



Department
for Education

Adoption Support Fund: learning from the prototype

Research report

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**Jane Lewis and Deborah Ghate – The
Colebrooke Centre for Evidence and
Implementation**

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Contents

Acknowledgements	2
List of figures	7
List of tables	8
EXECUTIVE SUMMARY	9
1. INTRODUCTION AND BACKGROUND	18
1.1 Focus of the report	18
1.2 The implementation analysis	19
1.2.1 Background papers	20
1.2.2 The ASF National Survey of local adoption support systems	21
1.2.3 Implementation analysis interviews	21
1.2.4 Analysis of the ASF Prototype Database	22
1.2.5 Reports produced during the course of the prototype period	22
1.3 Policy and research context	23
1.3.1 Policy context	23
1.3.2 Research on adoptive families' needs and experiences	23
1.3.3 The Adoption Support Fund	25
1.4 Viewing the Adoption Support Fund through an implementation lens	26
1.4.1 What is 'an implementation lens'?	26
1.4.2 Defining the adoption support system	27
1.4.3 Key principles of systems thinking	29
1.5 An overview of the prototype period	31
1.6 Development of the national model and support for national implementation	33
1.7 Report structure	34
2. LOCAL ADOPTION SUPPORT SYSTEMS FOR THERAPEUTIC PROVISION	35
2.1 Local authority adoption support teams	36
2.2 CAMHS	37
2.3 Other local authority services	40
2.4 Independent sector therapy providers	40
2.4.1 Post-adoption therapy in the independent sector	40
2.4.2 Local authority commissioning of the independent sector	43

2.5	Describing types of local adoption support systems	44
2.6	Strengths and weaknesses in local adoption support systems	45
2.6.1	A Quality Framework for adoption support systems	45
2.6.2	Analysing strengths and weaknesses	46
3.	USE OF THE ADOPTION SUPPORT FUND	54
3.1	An overview of use of the Adoption Support Fund	54
3.1.1	The interventions funded	54
3.1.2	The providers funded	55
3.1.3	Value of applications	56
3.1.4	Group-based applications	57
3.2	Variation in use between prototype sites	57
3.2.1	Volume of use	57
3.2.2	Providers funded	58
3.2.3	Breadth of use of independent sector	59
3.3	Explaining patterns in use of the Adoption Support Fund	60
3.4	The ASF and additionality	61
3.4.1	The potential for additionality	62
3.4.2	Shifting concepts of 'sufficiency'	64
3.4.3	Substitution	65
3.5	Extending the scope of the ASF	66
4.	FAMILIES' EXPERIENCES OF THE PROTOTYPE ADOPTION SUPPORT FUND	67
4.1	Families' experiences of ASF-funded providers	67
4.2	The outcomes sought by families	69
4.3	Families' perspectives on early outcomes from therapy	70
5.	IMPLEMENTATION OF THE PROTOTYPE ADOPTION SUPPORT FUND	72
5.1	Raising awareness of the Adoption Support Fund	73
5.1.1	Promotion to parents	73
5.1.2	Promotion through other services	74
5.2	Assessments and treatment decisions	75
5.2.1	LA assessment practices	75
5.2.2	Emerging models for clinical input into assessments	75
5.2.3	Independent providers' perspectives on assessment	76

5.2.4	Implications for the Adoption Support Fund	78
5.3	Parents' involvement in decision-making	79
5.4	Direct payments and personal budgets	81
5.5	The decision to apply to the ASF	81
5.6	Joint work between local authorities and external providers	82
5.7	Strategic service planning and commissioning	83
5.7.1	Strategic service planning	83
5.7.2	Market stimulation and development	84
5.7.3	Market intelligence	85
5.7.4.	Commissioning and procurement processes	85
5.7.5	Trading services	86
5.8	Monitoring, evaluation and the need for a data infrastructure	86
6.	IMPACTS ON LOCAL ADOPTION SUPPORT SYSTEMS	88
6.1	Reviewing systems impacts at an early stage	89
6.2	Impacts on systems components	90
6.2.1	Impacts on local authority adoption support services	90
6.2.2	Impacts on CAMHS	92
6.2.3	Impacts on other public sector provision	94
6.2.4	Impacts on independent sector provision	94
6.2.5	Impacts on families as active partners in local systems	98
6.2.6	Strategies to strengthen impacts on system components	99
6.3	Impacts on system connections	100
6.3.1	Connections between parents and local authority adoption support services	100
6.3.2	Connections between adoption and other public sector services	101
6.3.3	Connections among local authority adoption support services	101
6.3.4	Connections between local authority and independent providers	102
6.3.5	Strategies to strengthen systems connections	102
6.4	Impacts on system supports	103
6.4.1	Local and national policy	103
6.4.2	Systems leadership	103
6.4.3	Funding	104
6.4.4	Governance and quality assurance	104

6.4.5	Workforce development	104
6.4.6	Data and information	105
7.	KEY MESSAGES AND NEXT STEPS	106
7.1	The potential of the ASF	107
7.2	Key messages for the Department for Education	109
7.2.1	Strengthening the Adoption Support Fund model and operation	109
7.2.2	Strengthening the infrastructure for the Adoption Support Fund	109
7.3	Implications for local authorities	110
7.3.1	Local authority leaders	110
7.3.2	Commissioners	111
7.3.3	Adoption service leads	111
7.4	Implications for CAMHS	112
7.5	Implications for the independent sector	112
	APPENDICES	114
	APPENDIX 1. Glossary of therapeutic terms	114
	APPENDIX 2. Assessment instruments	117
	APPENDIX 3. Research methods	118
	REFERENCES	126

List of figures

Figure 1.1 The ASF prototype local authorities	18
Figure 1.2 The prototype ASF implementation analysis design	19
Figure 1.3 Lifelong issues in adoption: a conceptual framework (Silverstein and Caplan, 1988)	25
Figure 1.4 Key features of the national Adoption Support Fund	25
Figure 1.5 The adoption support system	28
Figure 2.1 Examples of multi-disciplinary teams	36
Figure 2.2 The Colebrooke Centre quality framework for adoption support systems	45
Figure 5.1 Preparing organisational processes to support the Adoption Support Fund	73
Figure 5.2 Promoting the ASF to parents	73
Figure 6.1 Potential forms of expansion of independent sector capacity	96
Figure A.1 Glossary of therapeutic terms	114

List of tables

Table 2.1 ASF National Survey: Provision of intensive support by adoption services in the year 1st April 2013 to 31st March 2014	37
Table 2.2 ASF National Survey: Known availability of interventions from Tier 3 CAMHS to adoptive families in the year 1st April to 31st March 2014	39
Table 2.3 Independent providers sample for implementation analysis interviews	41
Table 2.4 ASF National Survey: Contracting arrangements for commissioning of parenting programmes and therapeutic provision in the year 1st April 2013 to 31st March 2014	44
Table 2.5 ASF National Survey: Assessments of the quality and sufficiency of therapeutic support: mean average ratings	49
Table 3.1 ASF Prototype Database: Use of the Adoption Support Fund by service provider type, 1st June 2014 to 1st May 2015	55
Table 3.2 ASF Prototype Database: Value of approved applications, 1st June 2014 to 1st May 2015	56
Table 3.3 ASF Prototype Database: Number and value of applications by site, 1st June 2014 to 1st May 2015	57
Table 3.4 ASF Prototype Database: Use of provider types by total value of applications made by each site, 1st June 2014 to 1st May 2015 (row percentages)	58
Table 3.5 ASF Prototype Database: Number of independent sector providers commissioned by site, 1st June 2014 to 1st May 2015)	59
Table A.1 Local authority sample for implementation analysis interviews	120
Table A.2 Independent sector provider sample for implementation analysis interviews	121
Table A.3 Parents sample for implementation analysis interviews	123

EXECUTIVE SUMMARY

Introduction and methodology

The Adoption Support Fund (ASF) was set up by the Department for Education (DfE) to provide funding to **extend adoptive families' access to therapy**. The Colebrooke Centre for Evidence and Implementation was commissioned to undertake an implementation analysis of the prototype ASF.

The **prototype ASF was tested in ten local authorities** between June 2014 and May 2015, and the prototype period was used to refine key features and operating procedures of the ASF. Following an assessment of families' needs, local authorities applied to the ASF for funding for therapeutic support. The services funded could be provided by the local authority adoption support service, Child and Adolescent Mental Health Services (CAMHS), other public sector services, or by an independent sector provider.

The report is based on a **phased programme of implementation analysis and data collection** involving:

- Three background papers: a rapid review of literature on the needs and experiences of adoptive families; a rapid review of evaluations of personal budget schemes; and a high level mapping of therapeutic provision in Adoption Support Agencies (ASAs) and Voluntary Adoption Agencies (VAAs)
- The ASF National Survey of local adoption support systems. This involved telephone interviews with the leads of local authority adoption services, and collected data on therapeutic services in their teams, Tier 3 CAMHS, other local authority services, and commissioned from the independent sector
- Three waves of implementation analysis interviews involving fieldwork in Summer 2014, Autumn 2014 and Spring 2015 with:
 - **adoption service leads** in the 10 prototype sites
 - adoption service leads in five further local authorities
 - representatives of 28 **independent sector providers of therapeutic services for adoptive families**, including agencies that had been funded by the ASF
 - the heads of **two sector leadership organisations** for adoption support: the Consortium of Adoption Support Agencies and the Consortium of Voluntary Adoption Agencies
 - 17 sets of **parents** whose families were using therapeutic support funded by the ASF
- Analysis of the ASF Prototype Database, managed by the consultancy organisation commissioned to run the ASF, which captures summary information about applications made and approved

Our approach was informed by implementation science with a focus on systems. It analysed the ASF as **an intervention in a complex system**, where attention needs to be paid to the whole systems context and to alignment within it. It has highlighted the **distance travelled by the prototype sites** in implementing the ASF, the issues raised and work to address them, and the future work planned and needed. Overall it highlights that the ASF was widely seen by families and prototype leads as an important enhancement that had enabled access to more support. They felt that this support had, in some cases, been **crucial in sustaining placements** and keeping families together.

The context: local adoption support systems and access to therapeutic provision prior to the ASF

There was considerable variation between local authorities in the services and resources available pre-ASF for therapeutic support. Local authority adoption services are just one part of a wider and rather fragmented support system which also included CAMHS; other local authority services such as psychology, education psychology and family support services; and local and national independent sector providers.

The ASF National Survey showed that most local authority adoption support services provided some therapy interventions, particularly Theraplay, Dyadic Developmental Psychotherapy and systemic therapy, or support based on these models.

Specialist CAMHS service for or including adoption were seen as having strong expertise, offered a range of specialist therapies, and worked closely with adoption support services. However, the ASF National Survey showed that only half of local authorities have access to specialist CAMHS services. Elsewhere, support was provided by mainstream CAMHS services. Local authority adoption service leads described recurrent difficulties in accessing support here, centred around narrow eligibility criteria, and interventions and ways of working seen as poorly attuned to adoptive families.

The specialism and expertise of the independent sector was viewed very positively. However, the independent sector was widely seen as constrained, with few providers and limited capacity in many local areas. The extent of commissioning of the independent sector by local authorities varied considerably, primarily because it was used to fill gaps in public sector provision or capacity, but also because the resources available were variable.

Our analysis highlights a need for local authorities to strengthen their strategic planning and commissioning to support expansion in provision, especially but not only with regard to independent sector providers. This will be important to optimise use of the ASF. Local systems appeared generally to have evolved dynamically and opportunistically, rather than as a result of systematic needs analysis and planning. For the independent sector,

block contracts, Service Level Agreements (SLAs) and grant funding had in the past been important for service development and scale up. However, spot purchasing was the dominant funding model, which meant income was unpredictable and provided a weak platform for organisational growth. This is a key issue which suggests that both strategic planning and other initiatives alongside the ASF will be needed for the market to grow more than incrementally. These will need to reach out beyond local authorities into other parts of the children's support system.

Applications to and use of the prototype ASF

£2 million had been allocated to the prototype ASF. By the end of the prototype period, a total of **240 applications** had been approved by the ASF for the ten prototype local authorities, and **just over £1.6 million of payments approved**. The **median value of applications was just over £2500**. At the close of the prototype evaluation period, over 40 further applications from the ten prototype sites were still going through the approval process, to the value of a further £300,000. In addition, shortly before the end of the prototype period the ASF was made available to three further local authorities which made a further 22 applications to a value of over £200,000. These local authorities were not part of our evaluation.

The ten **sites used the ASF very differently, reflecting the different composition and relative strengths of local support systems**. The number of approved applications made per local authority varied from 11 to 45, and the funding received per local authority varied from £12,000 to over £500,000. The median value of applications per authority varied from £630 to £6945: two local authorities used the ASF particularly for large applications. Towards the end of the prototype period, sites began to submit applications based on groups of families rather than for individual families, to enable more capacity building and planning.

There was **universal support for using the ASF to fund a mixed economy of provision involving both independent and public sector providers**, as long as this gave families speedy access to high quality services and specialist expertise. Of the applications approved for the ten prototype sites, over 80% of expenditure was on independent sector providers (and 51% on registered ASAs or VAAs). Just over 10% of expenditure was on the local authority adoption support service, and under 5% on other public sector providers with only one application involving CAMHS.

In most of the prototype sites, the ASF was seen by all sectors represented in the research as **a very significant enhancement**. Therapeutic needs were being identified that would not previously have been identified, and there appeared to be an accelerated pathway to therapy. Support that was viewed as more comprehensive and intensive, and better attuned to families' needs, was now being provided. Consistent with the original policy intentions, the ASF appeared mainly to be providing additional help rather than

simply funding provision that would anyway have been offered, particularly in sites where it was acknowledged that, before the ASF, there had been gaps in provision. Thus, in general, additionality (rather than substitution) was created by the ASF.

Future work to **review the fit between families' needs and the interventions being funded by the ASF** will be important. There was variation between local authority adoption service leads in their confidence about current assessment practices and their access to clinical input. The ASF application process does not involve independent scrutiny of assessments, or of the clinical appropriateness of the interventions proposed. In addition, the strength of the evidence base for the interventions funded varies: some are reasonably well evidenced (although not necessarily for adoptive families), others much less so. DfE has commissioned an evidence review of post-adoption therapeutic interventions which may lead to further work to develop the evidence base.

Families' experience of the prototype ASF

Although it was early days for some, **the almost universal experience of parents using services funded by the ASF was of significant progress having been made.** Parents felt children had more self-insight and were better self-regulated, with more settled behaviour at home and at school. Parents themselves had new insights and strategies, had modified their behaviour and were managing their responses better. As a result the family environment was calmer for everyone, and several parents felt that therapy had interrupted a process likely to have led to the placement disrupting.

