouragement, love and affection that has been provided by the parents/carers over many years may have helped, in most cases, mitigate against any more negative and self-defeating early experiences these children may have had, irrespective of placement type.

4.3. Children's behaviour

The current study highlighted that there were no significant differences between means scores on the different dimensions of the SDQ across the placement groups. Some of the adopted children were viewed by their parents to be just as problematic in behavioural

Table 5
Percentages of children across the placements groups within the abnormal range on SDQ Total Difficulties and other subscales.

Placement	Total difficulties	Emotional symptoms	Conduct problems	Peer relationship problems	Prosocial behaviour	Hyperactivity
Adoption	28	28	28	28	0	33
Foster care	44	44	44	25	12	56
Kinship care	25	17	50	8	17	33
Residence order	14	14	21	7	0	21
Birth parents	50	42	50	17	0	33

Table 6
Percentage of parents/carers across the placement groups within the high/clinical range on PSI Total Stress; Difficult Child; Parent-Child Dysfunctional Interaction; and Parental Distress (%).

Placement	Total stress	Difficult child	Parent-child dys. interaction	Parental distress
Adoption	22	33	6	0
Foster care	44	31	19	6
Kinship care	33	42	8	8
Residence order	21	21	7	14
Birth parents	50	42	33	50

terms as children in the other placement groups. These findings substantiate the view that adoption should not be seen as a panacea for early adversity, and that a large minority of these children experience impairments in their socio-emotional development, and display challenging behaviours (Biehal et al., 2010; Howe, 1997, 1998; Quinton, Rushton, Dance, & Mayers, 1998; McSherry et al., 2013; Rees & Selwyn, 2009; Selwyn et al., 2014; Thoburn, 1991). The fact that as many as one fifth of the adoptive parents rated the behaviour of their children within the abnormal range, twice as high as would be expected with a community sample, reveals that some may be struggling to maintain these placements, and that the love and commitment they have for their children is being sorely tested.

These findings are similar to Selwyn et al.'s (2014) survey results, which indicated that a quarter of adoptive parents with teenagers are managing very challenging behaviours, and are struggling to get support. Thus, there is a need for those adoptive parents who are facing significant challenges to be afforded the opportunity to avail of support, be that for the children in the form of therapeutic support, or for themselves in the form of additional training or counselling/support services. Currently in Northern Ireland, beyond the provision of logistical support in relation to court-mandated contacts with birth family members, there is no statutory provision of post-adoption support for adoptive families. However, it is hoped that the new adoption legislation that is currently being drafted by the Northern Irish Department for Health will formalise the provision of statutory post-adoption support for both adoptive parents and their children.

Although there were no significant difference between the groups, over 40% of children in foster care fell within the abnormal range on the SDQ, twice as many as within the adopted group. These findings are consistent with those found in a recent cross-sectional study examining the physical and mental health of children and young people in care in Northern Ireland (McSherry et al., 2015), and from other jurisdictions (Chartier et al., 2009; Dregan et al., 2011; McCarthy et al., 2003; Meltzer et al., 2003; Radford et al., 2011; Richards et al., 2006; Sempik et al., 2008; Stein & Dumaret, 2011; Vostanis, 2010). The findings are not surprising given that children in long-term foster care tend to be older when they enter the care system (McSherry et al., 2010), and thus are more likely to have been exposed to early adversity in the home than adopted children; and being older at entry, they tend to spent shorter periods of time in placement (as reflected by the findings presented in Table 2).

The worst profile of all in terms of SDQ score came from the birth parents. Half of the children in that group fell within the abnormal range. These children were comparatively the oldest when they returned to their current placement with birth parents, and had the shortest placement duration (Table 2). Although most of the children were securely attached to their parents and had positive self-concept, the birth parents perceived their behaviour disproportionately negatively compared with the other parent/carer types. This would suggest that when efforts are made to have children returned home early, there are continuing pressures on these placements that

impact negatively on parents, even if the children are functioning normally, and these may have the potential to weaken the security of the placement themselves. These findings suggest that every effort should be made by social services to ensure that when children do return home from care, and particularly when care orders are revoked, these placements continue to be supported.