Families' experiences of the funded services were overwhelmingly positive. They felt therapists had a high level of specialist expertise and knowledge, formed positive relationships with children, and worked in partnership with parents.

Our analysis suggests the ASF has significant **potential to strengthen relationships between adoptive parents and local authority adoption support services.** Sites were now able to provide a service response to parents that they felt was better aligned with parents' expectations. It was felt that this would in future also help to make adoption feasible for more children. The prototype adoption service leads also thought the ASF would encourage more sustained relationships with parents after adoption, encourage early help-seeking, and build confidence in the adoption support system.

Key aspects of implementation in local authority adoption support services

Our analysis highlights the implementation activity needed by local authority adoption support services to support optimal use of the ASF.

Raising awareness of the ASF among parents was an important area of work, to encourage parents to come forward with requests for support. During the prototype period, most of the local authority sites went to significant efforts to raise awareness and it is likely that sustained outreach work directly to parents, and via other services (such as schools, other social work teams and GPs), is needed.

Many prototype sites identified a **need to strengthen assessments skills and processes in adoption support services**. Local authorities with ready **access to clinical expertise** (from CAMHS, psychology services or the independent sector) were beginning to use it more routinely, but such expertise was not always readily available and most leads felt this was an area that needed to be strengthened. Further work would usefully involve training for social workers on therapeutic assessments, training on different therapeutic interventions and their appropriate use, more use of structured screening and assessment instruments, and innovation in service models to strengthen access to clinical expertise.

Effective joint work and liaison between local authority adoption support services and independent sector providers was also identified as important, both to support positive impacts for families and to build and spread expertise. Families greatly valued the extensive liaison work undertaken by some independent providers. Our analysis suggests this is an area where more explicit and regularised arrangements will be helpful, with clear expectations and a supportive culture within both local authorities and independent sector providers.

Strategic approaches to needs analysis, service planning and configuration, across local systems will be important to optimise the use and impact of the ASF. Key areas here will be identifying gaps in provision and determining where in the system service development is required; joint planning and commissioning at regional or sub-regional levels (given the fragmented nature of demand and provision); and building a shared vision for adoption support across the system. Some of the prototype sites were just beginning work along these lines and were moving towards fuller engagement of forums such as the regional Adoption Leadership Boards.

The prototype local authorities had needed to **develop their market intelligence and establish approved provider frameworks**, often at regional or sub-regional levels. It was widely expected that the ASF will stimulate more trading of services between local authorities and this was viewed very positively.

Local authority **commissioning processes** were viewed, by prototype site leads and by providers, as cumbersome and a cause of delay in families accessing support. Some sites were finding short term strategies to work around these problems but they suggest a need for more flexible and efficient commissioning processes to support national

implementation of the ASF.

There is also a need to **strengthen systematic monitoring of outcomes of therapeutic interventions**. Local-level data will be important to enable local authority adoption support services to adjust their use of therapy services. At a national level, the ASF database collects summary information from applications and DfE has commissioned a national evaluation of the ASF. An embedded data infrastructure will need to be developed for systematic collection of data about intervention content, intensity and duration; family satisfaction with services; and clinical outcomes, with routinized collection of data including at a follow-up stage.

Early evidence of impacts of the prototype ASF on local adoption support systems

At this early stage in implementation of the ASF, we would not expect to see more than early indications of its impacts in adoption support systems. In addition, uncertainty about the future funding model and the likely overall impact on local authority budgets for adoption support meant that local implementation and strategic planning for its future use were somewhat under-developed. We did however find evidence of the **ASF beginning to impact on local systems** in ways that are very promising, as well as highlighting areas where sustained effort will be needed.

The ASF had **stimulated an expansion of provision in prototype local authority adoption support services**. Social workers were being trained in some therapeutic interventions, therapeutic parenting programmes were being extended, staff capacity was being freed up for therapeutic work, and there were plans for further service development.

The ASF was also stimulating the emergence or strengthening of a **differentiated, tiered service model** in the prototype sites involving universal preventative services, early therapeutic support and more intensive therapy interventions for families at higher levels of need.

The ASF had stimulated **more collaborative work between local authorities** in sharing intelligence, developing frameworks of providers, and early discussions about the scope for joint services or joint commissioning. It was also expected that the ASF would ease arrangements for funding support in out of area placements, where responsibility would previously have been disputed between agencies.

There is a pressing need to **strengthen alignment between the ASF and CAMHS**, and for local authorities to work closely with CAMHS in developing their use of the ASF. There was clear evidence of an **increase in demand for CAMHS services** and input. Some adoption services were involving CAMHS services more routinely in assessments,

and some were beginning to discuss possible expansion of CAMHS provision. However prototype sites had not been able to purchase additional CAMHS provision with ASF funding, some were using the ASF to 'bypass' CAMHS services seen as weak, and there was some tentative evidence of the ASF incentivising a withdrawal by CAMHS. The fact that most sites were in the process of re-commissioning CAMHS services at the time of our final interviews may partly explain this, but there were also suggestions that, in some areas, cultural and organisational readiness within CAMHS was insufficient for the collaborative work that service innovation always entails. The new CAMHS Transformation Programme provides an opportunity to address this.

There was clear evidence of the ASF **strengthening connections between adoption support services and independent support providers**, with a substantial increase in commissioning, many new relationships, local authorities commissioning more extensive packages of support, and support being put in place with greater ease and speed.

Although the ASF had clearly **increased demand for independent sector provision**, our analysis identified **little evidence of scale up or service development by independent providers, and significant barriers to this**. The main barrier is financial: independent sector providers need capital investment and greater certainty about future income to scale up their provision. The ASF's primary funding model of discrete budgets for individual families (which most obviously lends itself to spot purchasing) is not viewed as providing a robust financial platform for sustainable growth. The strong message from the sector was that grants for investment in development and more predictable income in the form of block contracts or SLAs are needed for substantial capacity expansion. An unexpected and perverse early consequence of the ASF was indications of some sites not renewing existing contracts with independent sector providers, in favour of developing services in-house or spot purchasing. This reinforces the importance of strategic planning by local authorities if capacity across the system is to be increased.

The introduction of **regional adoption agencies** offers a key opportunity to bring together public and independent sector providers across local authority boundaries. This could be a very important development supporting national implementation and impacts of the ASF.

Key messages and next steps

Key messages for DfE

The ASF model was refined during the prototype period, including widening scope to include therapeutic parent training, respite care and lifestory work and clarifying that public sector services were within scope. The **ASF model and its operation could be further strengthened** through developing a more robust data infrastructure to capture implementation and outcome data; strengthening the application process particularly to incentivise clinical input and scrutiny; and reviewing the quality of fit between families'

needs and the interventions funded. The ongoing review of the evidence base for therapeutic intervention in adoption support will also be important. It would also be helpful if DfE considered how to strengthen the availability of data and evidence for local authority needs analysis, review of provision, and decisions about appropriate interventions. Clarifying the future funding model will also be critical.

DfE needs to **work strategically with systems leaders across the public and independent sector** to strengthen the wider infrastructure for the ASF, including improving the alignment of policy drivers and funding streams across CAMHS, the health service, social care and education. Continued workforce development will be needed across service areas to provide a professional context supportive of appropriate responses, and there are early indications that training for social care staff in therapeutic methods, and for CAMHS staff in adoption issues, will need to expand rapidly.

Our analysis highlights the need for consideration of investment funding for capacity expansion in the independent sector. DfE would also usefully consider ways of strengthening quality assurance, since Ofsted is not seen as well oriented to clinical services and small scale providers, and covers only independent providers registered as ASAs or VAAs.

Key messages for local authorities

Local authority leaders will play an important role in reviewing and strengthening local systems, reconfiguring them and ensuring the potential of the ASF is realised. They could also usefully review the alignment of local policies and funding streams across health, social care and education. **Commissioners** need to support work on local needs analysis, service specification, market intelligence and market stimulation. Attention to speeding up and streamlining procurement processes, commissioning cultures and fostering readiness for an increase in trading services with other local authorities will also be helpful.

For **local authority adoption service leads**, the ASF is a key opportunity to advocate for improved provision for adopted families. The main operational processes that may need to be strengthened and engaged in support of the ASF are outreach work with parents and through services, assessment processes and clinical input, resource allocation processes, monitoring and evaluation, and staff training.

Key messages for CAMHS

The CAMHS transformation programme and the ASF together create an opportunity to **strengthen the role of CAMHS in adoption support** and for diffusion of the good practice that exists in some areas. There is otherwise a risk of CAMHS services becoming increasingly irrelevant to adoption support.

Key messages for independent support providers

Independent sector provider, sector leadership organisations and professional bodies should ensure that the opportunities the ASF presents for their expansion, diversification and better integration across the system are recognised and developed. They will want to ensure that local authority adoption services in their operating area are well informed about the support they can provide and to be ready to work collaboratively with them from an early stage in cases funded by the ASF.

1. INTRODUCTION AND BACKGROUND

1.1 Focus of the report

This is the final report from the analysis of the prototype Adoption Support Fund (ASF) undertaken for the Department for Education (DfE) by The Colebrooke Centre for Evidence and Implementation, with Adoption UK. It draws on a programme of work which has reviewed the implementation of the prototype version of the ASF and early evidence of its impacts and potential.

The ASF was established by the coalition government with the aim of extending access to therapeutic support for adoptive families. The ASF initially became available to ten local authorities in June 2014 for a prototype phase which lasted up to national implementation on 1st May 2015. The prototype period was used to refine key features and operating procedures of the ASF, and to develop an understanding of what would be required to support readiness for national implementation.

Figure 1.1 The ASF prototype local authorities

Cornwall Council	London Borough of Lewisham
East Sussex County Council	Manchester City Council
Gloucestershire County Council	Newcastle City Council
Hampshire County Council	North Yorkshire County Council
Leicester City Council	Solihull Metropolitan Borough Council

The implementation analysis was undertaken before and during the prototype phase, prior to national rollout. It captures learning from an early cohort of users as they worked through the issues involved in determining the cases and provision suitable for an application to the ASF, and embedding the ASF in local processes and systems. This was inevitably work in progress at the stage when our data collection finished (our last interviews with prototype sites took place at the end of March 2015). The organisations involved were still identifying new issues, working through solutions, and formulating plans. A separate evaluation of the national implementation from May 2015 onwards has been commissioned by DfE. The focus of this report is therefore on:

- understanding utilisation, implementation and early impacts of the ASF
- analysing the future potential of the ASF
- exploring what is required to maximise the positive impacts of the ASF and minimise potential negative consequences
- identifying other activity, at local and national levels, that might help to strengthen the infrastructure for and impacts of the ASF.

Within this, our analysis focused on three key themes:

- **How well aligned was the ASF with existing adoption support systems?**
What were the range of ways in which the ASF might impact on current provision and current systems? Where could alignment be improved to maximise potential beneficial impacts and minimise potential negative impacts? How far did the ASF address existing shortcomings in adoption support systems and what else might be required?
- **What was involved in effective implementation of the ASF?** How did local authorities and other providers need to develop or adapt practices, processes and planning to support implementation of the ASF? Where did the ASF model and its operating processes need to be refined for more effective implementation?
- **What potential did the ASF have to stimulate scale up in capacity for therapeutic adoption support?** What was needed to expand capacity, in the public and independent sectors, for the provision of appropriate, high quality, sustainable and effective services to families and children? What were the barriers to scale up and how far were they addressed by the ASF?

1.2 The implementation analysis

As a specialist implementation analysis and improvement support centre, The Colebrooke Centre’s approach draws on theory, frameworks and methods from implementation science, which inform and shape our work. Implementation science is a relatively new field which seeks to apply rigorous, theory-driven and empirically tested methods to create better insights into the design and delivery of services to people. Our approach to the analysis of the ASF blended conventional research methods with an innovative, theory driven *implementation lens* (Fixsen et al, 2005; Ghate, 2015). We explain this approach further in Section 1.5 below. The implementation analysis design is summarised in Figure 1.2.

Figure 1.2 The prototype ASF implementation analysis design

Element	Description	Timing
Background papers	<ul style="list-style-type: none"> • Paper 1: Rapid review of the needs and experiences of adoptive families • Paper 2: Rapid review of evaluations of personal budget schemes • Paper 3: Mapping of therapeutic services provided by Adoption Support Agencies (ASAs) and Voluntary Adoption Agencies (VAAs)¹ 	Jan-March 2014

¹ ASAs focus on adoption support and VAAs on adoption placements, although the boundary between them is blurred and some organisations are dual registered.

ASF National Survey	<ul style="list-style-type: none"> • Telephone survey of local authority (LA) adoption services in England to describe therapeutic services available in public sector and commissioned from independent sector 	Fieldwork July-Aug 2014
Implementation analysis interviews	<ul style="list-style-type: none"> • Wave 1: 10 prototype LAs, 5 non-prototype LAs, 10 ASAs or VAAs • Wave 2: 10 prototype LAs, 9 independent sector providers (most funded by ASF), head of CASA, 10 parents funded by ASF • Wave 3: 10 prototype LAs, 9 independent sector providers (funded by ASF), head of CVAA, 10 parents funded by ASF 	<p>Wave 1 fieldwork May-June 2014</p> <p>Wave 2 fieldwork Oct-Dec 2015</p> <p>Wave 3 fieldwork Feb-May 2015</p>
Analysis of ASF Prototype Database	<ul style="list-style-type: none"> • Analysis of summary information from applications to explore use of ASF by the prototype LAs 	Included all funded applications made 1 st June 2014 to 1 st May 2015
Reports produced	<ul style="list-style-type: none"> • Background papers: to DfE • Full interim reports: to DfE and prototype LAs • Report on ASF National Survey: to all participating LAs and prototype LAs • Briefing paper to aid preparation for national roll-out: to all LAs inc. prototype LAs 	<p>Jan-March 2014</p> <p>Oct 2014, Jan 2015</p> <p>Dec 2014</p> <p>May 2015</p>

The programme of work involved the following elements:

1.2.1 Background papers

Three background papers were produced early in the evaluation to inform DfE and the Expert Advisory Group² in early stages of preparation for implementation.

- Paper 1: a rapid review of literature on the needs and experiences of adoptive families seeking therapeutic services, their use of services, evidence about the effectiveness of interventions, and implications for the ASF (Lewis, 2015a)
- Paper 2: a rapid review of evaluations of personal budget schemes, under consideration as a feature of the ASF model (Lewis, 2015b)
- Paper 3: a brief, high level desk-based mapping of the therapeutic services provided by Adoption Support Agencies (ASAs) and Voluntary Adoption Agencies (VAAs) regulated by Ofsted (Lewis, 2015c). Our analysis was based on recent Ofsted reports and information from organisational websites. The aim was to map

² A group of policy, practice, research and implementation experts established by DfE to advise on the prototype and then national ASF

and describe the therapeutic services provided by this part of the independent sector.

1.2.2 The ASF National Survey of local adoption support systems

We undertook a national telephone survey of local authority adoption service managers, to provide a comprehensive national picture of local support systems (Lewis and Ghate, 2014). The survey collected data on therapeutic services provided by local authority adoption services, Tier 3 Child and Adolescent Mental Health Services (CAMHS), other local authority services, and provision commissioned from the independent sector. All local authority adoption services in England were invited to take part. Fieldwork was carried out by an independent survey organisation, IFF Research, in Summer 2014, and a 71% response rate was achieved. We refer to this in the report as ‘the ASF National Survey’.

1.2.3 Implementation analysis interviews

Three waves of interviews were undertaken (in Summer 2014; Autumn 2014 and Spring 2015), involving:

- **Implementation leads in the 10 prototype site adoption services** (interviewed three times over the course of the prototype period). Those interviewed were adoption team managers; service managers for adoption, fostering and adoption, or permanency; heads of service; adoption support team managers and Adoption Support Services Advisers. The first interviews took place face-to-face, subsequent waves by telephone. Interviews focused on service provision; preparation for the ASF; implementation and use of the ASF; the local independent sector and dynamics in its development; and perceived impacts across the local support system.
- **Adoption service leads in five further local authorities** (interviewed in the first wave only), to widen our understanding of the context and wider system in which the ASF was operating. Sites were selected based on region, local authority type, number of ASAs/VAs in the area, and number of children placed for adoption. Interviews focused on the local adoption support system.
- **Representatives of 28 independent sector providers** of therapeutic services for adoptive families. At Wave 1, prior to ASF implementation, we selected a sample of 10 ASAs and VAs (organisations and sole practitioners) based on the earlier mapping exercise. At Wave 2 we mainly selected providers funded by the ASF but also included two significant support providers not yet funded. At Wave 3 all those selected had been funded through the ASF. We sampled purposively for diversity in agency size (including sole practitioner therapists); services provided and regional coverage. Those interviewed were either sole practitioners or senior organisational representatives, and where necessary we also interviewed the practitioner or therapist involved in the ASF funded case/s. Interviews explored

service provision; funding sources and referral routes; organisational development and market dynamics; readiness for the ASF; and experiences of ASF funded cases/s.

- **The heads of two sector leadership** organisations for adoption support: the Consortium of Adoption Support Agencies (CASA) and the Consortium of Voluntary Adoption Agencies (CVAA)³. Interviews explored views about the ASF and its potential impacts on the sector.
- **17 sets of parents whose families** were using therapeutic support funded by the ASF. Prototype sites were asked to approach parents on our behalf forwarding information about the study, and to provide us with contact details where consent was given and parents wanted to participate. The sample was selected purposively for diversity in terms of the prototype local authority; age and sex of children; type of provider and intervention funded; and level of ASF funding. Three families interviewed at Wave 2 were interviewed again at Wave 3 to explore the further outcomes of therapy thus far. Interviews focused on prior experiences of help-seeking and services; involvement in the ASF application; experiences of the ASF funded services; and early progress and outcomes.

All interviews were recorded digitally and transcribed verbatim for full analysis. We refer to this part of the evaluation as ‘the implementation analysis interviews’ in the report.

1.2.4 Analysis of the ASF Prototype Database

The final element of our implementation review was analysis of the ASF Prototype Database. The database was set up and managed by the consultancy organisation commissioned to run the ASF (Mott Macdonald) and captures summary information from the online application forms completed by local authorities. We analysed the data held on all applications approved for funding during the prototype period, to review key features of use of the ASF and differences between the prototype local authorities. Further details of the methodology and samples are shown in Appendix 3.

1.2.5 Reports produced during the course of the prototype period

As well as the background papers noted above we produced:

- two interim reports to DfE on the implementation analysis, in October 2014 and January 2015

³ In the chapters that follow we treat these two individuals as independent sector provides, to ensure anonymity.

- a paper summarising findings from the ASF National Survey: sent to all participating local authorities in December 2014 (Lewis and Ghate, 2014)
- a briefing paper summarising early learning from the implementation analysis, sent to the adoption service leads in all local authorities in England in May 2015, to inform their preparation for national implementation.

1.3 Policy and research context

1.3.1 Policy context

The ASF was one of a suite of national policy initiatives intended to raise the priority of support for adopted children in social care, education, health and mental health service commissioning, planning and delivery. The national children and young people's mental health and well-being taskforce was set up in 2014, and its report (Department of Health, 2015) included proposals for restructuring CAMHS and improving support for vulnerable children. DfE and DH commissioned NICE to develop guidance on the attachment and related therapeutic needs of looked-after children and children adopted from care, due to report in Winter 2015. The focus on adoption support followed a sustained drive by DfE to increase the speed and use of adoption and substantial investment in VAA capacity. DfE have initiated a grants programme to support planning and development for the establishment of regional adoption agencies, working across local authority boundaries on recruitment of potential adopters, matching, and adoption support services (Department for Education, 2015b).

Until 2015 there had been a sustained increase in the number of adoptions from care. However, the number of adopted children fell slightly in 2015, and there was a much sharper fall in the number of agency decisions for adoption and Placement Orders indicating that the future number of adoptions would also fall sharply (Department for Education, 2015a). In part this reflects the increased use of Special Guardianship Orders (SGOs), and a DfE review of the use of SGOs was established in 2015. However, it is widely expected that the demand for post-adoption support will continue to rise, reflecting earlier increases in the numbers of children adopted.

1.3.2 Research on adoptive families' needs and experiences

Since this report is primarily concerned with the difficulties adoptive families face, we begin by emphasising the remarkable extent of recovery that adopted children can make in areas such as physical, cognitive and psychological development and educational attainment. A series of meta-analyses of international studies show that, although catch-up with normative groups of non-adopted children was incomplete, adopted children largely out-performed peers who remained in institutional or birth parent care (Van

Ijzendoorn and Juffer, 2006). Research also highlights the enormous commitment and resilience of adoptive parents (Selwyn et al, 2014).

'[A]doption is a successful intervention that leads to remarkable catch-up in all domains of child development studied here. Adoption documents the astonishing plasticity of human development in the face of serious adversity'
(Van Ijzendoorn and Juffer, 2006: 1237)

However, adopted children's early exposure to maltreatment and neglect makes them vulnerable to a wide range of emotional, cognitive, educational, behavioural, health and social development problems (Selwyn et al, 2014). Large scale surveys have shown that looked after children have significantly elevated risks of neurodevelopmental and psychiatric disorders (Ford et al, 2007), and the severity of their needs approaches what one would expect in clinical populations (Tarren Sweeney, 2008). Although there is less data on children subsequently adopted, studies have found high levels of need: a third of adopted children have clinically significant scores on the Strengths and Difficulties Questionnaire (SDQ) (Biehal et al, 2010). Early exposure to trauma and disrupted relationships with carers make adopted children vulnerable to disorganised, avoidant and insecure patterns of attachment, and attachment difficulties are frequently identified in research with parents (Selwyn et al, 2006). However, there is some concern that attachment disorders are over-diagnosed and that focusing too narrowly on attachment can lead to developmental problems being missed or to appropriate evidence-based interventions not being used (Barth et al, 2005; Woolgar and Baldock, 2015).

Adoptive parents particularly want support with parenting approaches and with understanding and responding to children's needs; support for children's learning; and therapeutic services. There is high use of social work, mental health, health and education support services by adoptive families, but parents often say what they receive is 'too little, too late' (Selwyn et al, 2006). Across service areas, they describe delays, multiple assessments, not meeting service criteria, service responses that are too dilute to be effective, professionals and interventions poorly attuned to the particular needs of adopted and maltreated children, and poor coordination and integration between agencies and professionals (Lewis et al, 2013; Pennington, 2012; Selwyn et al, 2006; Selwyn et al, 2014). CAMHS services are strongly criticised, although there is clearly also good practice. Research identifies gaps in the availability of support particularly for families at high levels of need, and the services which parents see as most needed – particularly mental health services, therapy and educational support - are often the most constrained (Holmes et al, 2013).

The rate at which adoption placements disrupt is remarkably low given these difficulties – around 3% over a 12-year period, with the highest risk of disruption when children are aged 11-16 (Selwyn et al, 2014). But beneath this is a picture of many adoptive families dealing with a high level of distress and difficulty. Although not the subject of consensus and consistent evidence, many specialists working with adoptive families would say that

adoption itself brings a particular dynamic to family life and children's needs. A commonly cited conceptual framework summarised in Figure 1.3 identifies seven core issues of adoption across adopted children, adoptive parents and birth parents.

Figure 1.3 Lifelong issues in adoption: a conceptual framework (Silverstein and Caplan, 1988)

- **Loss:** of the relationship with birth parents, and for adoptive parents affected by infertility, loss of the opportunity of their own birth family
- **Rejection:** adopted children's experiences of rejection by their parents, sometimes played out in their own rejection of adoptive parents
- **Guilt and shame:** a sense for adopted children of deserving rejection, and a continuing stigma around adoption
- **Grief:** for lost relationships and possible futures
- **Identity:** the complexity of children 'belonging' to two different families
- **Intimacy:** impeded by these complex feelings, with implications for attachment and bonding
- **Mastery and control:** not having been party to fundamental decisions about placements can leave children with strong feelings of helplessness and a need to regain or exercise control

The needs of children and families, and experiences of help-seeking, frame the introduction of the ASF and highlight the priority of improving access to therapeutic support.

1.3.3 The Adoption Support Fund

The ASF aimed to help families access timely and high quality therapy by making additional central government funding available through local authorities, and stimulating investment in therapeutic adoption support by local authorities and others. It was expected that, alongside other reforms, the ASF would contribute to making it easier for children for whom adoption was the right decision to be placed quickly, and would help to sustain strong long term relationships in adoptive families (Department for Education, 2013). A further aspiration was that the ASF would highlight weaknesses in local systems, catalyse and incentivise change, and stimulate an expansion in service capacity. A summary of the key features of the national model of the ASF is shown in Figure 1.4

Figure 1.4 Key features of the national Adoption Support Fund

- **Scope of eligibility:** The ASF is available to children adopted from care in England, or from Wales and living in England, up to and including the age of 18 (or 25 for children with a statement of Special Educational Needs or an Education Health & Care Plan). Adopted children in voluntary care for whom the plan is rehabilitation with the adoptive family are also eligible.
- **Post-order support:** Services provided before an Adoption Order are not eligible. However, an application can be made before an Adoption Order has been granted to secure funding for services that will be provided post-order, to ensure continuity in provision.

- **Assessment and application process:** Applications for funding are made by local authorities, following an assessment of needs. An assessment protocol and supporting documents were developed by the British Association of Adoption and Fostering (BAAF) and used by some of the prototype local authorities. The application form requires the local authority to specify the intended intervention, supplier, costs and outcomes. More than one application can be made per family, for example an initial application for assessment followed by one for therapeutic provision, or a second application to extend an initial set of therapeutic sessions.
- **Scope of therapeutic interventions covered:** The interventions that are eligible have not been narrowly specified but guidance has been issued. This guidance excludes services local authorities are required to provide under statutory regulations, and excludes health and education services. The guidance provides *examples* of eligible interventions, including Dyadic Developmental Psychotherapy (DDP); Theraplay; psychotherapy; systemic family therapy; music, art and drama therapy; therapeutic lifestory work; therapeutic parenting programmes, and therapy that is part of respite care. (See Appendix 1 for a glossary of these and other interventions to which we refer in the report.) DfE is currently undertaking work to support further specification of the interventions in-scope for the ASF.
- **Specialist clinical and multi-disciplinary assessments:** These are also eligible for funding.
- **Duration of therapy:** In the national ASF applications can be made for interventions of up to one year's duration, although further applications can be made for extensions.
- **Agencies eligible for funding:** Although the initial expectation was that the ASF would particularly fund services provided by the independent sector, therapeutic services (including assessments) provided in the public sector, including by local authority adoption support services, other local authority services and CAMHS are also in scope.
- **Funding:** During the prototype period the ASF was entirely funded by central government. Central government continued to be the sole funder for the first year of national implementation and £19.3m was been made available for this. Options for funding thereafter were being considered by DfE. DfE indicated that the size of the ASF was expected to be similar in 2016/17 and 2017/18 (Department for Education, 2014) to 2015/16.

For further information, see the Adoption Support Fund website:

adoptionssupportfund.co.uk

1.4 Viewing the Adoption Support Fund through an implementation lens

1.4.1 What is 'an implementation lens'?

Defined simply, implementation is the process of putting an innovation (whether in policy or in service design) into effective real-world practice, and an implementation lens (Fixsen et al, 2005) involves scrutinising an innovation from the perspective of the

emerging field of implementation science and practice. The developing learning from this field highlights that the process of implementation is complex and challenging. Effective implementation is a staged process and takes time (the evidence suggests between two and four years for a substantive new way of working to reach sustained implementation), and it is not uncommon for progress to falter along the way.

Implementation science and practice is centrally concerned with systems (Ghate, 2015): how they work, how they enable or inhibit innovation, and how systems can be made ready to nurture and sustain innovation and improvement. This is of immediate relevance to the ASF, which intersects with a complex system of universal to highly specialised provision, spanning social care services; CAMHS; health services; education support services, and crossing boundaries between the public and independent sectors.