4.4. Parenting stress

The findings from the current study regarding parenting stress reflect the findings in relation to the child's behaviour, i.e. there was a lower level of clinical need with the adoptive and residence order groups, compared with the kinship foster care, foster care, and birth parent groups. This would suggest that birth parents and foster carers face greater challenges than other parents/carers in their parenting role. Regarding birth parents, social services should ensure that these families are sensitively supported when the child returns home. The previous phase of the study had highlighted the range of difficulties experienced by this group of parents (McSherry et al., 2008). A recent cross-sectional study has examined the experiences of these families when children return home from care. This study highlighted a poor social support network for these parents, and a reticence to seek support from social services for fear of the child being taken into care again(Fargas Malet, McSherry, Pinkerton, & Kelly, 2014).

Foster carers (44%) and kinship foster carers (33%) were also found to have high levels of clinical stress. This may reflect the fact that the children that they were caring for were older than those in adoption and on residence order when they were first placed, and had not been in placement as long (see Table 2). In these circumstances, there would have been an increased likelihood of the child coming to placement with challenging issues. It appears counter-intuitive that those parenting within the confines of a formal care system, i.e. foster carers, would have much higher stress levels than those parenting without formal social service support, i.e. adoptive parents. However, as highlighted in the introduction, these carers might have additional stresses built within their role (Carbone, Sawyer, Searle, & Robinson, 2007; McSherry et al., 2013; Wilson et al., 2000) than other parents/carers do. Thus, greater efforts should be made by social services to examine the level of stress being experienced by foster carers and kinship foster carers when caring for these children, and to provide appropriate guidance and supports on the basis of those findings. Critically, this would help ensure that long-term placements, particularly in instances where the children are securely attached to the carers and have positive self-concept, do not break down due to the carers being highly stressed and feeling unsupported in their caring role.

Adoptive parents and those with children on a residence order had the lowest levels of clinical stress in this study, which is consistent with other research evidence (Judge, 2003, 2004; Palacios & Sanchez-Sandoval, 2006), and earlier findings from the previous wave of the current study (McSherry et al., 2008). However, it needs to be recognised that although lower than the levels observed in other placements, the level of clinical need was still higher than would be expected within a community sample, representing one in five adoptive parents. Thus, there is an onus on social services to ensure that they receive the support that they clearly need.

4.5. Study limitations

This study has a number of potential limitations. The first is the numbers of children and parents/carers who were interviewed. Although the numbers in each comparison group were appropriate for one-way ANOVA and subsequent post-hoc tests, assessing the power of the statistical tests using $\pi = 0.80$ (alpha = 0.05, two-tailed) as a standard for adequacy (SAS Institute, 2003), larger numbers of children and parents/carers would have increased statistical power. As such, an effort

will be made in the next wave of the study to significantly increase the study sample.

Secondly, although 135 families were identified to participate in the study, the research team had no control over which children and their parents/carers would decide to participate. Although non-participation was due in some instances to technical difficulties in the recruitment process (i.e. no current address, no answer to telephone calls, and the local authority being unable to locate telephone number), there were a number of cases where the families had directly declined to participate. It is not clear why these families declined to participate and it might be argued that they represent those families that were experiencing severe difficulties, thus skewing our sample towards those families where there may have been fewer difficulties. However, it could also have been the case that some parents and carers would have been reluctant to take part because their child was settled and content, and would have been wary of the potential unsettling impact of the interviews, particularly given the sensitivity of their content. The findings that are presented here clearly indicate that the families that did agree to participate in the study were themselves experiencing a range of difficulties, suggesting that an appropriate range of circumstances were represented across the various placements.

5. Conclusion

A key focus of the Care Pathways and Outcomes study is to ascertain whether or not young children in care fare differently in the longer-term depending on the placements provided for them. The findings highlighted in this paper have shown no evidence of a placement effect in terms of the outcomes for children (i.e. attachment and self-concept), and a statistically weak, but descriptively compelling, placement effect in terms of outcomes for parents/carers (i.e. children's behaviour and parenting stress). On one hand, most of the children had a strong sense of security of attachment with their parents/carers, and had developed a positive self-concept, irrespective of placement type. On the other hand, the birth parents of children who had returned home and foster carers considered the children's behaviour to be problematic, and were clinically stressed, to a greater extent than adoptive parents and carers with children on a residence order.