1.4.2 Defining the adoption support system

Compared to an organisation, which is essentially a self-contained entity, a system is '*an interconnected and interdependent series of entities, where decisions and actions in one entity are consequential to other neighbouring entities*' (Welbourn et al, 2012:10) . Some of the particular characteristics of systems, evident in the example of the adoption support system and with important implications for the ASF, are that:

- they involve multiple players and stakeholders, and multiple funding streams
- they involve dynamic connections, and direct and indirect interactions
- there are fuzzy, permeable boundaries and complex relationships and connections
- there is often ambiguity or contradiction between component parts or sub-systems in objectives, values, definitions and the construction of social issues

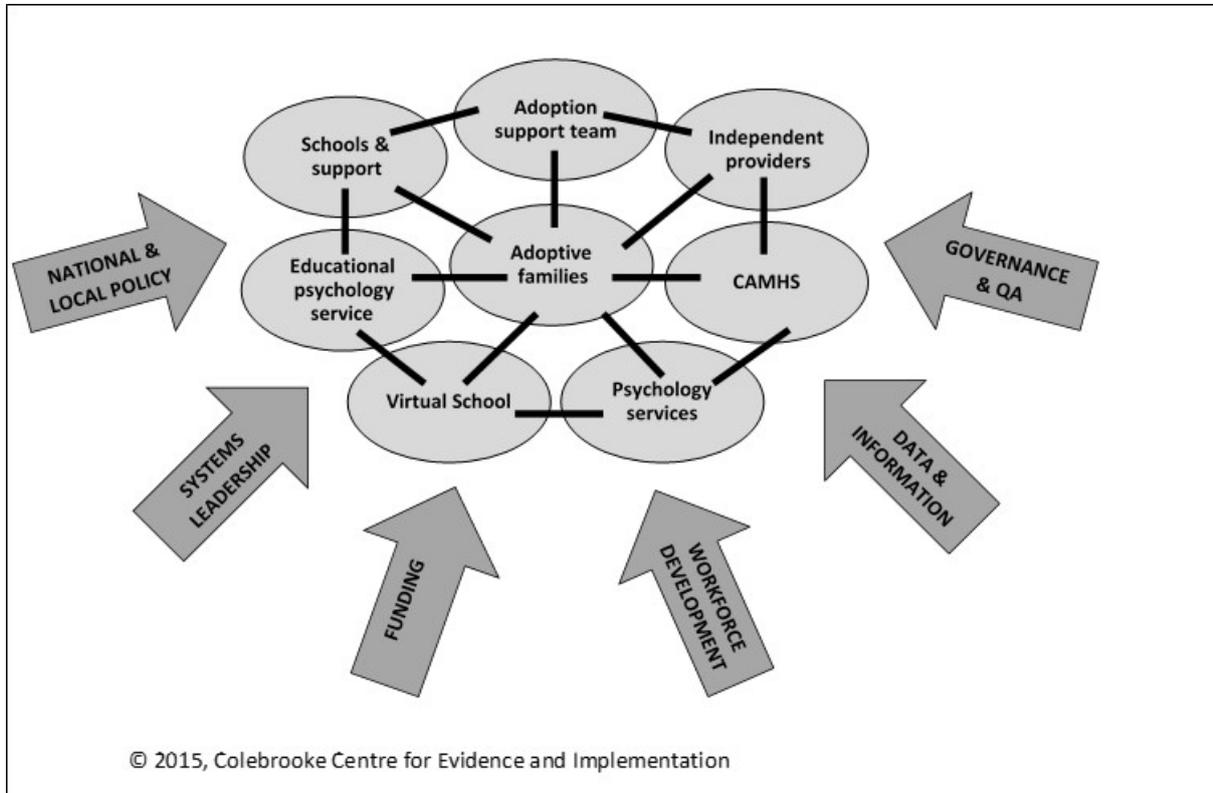
Drawing on systems thinking (Coffman, 2007; de Savigny and Adam, 2009; Foster-Fisman and Watson, 2012), we have developed and operationalised a conceptual model for understanding the adoption support system for this project which draws out three distinct elements, illustrated in Figure 1.5:

- **System components:** These are the core organisations or units of service delivery and practice that form the basis of the system, depicted as oval shapes in our model. Local authority adoption support services⁴ provided in-house are key,

⁴ We use the term 'local authority adoption support service' for simplicity throughout the report to refer specifically to the social work team with primary responsibility for adoption support. In most areas the adoption support function within social care is carried out by the adoption service or a designated adoption

but so too are CAMHS; other local authority services such as psychology services, Virtual Schools, educational psychology services, schools and other support they access; and independent sector providers. We have placed adoptive families at the centre of this model as active agents in the system

Figure 1.5 The adoption support system



- **System connections:** These are the linkages, relationships and multiple interactions between components that essentially make a set of components into a system. Connections (actual or ideal) are depicted in our model by the bold lines between the components. Our model shows a simplified set of connections: in reality each component is potentially connected to every other component
- **System supports:** These are aspects of the wider context within which the system operates, which provide (or could provide) infrastructure support to the system. They are depicted in our model by the arrows surrounding the system components.

The essence of a system is the multiple dynamic interactions that occur within and between these three elements. An important lesson from the study of implementation is that taking explicit account of these elements and the interactions between them is a critical factor in the design and implementation of systems interventions. Making the

support team within it. Some local authorities have other arrangements, such as a multi-disciplinary team whose work may be wider than adoption. We discuss this further in Section 2.

whole system visible in this way can help to focus attention on the fit and impacts of an intervention across the whole system, on the multiple reactions triggered by the intervention, and on ways in which the system may need to adapt or develop to host the intervention most effectively.

1.4.3 Key principles of systems thinking

The principles of systems thinking with greatest relevance to understanding the impact of the ASF are:

Use whole systems thinking

“A key feature of an implementation science approach and where it departs from traditional approaches to exploring ‘process’ in human service interventions, is its attention to the systems context and ecology of service delivery, and the recognition that all services (both new, or pre-existing) connect with a wider system of care - whether or not this is explicitly accounted for in the design [Emphasis in original]. Implementation scholars, in noting that the system can either nurture or crush innovation, realise that attempts to develop, deliver or study programs as if they existed independently of this infrastructure are unlikely to succeed in the long term.” (Ghate, 2015)

Systems, in other words, ‘trump’ individual initiatives (Fixsen et al, 2006). The evidence is overwhelming that innovations, no matter how well conceived, designed and resourced, rarely succeed in achieving *sustained* improvement unless they are supported by the wider service systems in which they sit.

In the context of the ASF, our aim was therefore to explore its interactions with the surrounding infrastructure, looking at simultaneous effects on system components, connections and (more tentatively) system supports.

Whole systems are complex and unpredictable

As our recent work on systems leadership makes clear (Ghate et al, 2013), systems science tells us to expect human service systems in complex economies to be characterised by volatility, uncertainty, complexity and ambiguity. Whole systems are inherently paradoxical, composed of opposing forces that cannot be resolved by the application of control or direct pressure but that must be actively maintained in careful balance. When intervening in whole systems we are always working in the ‘*zone of complexity*’ (Stacey, 2002) in which “*even knowing everything there is to know about the system is not sufficient to predict precisely what will happen*”. (Welbourn et al, 2012:15).

In the context of the ASF, this meant monitoring potentially opposing tensions created by the presence of different service systems in the field. It also meant widening the focus of analysis to consider whether activities at the edge of our field of vision were creating opposing pressures that could undermine the intended operation of the ASF. For example, a number of policy initiatives relevant to adoption support co-occurred with the

ASF and could create supporting or opposing pressures. These include investment in local authority provision via the Adoption Reform Grants and in VAAs via the DfE expansion grants; initiatives to strengthen educational support for adopted children; accumulating pressures on CAMHS; the re-commissioning of these and other public services; the revised process for adopter preparation; changes in local authority practices in seeking or obtaining Adoption Orders; scrutiny of local authority adoption rates by national government; and the increasing use of Special Guardianship Orders (SGOs).

Disturbing the system is integral

Implementation studies show that all innovations *necessarily* 'disturb' the system into which they are introduced or in which they develop. This disturbance can be beneficial, in the sense that it challenges entrenched ways of thinking or behaving that have become counterproductive and introduces improvements to the status quo. But it can also create perturbations with potentially negative consequences or perverse incentives that need to be thoughtfully managed. Otherwise, new innovations may have a destabilising effect, undermining existing strengths and resources that would more usefully be preserved.

It was clear that the ASF had the potential to disturb the wider system in ways that may ultimately be beneficial, stimulating the development of specialised therapy services and extending their provision to a larger and wider group of families in the community. But it may also have perverse consequences, in that currently effective provision may be undermined and displaced by alternatives of as yet unproven quality, or the market may expand in ways that were not well aligned with needs and with quality.

Alignment and fit are critical aspects of successful implementation

The chances of an innovation being successful are generally enhanced by paying attention to its strategic alignment with other systems, and its operational fit with the services within those systems that also serve the intended population (Ghate, 2015; Ghate et al, 2014). Thus, the strategic policy aims of the ASF need to be analysed for their alignment with those of the wider systems into which it will be inserted. Where these can be configured as essentially complementary, it becomes possible to galvanise joint cross-sectoral efforts to help reinforce the initiative to overcome barriers. Where potentially antagonistic or conflicting, avoiding actions are needed to keep a new innovation on track. The operational fit of the ASF to local authority and other agencies' practices and actual capacity was also a focus of our analysis. Issues around service planning and configuration, procurement and commissioning routines, joint work with independent sector providers and capacity for assessment emerged as critical determinants of success.

Scaling up raises its own challenges

One of the key features of the adoption support system was that, in almost all localities, it was viewed as constrained, and a key aim of the ASF is to stimulate market expansion

and development. At its simplest, scaling up has been conceptualised as the extension or replication of specific services to increase their coverage. The focus is now beginning to widen, to approaches that reflect the systemic and broader capacity-building issues involved in service development. For instance, scaling up in health services has been defined as:

“... more than the expansion of ... services. It can be defined as a set of processes that lead to expanded and sustainable coverage of services, and involve strengthening the capacity of delivery organisations, increasing diversity and robustness of funding and management arrangements, and growing the system’s overall capabilities to add ... or integrate services.” (Paina and Peters, 2012: 367)

This wider definition emphasises that scaling is likely to need sustained effort focusing on building the capacity, not just of individual agencies, but of whole systems, and likely to need interventions at multiple levels in systems that are dynamic and inter-connected. It raises questions not just about *what* to expand, but also *at which points in the system* to intervene and *how*, to support expansion that will secure quality, value for money and sustainability. The potential of the ASF to stimulate scale up of provision, and its alignment with existing barriers to growth, were therefore important parts of our analysis.

1.5 An overview of the prototype period

The prototype ASF itself was managed by the consultancy organisation Mott Macdonald, which set up a system of Key Link Advisers to support prototype local authorities’ implementation and use of the ASF. Alongside this, BAAF was commissioned to develop, and provide training on, a new assessment tool, and the consultancy firm Deloitte UK undertook work on future funding models. (This work is now being taken forward by DfE economists.)

By 1st May 2015, 240 applications had been made by the ten prototype local authorities and accepted for funding, and over £1.6 million of funding approved. A further 42 applications made by the prototype sites, totalling just over £300,000, were awaiting approval. In addition, shortly before the end of the prototype period the ASF was made available to three further local authorities, which made a further 22 applications to a value of over £200,000 during the prototype period. These local authorities were not part of our evaluation.

The ASF was widely welcomed by the prototype sites as a significant initiative which had enhanced the support available to families. As we discuss in Section 3 there was variation in the extent to which, and purposes for which, they drew on it. However, there was widespread confidence that the greater availability of therapeutic support to adoptive families would help improve the happiness, wellbeing and stability of adoptive families, and help to reduce the long term psycho-social problems that many adopted children and young people face. There was also confidence it would encourage more potential

adopters to come forward, make it easier to place children, help to sustain placements and prevent re-entry into care.

'It's enabled some quite intensive pieces of work to be done, which have probably – almost certainly – in several cases prevented children coming [back] into care.' PROTOTYPE SITE LEAD

'[Describing an inter-agency placement, which has needed additional support pre-order which will continue post-order funded by the ASF] It has been quite a challenge for [the adoptive parents] but ... because they feel supported and they can see there's a route map for where they can get support in the future, they have no hesitation, they're going to put in the application for the Adoption Order. I wonder if they would have been quite as confident without the ASF.' PROTOTYPE SITE LEAD

There were many positive comments by the prototype implementation leads about the experience of the prototype period and particularly about the way in which the learning from early implementation influenced the development of the ASF during the course of the prototype. Therapeutic parenting training, respite care and lifestory work, all initially outside the scope of the ASF⁵, became within scope during the prototype period in response to early findings from the implementation analysis. Sensory assessments were also included. Whereas the initial intention was that the Fund would be used for provision from the independent sector, eligibility was widened to include public sector services. Applications for services for groups of parents, for clinical supervision and for training of social workers⁶ in therapeutic methods were all accepted, although not initially envisaged. Therapy provided before an Adoption Order remained out of scope. Many of those we spoke to would have liked to see it included, but the facility to submit applications pre-order to secure funding for services to be provided post-order was viewed as a positive compromise.

'I think the broadening of the criteria has been really helpful. I think it shows real evidence that there's been a lot of learning from the pilots. What at the beginning seemed a bit confusing, they recognised that, they listened and tried to clarify lots of issues, and I think that's definitely been helpful, very much so.' PROTOTYPE SITE LEAD

Perhaps inevitably during a prototype phase, some aspects of eligibility criteria and operating procedures, and some of the changes made, also produced a degree of frustration or uncertainty. Although the ASF was generally very positively viewed by the prototype sites, some sites made less use of the ASF initially but felt under some pressure, as a result of the level of scrutiny and further support offered, to submit applications. There was also a rather uncomfortable sense of a dissonance between the apparent largesse of the ASF and the wider experience of public sector austerity, and

⁵ Parent training was in-scope in some circumstances only at the start of the prototype period

⁶ Training for social workers is out of scope in the national model

concern about whether the scale and flexibility of funding would be sustained in national implementation. This centred around three issues:

- the level of any future local authority funding contribution and its possible impact on the budgets available for existing provision funded by the local authority
- the sufficiency of funding for the national model and whether the scope of eligible interventions would be narrowed or funding criteria tightened in other ways: there was a particular concern about raising parental expectations that it might not be possible, in the future, to meet
- how access to ASF funding would be managed equitably across all local authorities, bearing in mind variation in existing therapy provision, and how it would be ensured that some local authorities do not '*over-use*' the Fund to the detriment of others.

Overall, then, the experience of the prototype period was a positive one for the local authorities involved, but there was a sense of a collective 'holding of breath' pending clarity about the scope and sufficiency of the national implementation model.

1.6 Development of the national model and support for national implementation

The ASF model evolved, as we have outlined above, during the course of the prototype phase. The national model implemented was effectively the prototype model in its final form before national implementation, with three changes:

- training for social workers in therapeutic methods, an eligible cost during the prototype phase, was not within scope in the national model
- the national model introduced a one-year limit on the duration of therapy in initial applications although this can be extended through further applications. During the prototype phase a small number of applications for longer duration of therapy had been funded
- the scope of the national fund was clarified by DfE with some therapies added and some excluded.

As we noted earlier, a briefing paper by The Colebrooke Centre summarising learning from the prototype sites' early implementation of the ASF was sent to all local authorities to inform their preparation and readiness for national implementation. Mott Macdonald was also commissioned to support preparation of non-prototype local authorities for national implementation. The Key Link Adviser system was expanded and visits made to all local authorities to assess readiness and identify key operational areas for further support, which was provided to 42 local authorities. Almost all local authorities attended

regional training events, and support was provided through webinars, a help line and a range of materials and resources on the ASF website (<http://www.adoptionssupportfund.co.uk/>). There was provision for more support activity in 2015/16 if required.

1.7 Report structure

- Section 2 looks at the composition of local adoption support systems for therapeutic provision, and strengths and weaknesses in systems and provision.
- In Section 3 we give an overview of how the Fund has been used, variation between the prototype sites, and whether and where it is providing added value.
- Section 4 looks at parents' experiences of therapy provision funded by the ASF and evidence of early impacts.
- Section 5 looks at how operational processes needed to be aligned with the ASF to support its implementation, and the activity undertaken by prototype site leads to make ready and strengthen the practices and processes surrounding the ASF.
- In Section 6 we turn to the evidence thus far of the impact of the ASF on local adoption support systems.
- Section 7 synthesises our analysis to address some key summative questions about the ASF, and summarises implications for supporting its implementation and optimising its potential impacts across the system.

We have attributed some key features of adoption support systems and implementation of the ASF, and data concerning their use of the ASF, to named prototype sites. This has been done with their permission and prior sight of the draft report, and is intended to help other local authorities to use the report to anticipate the implementation issues and potential impact of the ASF in their own area.

2. LOCAL ADOPTION SUPPORT SYSTEMS FOR THERAPEUTIC PROVISION

Key messages:

- Local 'whole systems of care' in adoption support had emerged dynamically, shaped by interaction between component parts, so each local system had a unique make-up. This suggests that take-up of the ASF nationally will be highly variable
- Some local authority adoption support services had invested in training staff in therapeutic methods, and in others support was provided by a multidisciplinary service including CAMHS and other therapist resource
- There was a clear distinction in how well specialist CAMHS services and generic, mainstream CAMHS services were viewed as providing for adoptive families, with specialist services much more highly rated, and much criticism of generic services
- Therapeutic provision was also available in local authority services such as educational psychology, school support, family and youth services
- The independent sector was viewed as fragmented and constrained but provided specialist support used by local authority adoption support services to fill gaps in public sector provision. A significant part of the market consisted of sole practitioners, and the dominant funding model was spot purchase although Service Level Agreements and block contracts were also used
- There were strengths, but also significant weaknesses, in local systems which varied between localities. In particular, criticism of the quality of support in the public sector, limited capacity and weak scope for scale up, fragmentation and lack of integration, and the evidence base are areas that need to be strengthened for the impact of the ASF to be optimised

In this section we describe the make-up and organisation of local systems and the access they provide to therapeutic services, and present a brief analysis of the strengths and weaknesses of local adoption support systems. These issues provide context to the potential contribution and impacts of the ASF, discussed in subsequent sections. Our focus in this chapter is on adoption support systems prior to the introduction of the prototype ASF: we look at changes in systems arising from the ASF in Section 6.

Consistent with systems theory, each local 'whole system of care' has emerged and been shaped by reaction and interaction between component parts. For example, there were examples of investment in one component to compensate for a weakness elsewhere in the system; services being developed collaboratively or to complement each other; and expertise and skills being exchanged within and across sectors. Also consistent with systems theory is that the boundaries between components were sometimes blurred. Staff in one service area might be funded by, designated to work with or seconded to another; independent sector providers sometimes worked closely with adoption support services and were regarded almost as part of the team; and some local systems involved a high level of structural integration across service areas and agencies.

This is important context for the ASF. Each local system had a unique make-up, and highly variable resources and arrangements for accessing therapy. The potential added value, take-up and role of the ASF was highly variable, and the specific ecology of the local adoption support system needed to be taken into account in planning for local implementation and use of the ASF. It also makes the consequences of intervening in the local adoption support system complex and hard to predict. Any intervention will produce not only direct impacts (components of the system responding to the intervention individually) but also indirect impacts (components responding to each other's response).

2.1 Local authority adoption support teams

Our analysis highlighted that different local priorities and policies had led to variation in the extent of therapeutic support provided directly by staff in local authority adoption support services. In some local authorities, all or some of the team had been trained in therapeutic models, particularly Theraplay and DDP (not necessarily at higher levels) and also sometimes in other models including systemic family therapy, Non Violent Resistance and filial therapy. There had also been training in therapeutic parenting support approaches and services provided a range of parenting programmes including home-grown models. Among the prototype local authorities, Leicester, Lewisham, Cornwall, Solihull and Gloucestershire appeared particularly to have invested in training adoption staff in therapeutic work. These approaches were used in intensive one-to-one work with parents and children, alongside '*good old fashioned social work*'. Therapeutic capacity in the adoption support service had also been increased through close work with CAMHS. Almost all the teams where there had been investment in therapeutic methods *also* had access to specialist CAMHS services for adopted children (see further below).

Some of the 15 local authorities in the implementation analysis had established multi-disciplinary teams providing adoption support.

Figure 2.1 Examples of multi-disciplinary teams

- Manchester's adoption support, for the first three years following an Adoption Order, is provided by the Adoption Psychology Service, which brings together staff from CAMHS, the adoption team, education support and the voluntary sector ASA After Adoption, with a largely clinical team providing a range of therapeutic interventions.
- East Sussex's AdCamhs service brings together staff from CAMHS and the adoption service providing a range of therapeutic interventions.
- In Leicester, the Children and Families Support Team provides post-placement support to adoptive families (and also to looked after children) and includes mental health practitioners and a nurse as well as social workers.
- Cornwall's support service, the Family Plus Team, includes psychologists, Theraplay workers and youth workers and provides support to children placed under SGOs and Child Arrangement Orders as well as adoptive families.

Local authority sites providing less therapeutic support directly from within their adoption support service had fewer or no staff trained in therapeutic interventions or had only recently trained staff. This had sometimes been a deliberate policy, with the intention of drawing in therapeutic support from elsewhere in the local system – an approach seen as more cost effective and giving access to a wider range of therapy provision. There appeared to be less (although still some) therapeutic capacity in the local authority adoption support services in Hampshire, Newcastle and North Yorkshire.

Table 2.1 ASF National Survey: Provision of intensive support by adoption services in the year 1st April 2013 to 31st March 2014

TYPE OF SUPPORT	Provided by adoption service	
	%	<i>n</i>
Specific therapeutic approaches		
Theraplay or support based on it	70	71
DDP (Dyadic Developmental Psychotherapy) or support based on it	41	41
Systemic therapy or support based on it	36	36
Other child or family therapy	28	28
Play therapy	26	26
Other creative therapy e.g. art, music, drama, sand-tray	21	21
Sensory integration	15	15
Filial therapy or support based on it	10	10
Base: n=101 adoption service managers. Percentages do not add to 100% as multiple forms of support could be provided		

The ASF National Survey of adoption support managers highlighted that most adoption services provided some form of therapeutic intervention: only 18% provided none of those listed in Table 2.1. The mean average number of therapeutic approaches available was 2.5 per local authority.

2.2 CAMHS

There was a clear distinction in both the implementation analysis interviews and the ASF National Survey between areas with access to specialist CAMHS teams for adoption⁷, and those dependent on generic, mainstream CAMHS services. (Our focus here was on Tier 3 CAMHS, in keeping with the ASF's focus on more intensive therapeutic forms of adoption support.) The ASF National Survey showed that overall just over half (54%) of local authority adoption support services had access to a specialist CAMHS service including adoption, while just under half (45%) accessed mainstream CAMHS provision.

⁷ These specialist teams focused on looked after children including adoption; fostering and adoption; adoption alone, or vulnerable children more widely defined and including adoption.

In both the implementation analysis interviews and the ASF National Survey, sites with access to specialist CAMHS teams for adopted children described the CAMHS service in much more positive terms, and it was central to the provision in prototype sites with access to such services. Of the prototype sites this involved Manchester, East Sussex, Leicester and Lewisham (in Gloucestershire the picture was perhaps a little more muted because of service capacity constraints).

In these specialist teams, adopted children were recognised as a priority group for whom a different approach was needed, specifically attuned to the impacts of early trauma and neglect, attachment, and the *'added layer'* of the dynamics of adoption. This was evident to the prototype leads in the range of therapeutic approaches used, the expertise of CAMHS staff and more generally in wider ways of working. There were also examples of reciprocal or joint staff training across CAMHS and social care staff. These approaches were all important in sharing skills and building capacity in adoption teams.

'Particularly they are aware of the adoption needs. They do support us They're very active and I think they do above and beyond actually what they're commissioned to do, because they're interested in it and they've got a passion about it, which is why they are different to some other [CAMHS] services really.'
PROTOTYPE SITE LEAD

By contrast, local authorities without specialist CAMHS projects for adopted children described severe difficulties for adoptive families in accessing CAMHS effectively. They reported consistently negative feedback from families, and relatively few families actually receiving a service. Their perception was of limited understanding within CAMHS of the impact of trauma and the dynamics of adoption; limited expertise in the most relevant therapeutic approaches; and a clinical mental health model that was seen as poorly aligned with the broad-based and often overlapping needs of adoptive families.

Problems highlighted included:

- unhelpfully narrow definitions of mental health disorders and narrow application of clinical criteria for eligibility for services, for example not encompassing developmental trauma or attachment difficulties, so that many adoptive families were not eligible for CAMHS services
- long waiting lists before and after initial assessments
- interventions and approaches not seen as well attuned to adoption, including a focus on working with children without involving parents
- interventions at too low an intensity to be effective
- inflexible service models with little or no scope for outreach work or sessions outside daytime hours and clinic sites, limited skills in reaching out to troubled children and young people, and being too quick to close a case when appointments were missed.

In some areas there was a well-regarded specialist CAMHS service for looked after children but children were outside its remit once adopted, or a specialist team serving only part of the area, or the previously highly valued specialist service had been replaced by a mainstream CAMHS service.

Table 2.2 ASF National Survey: Known availability of interventions from Tier 3 CAMHS to adoptive families in the year 1st April to 31st March 2014

TYPE OF PROVISION	WHETHER KNOWN TO BE AVAILABLE					
	Known to be available		Not available		Don't know if available	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Consultation, advice and general support						
Consultation and advice to parents	82	83	6	6	12	12
Consultation and advice to other professionals working with the family	78	79	7	7	15	15
Support to strengthen systems around the child or family	72	73	10	10	18	18
Family or child therapies						
Systemic Therapy	64	65	11	11	25	25
Play therapy	50	51	26	26	24	24
Other creative therapy (such as art, music, drama, sand-tray)	46	46	27	27	28	28
Other child or family therapy	72	73	9	9	19	19
Specific therapeutic approaches						
DDP (Dyadic Developmental Psychology)	39	39	32	32	30	30
Theraplay	38	38	37	37	26	26
EMDR (Eye Movement Desensitisation and Reprocessing)	26	26	34	34	41	41
Filial therapy	24	24	42	42	35	35
Dialectic Behavioural Therapy	21	21	30	30	50	50
Sensory integration or similar therapy	19	19	39	39	43	43
Other						
Other specialist support related to adoption	28	28	45	45	28	28
Base: <i>n</i> = 101 adoption service managers. Percentages do not add to 100% as multiple forms of support may be provided, by more than one provider.						

Drawing on the ASF National Survey, Table 2.2 shows that most CAMHS services provided consultation and advice to parents and professionals, and individual types of the main family or child therapies were offered by between half and two-thirds. Specific therapeutic approaches such as DDP and Theraplay were less often available, although each were provided by just under 40% of CAMHS services. Most adoption service leads reported some form of joint working with CAMHS: around half making joint decisions about support, the same proportion reporting joint case work, around 40% reporting joint meetings and a third shared staff. However, the proportion of local authority adoption support service leads who did not know whether their CAMHS service provided specific

types of therapy is striking (see Table 2.2), and suggests widespread poor communications and lack of joined up working.

2.3 Other local authority services

Other local authority provision was, in some areas, an important part of the post-adoption therapeutic support system. Key here were educational psychology services, psychology services, family and youth services, the Virtual School and other education support services. These services provided access to therapeutic interventions such as Video Interaction Guidance (VIG), Functional Family Therapy (FFT) or interventions for children who have experienced sexual abuse; therapeutic parenting courses; consultation to parents and adoption support staff; and training. Among the prototype sites, these services seemed to be a particularly important part of provision in Hampshire and Cornwall, and in Manchester as part of the integrated Adoption Psychology Service.

The ASF National Survey found that individual therapies were not commonly provided by other local authority services. The most common were Theraplay, systemic therapy or 'other' child and family therapy, but each were provided by just under 20% of local authorities.

2.4 Independent sector therapy providers

The fourth key component of local adoption support systems was the independent sector. It is of course somewhat misleading to suggest the independent sector is a single component in adoption support systems since this 'market' is complex, multi-faceted and fragmented: features that provide a challenge to implementation of the ASF. We begin by describing the structure and content of therapeutic provision in the independent sector, and then look at the role it played in local adoption support systems.

2.4.1 Post-adoption therapy in the independent sector

The fact that the independent sector for post-adoption therapeutic support consisted of multiple types of providers, not coordinated with any single service framework or professional network, makes any attempt to define, map or analyse it challenging. The most easily 'known' segment is ASAs and VAAs since these are registered with and regulated by Ofsted. Our initial mapping exercise undertaken in January 2014, based on a review of Ofsted inspection reports and organisational websites of registered ASAs and VAAs, identified 56 such agencies providing therapeutic support. Around a fifth were identifiable as sole practitioners. The geographic distribution of agencies was highly uneven, with around 40% based in London and the South East.

However, therapeutic adoption support was also provided to a significant degree by individuals and organisations not registered as ASAs and VAAs. Systematic analysis of

this part of the market is exceptionally difficult since there is no single coordinating organisation or regulatory system. This is a significant challenge to local authorities and a significant gap in the information system surrounding the ASF. We therefore provide a brief description of the 28 therapy providers in our sample, to illustrate the key market dimensions. Table 2.3 below illustrates key characteristics and they are described further below.