So, does placement type matter? The answer is that it would appear to depend on the outcomes being measured and the source of the data. If outcome data is collected from children regarding their parental/carer attachment and self-concept, then it would appear that placement type does not matter. The findings indicate that the children were mostly securely attached with positive self-concept across the different placements. However, if outcome data is collected from parents and carers regarding the children's behaviour and their own parenting stress, then adoption and the use of residence orders do appear to deliver more positive outcomes. The particular challenges being faced by long-term foster carers and the birth parents of children who return home require serious and thoughtful consideration and action by social services.

It would also appear that, specifically in relation to attachment to parents and carers, and child self-concept, adoption is not necessarily the gold standard in terms of delivering positive long-term outcomes for children in care. Instead, it may be more appropriate to define placement longevity as the gold-standard. These were all very long-standing placements, and the benefit that type of longevity brings was clearly accrued by the vast majority of the children, irrespective of the social and/or legal definition of the placement and/or legal authority of their parental/carer relationships. If Sinclair et al.'s (2005) categorisation of permanence in foster care is applied, these findings appear to suggest that *subjective permanence* (child's perception of belonging to the family) is likely to occur when there is *objective permanence* (child is settled in placement long-term). Of course, different outcome measures may have produced a different perspective, as was the case with the SDQ and PSI measures completed by the parents and carers. This emphasises the importance of specifying what type of outcomes are under consideration when conducting outcome research and from whose perspective.

The findings also present an unexpectedly positive story. As highlighted in the introduction, the main thrust of outcomes research, and media commentary, regarding children in care is often negative. However, the findings presented in this paper were generally positive in terms of the children's attachments and their self-concept. Commenting on this issue, Hare and Bullock (2006, p. 26) noted that poor outcomes for looked after children 'are often emphasised at the expense of good ones and pejorative stereotypes can prevail'. Much of the problem appears to stem from the characterisation of the care population as a homogenous group, with little effort to make distinctions between different sub-groups whose experiences in care can be very different. The children in care in the current study were in what Biehal et al. (2010) defined as 'stable' care. Most had been with their carers since very early childhood, and again it did appear that it was this placement longevity, and the depth and quality of relationship that enabled with parents and carers, that was of critical importance in determining the children's positive profiles. These findings highlight how important it is for researchers and academics in this field to ensure that they describe research on the care population in ways that allow for the different sub-groups to be described discretely, and for accurate comparisons to be drawn between groups, and with children who have been adopted from care.

Of course, it is also important to note that not all the children were doing well. A small minority across the different placement groups appeared to struggle in terms of their sense of identity within their current placement, were not securely attached to their parents/carers, struggled with their behaviour, and their parents/carers were highly stressed as a result of their interactions. This is not unexpected, given the difficult early experiences that all these children would have faced, to a great or lesser extent, and the types of lingering insecurities and relational difficulties that can persist for some children in such circumstances. Clearly, there needs to be some mechanism for all the different types of long-term placement to be reviewed at some point in a manner that is not about scrutiny, but about identifying additional support to ensure placement stability. These reviews exist in principle for children in foster and kinship care, but none exist at present for children who are adopted, on residence orders, or living with birth parents, and this discrepancy requires urgent attention.

The level of stress being experienced by some parents/carers, particularly by foster carers and birth parents, is a cause for concern. Certainly, the fact that, despite these difficulties, these placements had not disrupted by the time the children were aged between nine and 14, is a welcome sign of placement stability. However, some of the parents and carers commented that they had at times been on the brink of ending the placement due to these problems, and one wonders how they will cope as the children progress through the teenage years. Clearly, there is an onus on policy makers, service managers, and practitioners to take cognisance of these findings. More importantly, action is needed to make sure that appropriate supports are provided to ensure the continuation of long-term placements, of whatever type.

A key question remains as to how this population of children has fared through the often turbulent late teenage years and into early adulthood, and whether or not there is any mediating effect of placement type on longer-term outcomes. The research team has recently received funding from the Economic and Social Care Council (ESRC) in the UK to continue the study through to early adulthood, interviewing the children when they are aged between 18 and 22 years old. On this occasion, an attempt will be made to recruit the full population for direct data collection.

The issues being considered within this study are universally relevant and important. The hope is that the findings of this study can continue to assist our collective understanding of the long-term outcomes of different types of long-term placement provided to young children in care throughout their life course.

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