Table 2.3 Independent providers sample for implementation analysis interviews

	n=28
Focus of work	
Therapy only	20
Wider services, only/mainly adoption	5
Wider services, not only/mainly adoption	3
Size of organisation (all staff⁸)	
Sole practitioner	8
2-5 staff	4
6-10 staff	2
11-20	6
21-50	4
51+	4
Organisational type	
ASA	9
VAA	6
Both	3
Neither	10

Size, specialism and reach

The sample of 28 ranged from sole practitioners, pairs or small groups of therapists, to organisations with around 200 therapist staff or associates. There was much variability in the degree of specialism in both adoption and therapeutic provision. Our sample encompassed:

- providers of wide-ranging child and adult services across multiple client groups
- organisations which specialised in therapy and worked across varied child and adult populations
- VAAs which provided the full range of adoption (and sometime also fostering) services: therapy was a significant component for some, provided beyond their own placements, but for other agencies it was marginal and focused on their own families

⁸ Some organisations also worked with associates, sometimes with pools of more than 50 such professionals.

- specialist providers of adoption support, mostly ASAs. Some were highly focused on therapeutic support, and others provided wider social-work based services including support groups and parenting support.
- sole practitioners: all in our sample specialised in therapeutic provision and had trained in specific techniques and methods, often with extensive clinical experience in mental health or psychology services before moving into independent practice. They varied however in the degree of specialism in adoption, which accounted for almost all the caseload of those registered as ASAs but was a relatively new client group for others.

Sole practitioners and smaller partnerships generally worked in clients' homes within a two-hour travel range. Medium sized organisations had one or two main delivery sites, sometimes extending their coverage through outreach surgeries within local authorities. A few organisations had broadly national coverage, through a regional infrastructure or a network of associates. A significant feature generally, however, was the considerable distances that some families travelled to access therapeutic services.

Therapeutic interventions available

Across the sample a wide range of therapies were available. Sole practitioners generally worked within one or two specific models or a hybrid 'home grown' model drawing on a number of different methods. Larger organisations provided several different specific interventions, with treatment models centred on developmental trauma and attachment, and interventions including DDP, Theraplay, EMDR, sensory integration, creative therapies, VIG, equine therapy, mindfulness and therapeutic parenting programmes. Some had multi-disciplinary teams including psychologists, psychotherapists, psychiatrists, play and other therapists, social workers, occupational therapists or paediatricians. The intensity or duration of work also varied, some sole practitioners or organisations providing a short programme of perhaps six to 12 sessions, others expecting to work with families for one or more years.

Funding sources

Local authorities were the most significant source of income for independent sector providers, mainly in the form of spot purchasing but also with some Service Level Agreements (SLAs) or block contracts (see further Section 2.4). The interagency fee was an important source of income for some of the VAAs in the sample.

Grant funding had also been an important form of funding for some, essential for scale up or sizeable expansion. Sources included DfE, other central government departments, local multiagency budgets and philanthropies. Other funding came from CAMHS, other health services and education support budgets.

Overall a clear picture emerged of funding constraint. Providers described long periods of delay between the initial approach by social workers and funding having been secured,

and frequently being commissioned for a shorter programme of intervention than they had recommended (see further Section 5.2). Self-funding by parents was strikingly significant, accounting for a third of service users in two agencies and almost all in one intensive therapy provider. One organisation had established a charitable arm to fundraise through family activities such as sponsored walks; another had at one point organised a street collection by staff to fund their own salaries.

2.4.2 Local authority commissioning of the independent sector

The ASF National Survey found that 50% of local authority adoption support services had commissioned a parenting programme in 2013/14, and 74% had commissioned some form of therapeutic support. The numbers of families involved were relatively small. Half of those commissioning parenting programmes and 40% of those commissioning therapeutic support had done so for fewer than five families. Most of the commissioned providers of parenting programmes (85%) were organisations, but the profile of providers of therapeutic support was different with 45% being sole practitioners and 55% organisations.

Drawing on the implementation analysis interviews with local authorities, the independent sector fulfilled a number of roles:

- it enabled access to a form of support not provided by the local authority or CAMHS, particularly specialist therapies such as DDP, sensory integration or attachment-based therapy
- it enabled access to an intervention provided in the public sector but where the family did not meet eligibility criteria – particularly true of CAMHS services
- it provided support at a higher level of intensity or level of expertise than was available in the public sector
- it supported out of area placements too distant for the use of the placing authority's services to be feasible
- more rarely, it was a response to an expressed parental preference for a specialist independent provider (generally reflecting a strained relationship with the adoption team or poor experiences of other public sector providers)

The fact that the independent sector was primarily used to fill gaps in public sector provision or capacity means that the extent to which it was engaged varied considerably. There was less emphasis on external commissioning where public sector provision was strong, and more where there were gaps particularly in CAMHS provision or where the majority of placements were out of area. Access to funding was also highly variable. Finally, levels of use also reflected – and influenced – the capacity of the local independent sector.

'I wouldn't turn down [a family]. I would buy it in if I had to. It doesn't make sense, in any which way you look at it, not to provide families with support when they need it.' PROTOTYPE SITE LEAD

'We don't have the money to be able to [commission in] as we did, and so it is limited, and families do get really frustrated with us and can't understand why we're not paying what we should be paying. Often it leaves not very good relationships.' PROTOTYPE SITE LEAD

The ASF National Survey showed that most therapy provision, and particularly the more intensive packages of support, was commissioned through spot purchasing. SLAs were also used, often covering multi-modal support including advice, mentoring, counselling, support group and family days as well as therapy and parenting training programmes.

Table 2.4 ASF National Survey: Contracting arrangements for commissioning of parenting programmes and therapeutic provision in the year 1st April 2013 to 31st March 2014

TYPE OF CONTRACT	TYPE OF PROVISION			
	Parenting programme		Therapeutic provision	
	%	<i>n</i>	%	<i>n</i>
SLA or block contract	40	27	22	40
Spot purchase	46	31	72	134
Combination/other	12	8	6	10
Don't know	3	2	1	2
Bases: Adoption service managers: 51 responses covering 68 providers of parenting programmes and 75 responses covering 186 providers of therapeutic support. Percentages do not sum to 100 because of rounding and the use of more than one form of contract per provider.				

2.5 Describing types of local adoption support systems

Looking across the range of service areas from which therapy could be accessed for adoptive families, our analysis identified four types of local adoption support systems:

- Systems that were based on **integrated public sector provision** with a strong emphasis on therapeutic provision: bringing together all or some of adoption support social workers, CAMHS, local authority and independent sector provision. External commissioning is used to fill gaps as necessary, for example to provide a specialist or more intensive input or for children placed out of area.
- Systems that were based on therapeutic provision in **the local authority adoption support service plus other public sector services**. Specialist CAMHS services and psychology services were key here alongside the adoption service. Some made almost no use of external commissioning; others made some use, for

example to provide consultations and short term therapy, or to support out of area placements

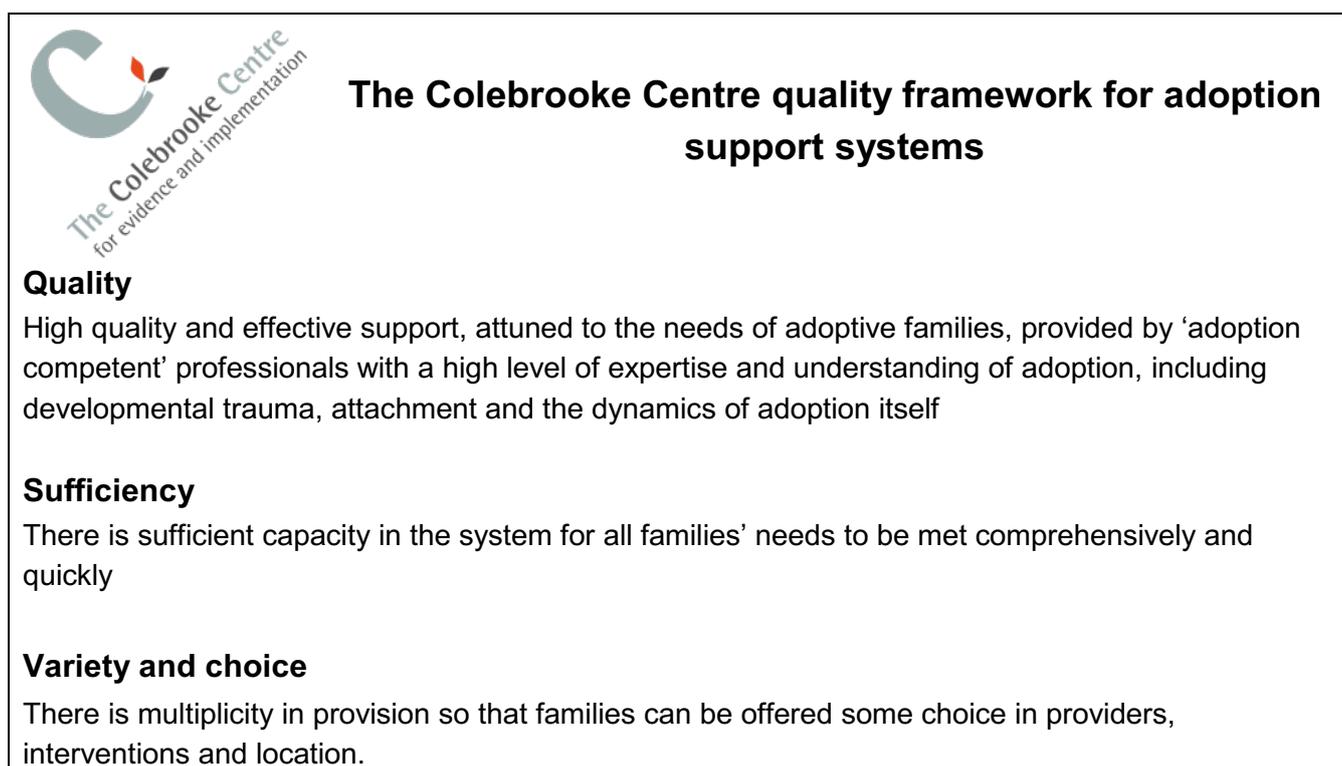
- Systems that were based on the **local authority adoption support service** with little other public sector provision. Perhaps surprisingly, in our sample these local authorities also made comparatively little use of the independent sector.
- Systems where there is **limited therapeutic provision in the local authority adoption support service** with other public sector services and/or commissioning used to varying but sometimes limited degrees.

2.6 Strengths and weaknesses in local adoption support systems

2.6.1 A Quality Framework for adoption support systems

Our analysis of the strengths and weaknesses of local adoption support systems, and the access they provide to therapy, uses a Quality Framework which draws on the international and UK evidence about adoption support and highlights ten key quality features. We have validated the framework informally through discussion with service providers and parents in this and other projects, and the framework informed our review and analysis of the ASF. Using it to review local services highlighted the issues the ASF needed to address and the ways in which it needed to impact to strengthen local systems.

Figure 2.2 The Colebrooke Centre quality framework for adoption support systems



Comprehensiveness and integration

There is coordinated work across professional groups and agencies, providing a comprehensive and integrated approach, avoiding service fragmentation and the 'assessment paralysis' that occurs when uncoordinated iterative assessments lead to delay or an absence of service provision

Evidence-based and data-driven

Approaches are based on testable theory and supported by empirical evidence of effectiveness. Interventions are situated within a data infrastructure for monitoring needs, the quality of delivery, and the ultimate outcomes for families

Efficiency and cost-effectiveness

The form, intensity and duration of provision is aligned with needs, and services provide value for money

Early intervention and prevention

The value of providing early support is recognised, to prevent problems from escalating

Timeliness and ease of access

There is access to timely support with minimal delay and as simple as possible a process, with eligibility criteria that are aligned with the impacts of early trauma and needs of adoptive families, and with delivery models that fit the reality of family life

Partnership with parents

The system recognises the central role of parenting and parents; strengthens the parent-child relationship and builds capacity for therapeutic parenting; operates with a 'family systems' perspective; recognises the challenges of adoptive parenting and is non-blaming; parents are listened to and valued as advocates for their children with privileged insights and understanding

Equity, sustainability and continuity

There is consistency in what is available between geographic areas, and families with equivalent needs are treated equally. There is continuity of providers, services and relationships with children and families, avoiding disruption or early withdrawal which can do further harm to relationships and wellbeing

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2.6.2 Analysing strengths and weaknesses

Our review of strengths and weaknesses draws on the implementation analysis interviews with local authority adoption support service leads, independent sector providers and parents. An important point to note here is that our sample of parents is likely to be biased towards families whose needs were not well met before the prototype ASF was introduced. After all, the fact that an application was made to the ASF implies

that, previously, local services had not been able to meet needs. Their experiences were however consistent with findings from wider research.

Quality

It was clear that some implementation leads regarded some of their local services highly and that there has been considerable investment in skills and capacity in public sector services, most recently with funding from the Adoption Reform Grant. However, it was rare for implementation support leads to view local services as being of high quality across the board: more often there were pockets of quality, and in most areas there were at least some services that they judged not to have the expertise and understanding required.

Parents similarly reported mixed experiences of public sector services. Schools were for some the place where specific problems concerning children's development or behaviour were first identified, and an important point of access to therapy services. Some families found schools – particularly primary schools – very supportive. But for others, schools had made only limited effort to support children, the positive approach of one teacher had not been consistent across the school, and interventions thought not appropriate for a child, particularly behaviourally-based approaches, had been used or commissioned.

'The mainstream school was extremely supportive. They tried very, very hard to keep him within the school. I can't fault them at all actually, they were really good. It just [wasn't enough].' PARENT

'He's doing okay but last year he was doing superb. But unfortunately some teachers ... are better than others. This year we're fighting a battle because the teacher doesn't have any understanding of children coming from these backgrounds. [To the teacher] they're just naughty children, which isn't good And his education's gone down this year, so I'm not happy, because he's a very clever boy.' PARENT

Experiences of CAMHS were particularly problematic for parents and none had received an in-depth therapy response from CAMHS with which they were satisfied. (This is where any bias in our sample will be most evident, since had they done so it is highly unlikely that an application would have been made to the ASF). They described being told that the service did not have the necessary expertise to help; therapy of insufficient intensity, wrongly focused, excluding the parent, and ending with no resolution or improvement; and clinicians who had not connected with children and had left parents feeling blamed and judged.

Experiences of other local authority services – educational psychology, occupational therapy, speech and language therapy and paediatric assessments - had similarly, almost without exception, been poor. Parents reported referrals being turned down, delays, assessments but no service either because the child was below the threshold or because the service did not have the expertise to meet the child's needs, and having to chase to get appointments and reports.

Some parents had had very positive experiences of their local authority adoption service, feeling the service had understood the families' needs, had specialist knowledge and expertise, and provided helpful and effective advice and support. Others however saw social workers as experienced and committed but without the time and resources to help, or questioned the expertise of the social workers they had met particularly in addressing higher levels of difficulty.

As a result of these varied service responses, several families had funded access to therapists themselves (including occupational and speech therapy as well as psychologically-based therapy), sometimes for considerable periods of time. Overall, although our implementation analysis interviews point to some services that appear to provide high quality support, the picture is one of much variation in quality and some areas of real short-coming.

Sufficiency

A perhaps surprising finding was that not all local authority adoption support leads, at the beginning of the prototype, felt that there were needs that went unmet among their adoptive families. There is an obvious dissonance here with the findings from wider research, and this view became a little more diluted with experience of using the prototype ASF. None of the sites had undertaken systematic needs analyses, and adoption service leads can only be aware of deficiencies that come to their attention. However, several described extensive and multiple forms of support being available, and as we noted above some parents described good access to support.

More often, though, capacity and funding constraints were highlighted. Most local authority adoption support service leads acknowledged that, even where there was strong expertise, capacity was limited across the public sector system, with service constraint in adoption support services, other local authority services and CAMHS. Although they acknowledged that their knowledge of the local market was unlikely to be complete, there was widespread concern that it was insufficient to meet current, let alone expanded, demand. There were different views in different local markets about the exact nature of gaps, but, across the sample of local authorities, gaps were identified in the availability of most forms of support, particularly:

- attachment and trauma-related therapies
- specific approaches such as Theraplay, DDP, play therapy, creative therapies and EMDR
- emerging approaches such as sensory integration and mindfulness
- intensive and multi-disciplinary support, both short term interventions where there was a high risk of disruption, and long term interventions
- support for children who have experienced sexual abuse

- interventions across the age range, but particularly in services for children in middle childhood and adolescence
- respite care provided within a therapeutic model

Budgets for commissioning of external providers were often constrained. Balancing provision equitably across a number of families was clearly challenging, especially since demand is unpredictable and a single family requiring an intensive, long term therapeutic intervention will make a significant demand on a budget, with implications for other families. Some local authority adoption leads said they were able to fund all the external commissioning for which a need was demonstrated; others reported constraints which might mean providing social work-based support rather than commissioning therapy, purchasing less intensive external provision, or asking the family to co-fund provision.

Compounding this, it was also clear that there was weak capacity for scale up of activity and diversification of provision in the independent sector. There was widespread concern that the market is not ready for the rapid increase in demand that national implementation of the ASF was likely to stimulate, and that capacity will run out and providers be overwhelmed. This was seen as a very real risk to the sustainability of the ASF, discussed in more detail in Section 6.

There is further evidence about quality and sufficiency in the ASF National Survey. We asked local authority adoption support leads to rate both in relation to their own service, independent sector providers and CAMHS, on a scale from 1 (lowest) to 10 (highest). As Table 2.5 shows, the *quality* of independent sector and local authority adoption service provision was rated reasonably highly, with a mean of 7.7 and 7.5 out of 10 respectively. Quality ratings were lower for specialist CAMHS services (a mean of 6.0: only half rated it at 7 or more out of 10), and very low for mainstream CAMHS (a mean of 3.8). The *sufficiency* of provision was viewed less positively for all parts of the market, with mean scores of 6.4 for independent providers, 5.9 for the local authority adoption service, only 4.3 for specialist CAMHS services and a very low 2.4 for mainstream CAMHS.

Table 2.5 ASF National Survey: Assessments of the quality and sufficiency of therapeutic support: mean average ratings

	MEAN AVERAGE SCORE BASED ON SCALE FROM 1 (VERY POOR / VERY INSUFFICIENT TO 10 (EXCELLENT / COMPLETELY SUFFICIENT)			
ASPECT OF SERVICE RATED	Mean average score per type of provider			
	Independent providers	LA Adoption Service	Specialist CAMHS	Mainstream CAMHS
Quality	7.7	7.5	6.0	3.8
Sufficiency	6.4	5.9	4.3	2.4
Base: 92-97 Adoption service managers rated quality; 90-99 adoption service managers rated sufficiency. Excludes don't knows				

Variety and choice

Although all the local adoption support systems we reviewed had multiple providers of therapeutic interventions (for example play therapy accessible from the local authority adoption support service, via schools, in CAMHS and from local independent sector providers), capacity constraints and divergent eligibility criteria meant that it was rare for there to be a real sense of variety and choice. Similarly, it was rare for parents, before the introduction of the prototype ASF, to have been offered any choice in intervention or provider. The constraints on service sufficiency noted above suggest the system was not yet ready for choice to be a key feature of early implementation of the ASF.

Comprehensiveness and integration

Many examples were given – more by practitioners but also by parents - of effective collaboration and cross-agency working. Implementation leads felt these examples reflected their own advocacy, the commitment and vision of other service leads, and the priority placed by senior leadership on adoption support.

'The multi-disciplinary meetings, without a doubt [have been most effective]. All those people are supporting us and we've got all those ideas in It has been the gold standard For us it's been brilliant.' PARENT

However, there were also many examples, in the interviews with implementation leads, independent sector providers and parents, of poorly coordinated services, inconsistent thresholds and disputes between agencies of where responsibility for funding lay. The general picture that emerged was one of a fragmented service system that was not cohesive and integrated, without shared service standards or frameworks across services. There were discontinuities in provision and in entry criteria, which mean that families easily *'fall through the gaps'*.

A particular challenge was the 'three year rule', under which a local authority that places a child out of area is responsible for adoption support for the first three years after an Adoption Order, following which the local authority where the child lives becomes responsible. There was clear variation in how the rule was interpreted and operated. Some agencies interpreted the rule pragmatically, providing at least some support for a local child even if the placing authority was still responsible. But adoption services often had to commission CAMHS, local authority services or the independent sector to fill the gap. Local authorities, independent providers and parents all frequently described funding battles between different local authorities about where responsibility rested, leading to delay in service provision. This was highlighted as an area where the ASF could make a significant difference.

Evidence-based and data-driven

Our implementation analysis interviews identified three issues here. First, our analysis did not suggest that approaches to whole systems design were obviously data-driven. We were not aware of any sites where the development of the local system had been led by systematic needs analysis and planning. Rather, systems had evolved dynamically and opportunistically, with resultant gaps and discontinuities in many areas.

Second, the strength of the evidence base for the interventions used is mixed: some are reasonably well evidence, other less so, and more needs to be known about what works, for whom and under what circumstances in the context of adoption support. DfE are planning further work to address this, but it will take some time before a more robust and thorough evidence base has been developed.

Third, local authority adoption leads also generally felt their arrangements for monitoring and evaluation of their own services and those secured from other public services or commissioned from the independent sector were not particularly robust. There was more focus among independent sector providers on monitoring therapy outcomes although much variation in approaches, some describing multi-stage monitoring involving standardised instruments and others simpler narrative approaches.

Efficiency and cost-effectiveness

We cannot comment on the efficiency and cost-effectiveness of adoption support systems and the interventions they provide, since this was not a focus of our analysis. However, our implementation analysis interviews highlighted two issues. First, independent sector providers and parents were often critical of the form or intensity of services that had been provided before the case came to them. They frequently described families' early needs having gone unmet, with what they saw as inappropriate or insufficient therapy, or non-therapeutic approaches, having been used.

'Sometimes [when you see] who families have been to see before they get to us ... you think 'why on earth did they ever send you there in the first place? That would not be a helpful person to be seeing given your presenting issues' I think often it has been local authorities grabbing at whoever is available to plug the gap because you've got a family in crisis.' INDEPENDENT SECTOR PROVIDER

Second, our analysis suggests it will be important to review the cost effectiveness of arrangements for accessing external provision, since commissioning did not appear to be particularly strategic in its focus. There was relatively little use of SLAs or joint commissioning across local authorities. Although prototype site leads noted that commissioning for individual families is sometimes necessary, they and independent sector providers questioned whether it was the most cost-effective approach.

Early intervention and prevention

An important strength in local systems was a growing focus on early intervention, building parenting capacity through the assessment and preparation process and with some local authority adoption support services providing therapeutic support from the point when a match was made. This was particularly the approach of adoption support services with high rates of out of area placements, such as Lewisham and Leicester, recognising the difficulty of supporting distant placements. But other local authority leads also described an increasing orientation towards early intervention, and it was widely seen as the direction of travel particularly as understanding of the impact of early trauma and neglect grows. Implementation leads recognised the importance of ‘normalising’ help-seeking and therapy and encouraging parents to come forward early as difficulties emerged.

‘It does feel that a lot of the focus is actually on kind of systematic therapeutic parenting and attachment building at that stage, rather than more specific pieces of intervention with a child The focus is definitely shifting towards the very early end.’ PROTOTYPE SITE LEAD

Timeliness and ease of access

For parents, the stage at which the difficulties that subsequently led to therapeutic interventions first emerged varied. Some families began to access support that led to therapy within the first year or two following the placement; others not until children were teenagers. Families had often been reluctant to ask for help, although this was less true where the likely need for intensive support had been highlighted by social workers *in relation to their individual children* from an early stage. Despite the emphasis most local authority sites placed on maintaining links with adoptive parents through newsletters, emails and social events, parents sometimes described an abrupt end to social work contact with the Adoption Order, which made it difficult to ask for help when problems emerged.

Although some families had received support from early in the adoption, or a swift response when problems later emerged, parents frequently reported not receiving help until the situation had reached a crisis. There were reports of long delays for assessments and services from CAMHS and other public sector providers, and of having to chase to get appointments and reports. It was common for independent sector providers to regard cases as being at or close to crisis by the time they became involved, with earlier needs having gone unmet.

‘My husband all but had a breakdown at work He rang social services and said ‘We can’t do this any longer. We’ve been fighting and struggling with this and we can’t do it any more’. And that’s when they wheeled out help funded by the Adoption Support Fund.’ PARENT

‘By the time I get to see them, they’re absolutely and utterly exhausted and on their knees.’ INDEPENDENT SECTOR PROVIDER

Overall, there was clear scope to strengthen the system in areas including early identification of needs, sustained engagement with parents, and service capacity that enables rapid access to support.

Partnership with parents

Local authority adoption support leads emphasised the importance of working in partnership with parents, but parents' experiences were again mixed. Parents' sense of failure, shame or guilt surrounding their need for help makes them particularly vulnerable to feeling blamed or to suggestions that their parenting is at fault. Adoption service leads and independent sector providers highlighted that parents often initially see the child as 'the problem' and that careful, sensitive work is needed to highlight the value of addressing parenting to provide the particular care that adopted children may need. Some parents noted the supportive and non-judgemental approach of adoption support social workers, and independent sector providers were widely praised for the strength of their partnership work with parents (see further Section 4). However, this was a common area for criticism of public sector services, particularly CAMHS.

Equity, sustainability and continuity

Our analysis – and the wider research literature – highlight much inconsistency between geographic areas and in the experiences of parents. There were occasional experiences of disruption or discontinuity in service provision, but a more significant issue is the need for scale up in therapy capacity across local systems in ways that ensure sustainability.

Overall, our analysis highlighted that there were weaknesses in all the ten characteristics listed in our Quality Framework, and in all three of the aspects of systems (components, connections and supports) we described in Section 1. These issues reinforce the need for the ASF as an intervention to strengthen local adoption support systems and extend current provision, but also highlight the constrained capacity of both public and independent sector provision as a key challenge.

We return to these issues in Section 6 where we explore the impacts of the prototype ASF on the adoption support system. The next section discusses how the prototype sites used the ASF, highlighting variation in their use that reflected the differences in local support systems.

3. USE OF THE ADOPTION SUPPORT FUND

Key messages:

- The prototype ASF appeared to be used predominantly to fund support that would not otherwise have been possible. More therapeutic needs were being identified, the pathway to therapy was accelerated, and more comprehensive or intensive therapy provided
- The prototype ASF was predominantly used to fund independent sector provision. Half of the total expenditure involved registered ASAs or VAAs
- Applications were on average relatively small: half were for under £2500
- The prototype local authorities used the ASF differently, reflecting the strength of public sector provision and the extent of, knowledge about and cultural disposition to use the independent sector
- There was consistent support for using the ASF to fund a mixed economy of provision, although at this stage use of public sector services was low

In this chapter we look at how the ASF was used by the prototype sites, based on analysis of the database of applications (maintained by the Fund manager Mott Macdonald), as well as the accounts of prototype leads. We also look at whether and how the ASF was being used to meet needs that would not otherwise have been met, rather than simply replacing equivalent existing provision.

3.1 An overview of use of the Adoption Support Fund

3.1.1 The interventions funded

DfE had allocated £2 million to the prototype ASF. By the end of the prototype period, a total of 240 applications made by the prototype sites had been approved for funding, representing just over £1.6 million of payments approved. At the close of the prototype period, over 40 further applications were still going through the approval process, to the value of a further £300,000. In addition, shortly before the end of the prototype period the ASF was made available to three further local authorities which made 22 applications to the prototype ASF, to the value of a further £300,000. These local authorities were not part of our evaluation. The analysis we report in this chapter relates to the £1.6 million and 240 applications by the prototype sites which were approved during the prototype period. These involved:

- assessments: therapeutic, cognitive, paediatric, sensory or other occupational therapy assessments
- single therapies (e.g. DDP, Theraplay, 'attachment-based therapy', psychotherapy, music or art therapy)

- multi-modal interventions (e.g. several therapeutic approaches, or therapy plus another intervention such as a parenting programme or youth work)
- therapy for the child, parent/s or both
- parenting programmes
- equipment (e.g. a sensory blanket, or equipment for play therapy or group work)
- training for social workers in therapeutic approaches⁹

Information about the nature and intensity of interventions is not captured systematically in the ASF Prototype Database. From the information available, the number of sessions identified as intended in applications varied from under 10 to over 70, and the most extensive programme involved three years of therapy for a sibling group and parents¹⁰.

3.1.2 The providers funded

As Table 3.1 shows, over 80% of expenditure involved independent sector providers, either sole practitioners or organisations.

Table 3.1 ASF Prototype Database: Use of the Adoption Support Fund by service provider type, 1st June 2014 to 1st May 2015

	Total value of applications £	% of total value of applications	No. of applications	% of total no. of applications
Independent sector – organisation*	1023008	63	81	34
Independent sector – sole practitioner/s	305454	19	94	39
Local authority adoption support service	174027	11	36	15
Public + independent sector	68537	4	12	5
Other public sector provider**	37717	2	14	6
Provider not identified or could not be categorised	4731	0	3	1
Total	1613473	99	240	100
* includes 3 applications involving both sole practitioner and organisation				
** includes 3 applications involving local authority adoption support service plus other public sector				
Base = 240 approved applications. Percentages do not sum to 100 because of rounding				

⁹ Not eligible in the national ASF model

¹⁰ There is a one-year limit per application in the national ASF model

Sole practitioners accounted for more applications but less expenditure than organisations. Half of the total expenditure involved an independent provider registered as an ASA or VAA¹¹. The limited use of public sector provision is striking. Only 11% of expenditure involved services provided by the local authority adoption support service, and 2% involved other public sector providers - CAMHS (one application), local authority psychologists, youth workers, respite care and health services particularly for specialist assessments. Some efforts had been made to commission assessments or services from CAMHS or from other health services, but this had not proved feasible because of capacity constraints. We discuss this further in Section 6.

3.1.3 Value of applications

The average value of applications was relatively low, with a median average of £2544 and mean of just over £6700, reflecting a high number of small applications and a small number of very large ones. Only 6% of applications were for £20000 or more. Values ranged from under £150 (funding one place on a training course) to just under £175,000 (a three year programme of support by an ASA for a large family).

Table 3.2 ASF Prototype Database: Value of approved applications, 1st June 2014 to 1st May 2015

Value:	% of total applications	No. of applications
< £1000	23	56
£1000-2499	24	57
£2500-4999	24	58
£5000-9999	14	33
£10000-19999	9	21
£20000-49999	5	12
£50000+	1	3
Total	100	240
Base = 240 approved applications		

The value of applications was highest for independent sector organisations (median of £4778), and particularly for those registered as ASAs and VAAs (median of £6768). For provision by the local authority adoption support service or by independent sole practitioners, average values were much lower (median of £1160 for provision by the local authority adoption support service and £2289 for sole practitioners).

¹¹ This includes 8 applications for provision by an ASA/VAA in combination with public sector provision, where costs were not disaggregated

3.1.4 Group-based applications

Towards the end of the prototype phase, some sites began to submit applications for groups of families, rather than an individual named family as initially envisaged in the design of the ASF. This approach was used for funding for parenting programmes or training days, a therapeutic youth group and to secure therapist resource for individual therapy for children. Prototype site leads reported using this, essentially capacity building, approach to enable better planning, secure guaranteed provision, enable the support funded to be an integral part of the service offer, and for economies of scale. Group-based applications are not systematically identified in the database, but our analysis suggests that at least 13 such applications were approved in the prototype period.

3.2 Variation in use between prototype sites

The ten prototype local authority sites used the prototype ASF differently in terms of the number of applications made, the total funding secured, the size of applications, and the use of different forms of provision.

3.2.1 Volume of use

The total value of funded applications per local authority ranged from just over £12000 to over £500000. The highest users in terms of total expenditure were Gloucestershire and

Table 3.3 ASF Prototype Database: Number and value of applications by site, 1st June 2014 to 1st May 2015

	Total value of applicns £	Number of applicns	Smallest applicn £	Largest applicn £	Median average value of applicn £	No. of applicns £20000+ excl. group/training
Gloucestershire	526776	45	540	174390	2722	7
North Yorkshire	336229	17	1200	102250	6945	9
Solihull	146427	28	144	24000	3420	5
East Sussex	134616	43	290	17715	1400	1
Manchester	132093	14	720	36470	4750	3
Hampshire	127640	24	600	30000	1600	2
Cornwall	91117	31	156	12930	1852	0
Newcastle	74098	14	250	16125	1560	2
Leicester	32325	11	850	8340	1530	0
Lewisham	12153	13	250	2634	630	0
Average	161347	24	500	42485	2544	3

Base = 240 approved applications.

North Yorkshire, with East Sussex, Manchester, Hampshire and Solihull forming a group of medium users. The highest users in terms of number of applications made were Gloucestershire, East Sussex and Cornwall. North Yorkshire and Gloucestershire, and to a lesser extent Manchester and Solihull, made more applications for relatively large budgets, once group-based and training applications are excluded.

3.2.2 Providers funded

There was consistent support among those we interviewed for using the ASF to fund a mixed economy of provision, as long as this gave families speedy access to high quality services based on specialist expertise. This was even the view of parents who had not been well-served by public provision before the prototype ASF. Parents and providers felt it was important that expertise is sustained and developed in the public sector, existing services not under-utilised, and fragmentation avoided. Parents also wanted locally-based support.

'My ideal view is to have a mixed economy What I know from other areas of service where we've got a mixed service in terms of in-house and out of house, there is competition within that. They are I think much more focused on outcomes. So I think it will also help our internal service as well as the external service to be more focused.' PROTOTYPE SITE LEAD

'I'm personally not very interested in the public/private/voluntary argument. I am interested in sufficiency, appropriateness, consistency and value.' INDEPENDENT SECTOR PROVIDER

Table 3.4 ASF Prototype Database: Use of provider types by total value of applications made by each site, 1st June 2014 to 1st May 2015 (row percentages)

	Indpdent sector organisations %	Indpdent sector sole pract'ers %	Adoption Support Team %	Other public sector %	Public + indpdent sector %	Not identified %	Total %
Gloucestershire	80	20	0	0	0	0	100
North Yorkshire	79	1	15	0	5	0	100
Hampshire	72	25	0	3	0	1	101
Manchester	71	1	27	0	0	1	99
Solihull	69	31	0	0	0	0	100
Lewisham	51	7	25	17	0	0	100
Cornwall	21	5	30	2	40	3	101
Newcastle	16	53	2	30	0	0	101
East Sussex	10	56	23	2	9	0	100
Leicester	0	0	76	17	6	0	99
Average	47	20	20	7	6	1	101
Base = 240 approved applications. Percentages do not sum to 100 because of rounding							

The extent to which the ten prototypes were using the ASF across a mixed economy varied considerably, as Table 3.4 shows, with use by some very strongly oriented to the independent sector and others using the ASF to fund a more diverse set of providers.

These variations reflect at least in part the provision available in different local adoption support systems. For example, Leicester, with a therapeutically oriented local service and limited independent sector market, primarily used the prototype ASF to fund its own adoption support service. Cornwall funded its own adoption support team (which included Theraplay workers and a psychologist) but also extended its existing commissioning of the independent sector. Hampshire, with limited therapeutic capacity in the adoption support service, focused its expenditure on the independent sector.

In addition, among the sites with therapeutic capacity in the local authority adoption service, there were different decisions about whether to use the prototype ASF to fund it. One group of sites did so only for interventions involving specific therapeutic models or parenting programmes. At least one local authority operationalised a wider definition, applying for funding for any therapeutically-based support (and indeed for support that appeared to be only loosely therapeutically based). Others did not use the ASF to fund their own services. They had not considered it, or took the line that the ASF was for additional support only.

3.2.3 Breadth of use of independent sector

Finally, sites also varied in the number of independent providers used. Gloucestershire and East Sussex used a particularly large number of different independent sector

Table 3.5 ASF Prototype Database: Number of independent sector providers commissioned by site, 1st June 2014 to 1st May 2015)

	No. of independent providers commissioned	
	Sole pract'ers	Organisations
East Sussex	13	3
Gloucestershire	11	10
Hampshire	7	4
Cornwall	5	2
Newcastle	3	2
North Yorkshire	3	4
Leicester	1	0
Lewisham	1	4
Manchester	1	4
Solihull	1	2
Total	43	28
Base = 240 approved applications. Column totals reflect use of some providers by more than one LA.		

providers. These two sites, along with Solihull, were also the highest repeat users of individual providers. For example Solihull commissioned the same sole practitioner 13 times over the prototype period and one organisation (with which the sole practitioner was associated) 11 times. Repeat commissioning may be advantageous in that close working relationships could be developed with providers. But the accounts of prototype leads also pointed to it reflecting weaker local markets, the need for continued work on market intelligence (see Section 5) and a less embedded culture of external commissioning, issues which are likely to be interrelated.

3.3 Explaining patterns in use of the Adoption Support Fund

Given the high level of variability in local systems that we highlighted in Section 2, it is unsurprising that the prototype sites used the ASF in different ways. As we discuss further in Sections 5 and 6, the prototype ASF was not yet being used by prototype sites to catalyse or support change in their local 'whole system' of adoption support. The focus instead was on using it to fund existing known providers. In addition, the funding parameters were, deliberately, not tightly specified at the start of the prototype and were adapted during it, often in response to feedback by the sites. These issues help to explain why its use was very varied, and mean that the prototype provided less clear signals about possible use in national implementation than might have emerged had the model been unchanged between prototype and national implementation.

As we expected, use of the ASF largely reflected strengths and weaknesses in the existing local support system, particularly the availability of specialist provision from CAMHS, the extent of investment in therapy in the local authority adoption support service, and the extent of, knowledge about and cultural disposition to use the independent sector. The sites that identified more gaps in provision and more families reaching crisis and near-disruption used the ASF most actively, whilst those confident in their ability to meet families' needs prior to the introduction of the ASF generally used it less, although there were exceptions to this.

Looking at patterns in use of the Fund by the types of local adoption support system we described in Section 2:

- The two sites with **integrated therapy provision** were both moderate users of the Fund, by value, both using it for out of area placements, to provide more intensive support or specialist therapies, or (in the case of East Sussex) to complement the AdCamhs service adding therapies it did not provide. For both, the Fund was used mainly for independent providers. There was little use of the Fund for the integrated adoption support service. However, by the end of the prototype period both sites were making group-based applications and looking to use the ASF to extend and innovate their integrated therapy service

- The three sites with **therapeutic provision in the local authority adoption support service and in other public sector services** mainly used the ASF to fund this internal provision. Two were low users of the ASF; Cornwall was a high user
- The three sites where therapeutic capacity was **mainly in the local authority adoption support service with little other public provision** were more varied in their use of the Fund. Gloucester, which described more constraint on internal therapy capacity, was a high user of the ASF; the other two were moderate or low users. Only one used the Fund significantly to fund in-house services
- The two sites where there was **limited therapy capacity in the local authority adoption support service** were also varied in their use. Hampshire, with stronger public sector therapy provision, was a moderate user of the ASF; North Yorkshire with less access to public sector therapy provision was a high user. Both used it almost entirely to commission external provision
- Overall, sites with strong **CAMHS provision** made less use of the ASF. It was used actively by sites with weak CAMHS provision unless they had other public sector provision to compensate
- Sites with a strong orientation to **pre-order support and early intervention** also made less call on the ASF. These sites also tended to make more out of area placements and so had time-limited responsibility for adoption support. Some local authority representatives highlighted disproportionate use of the ASF for children placed by another local authority¹² and for older children.

3.4 The ASF and additionality

The ASF was intended to provide *additional* help, meeting needs that, without the ASF, would not have been met, or not fully. There was potential for use instead that was *substitutional*, with families receiving help funded by the ASF that they would have received anyway, either from the same service or from a different service. Implicit in the intention of additionality is the assumption that some needs, prior to the introduction of the prototype ASF, went unmet. As we highlighted in Section 2, this was not the view of all site leads, at least at the start of the prototype phase.

¹² There is no data in the ASF Prototype Database about whether placements are in or out of area, although applications made in the first three years post Adoption Order are flagged

Our discussion of funded cases with the prototype site leads highlighted that the ASF was mainly providing access to therapy that would not otherwise have been available, although there was some evidence of substitution. An important point to make is that we cannot comment on whether they represent a better use of public money or are more appropriate. The extent of evidence about the effectiveness for adoptive families (or more widely) of the interventions being funded is mixed. Some are reasonably well evidenced (although not necessarily for adoptive families), others much less so. It will be important, for the longer term sustainability of the national ASF, to assess whether the therapy interventions provided are appropriate and effective.

3.4 1 The potential for additionality

Prototype site leads described additionality *potentially* arising in four ways:

- **Families with therapeutic needs were identified, or identified earlier, than before the ASF:** There was little evidence for this by the end of the prototype period. On the whole, local authority adoption leads were of the view that, even without the ASF, they would have been aware of all or almost all the families for whom they had accessed funding. They were aware of a few families prompted to ask for support specifically by knowledge of the ASF. As we discuss in Section 5, all the local authorities were promoting the ASF actively by the end of the prototype period, and it was expected that in time, with sustained outreach work, more families would come forward, and would do so earlier.
- **Therapeutic needs were identified which would not have been identified, without the ASF:** There was more evidence of additionality here. In some prototype sites, (again discussed in more detail in Section 4) assessments were now more thorough and robust, and social workers more aware of and attuned to therapeutic needs than before the ASF. Perhaps more significantly, there was also a sense of a notional ‘threshold’ for therapeutic intervention being lowered. Therapeutic needs were being identified where previously the response would have been a social work or other family support approach. The ASF meant sites were able to provide therapy *without this being at the cost of support for other families*.

‘I wouldn’t say some of these families wouldn’t have had therapy, but it would be focused on those that were most in need and at crisis point. That’s not how it should be That’s not to say we wouldn’t have put in additional support ourselves, and done what we can to support them, and pushed CAMHS ... but we wouldn’t have been able to provide it in the same way’ PROTOTYPE SITE LEAD

- There was also evidence of **an accelerated pathway to therapy:** Families no longer had to work their way through lower tiers of support if it was clear that a

therapy intervention was needed. Sites also used the ASF to avoid lengthy argument between agencies about responsibility for funding. We were aware of a few funded cases where the prototype site accessed the ASF to fund therapy for an incoming placement in the first three years following an Adoption Order, before becoming formally responsible. This suggests that the ASF will have a highly significant impact in easing access to therapy in cases where responsibility is disputed, with particular relevance for out of area placements

- **Therapeutic support that was more comprehensive, intensive or a better fit to families' needs than would have been available, absent the ASF:** This was the key area where prototype leads felt the ASF had added value. They saw this added value arising in a number of ways:

- commissioning providers and therapies that would not have been used without the ASF

'We've found DDP has been an absolutely marvellous addition.' PROTOTYPE SITE LEAD

- providing support that was more *'creative'*, *'innovative'* or *'experimental'* than might have been secured through other routes, such as art, play and music therapy, or other therapies seen as more experimental such as sensory integration¹³. Whilst experimentation may well be valuable, this highlights the importance of robust outcomes monitoring in the national ASF
- providing support that was viewed as better attuned to the child or to the parents' expressed preferences. As we discuss in Section 5, local authorities did not follow parents' preferences unquestioningly, but they valued being able to tailor the therapeutic response to the particular interests of the child (for example an orientation to music, drama or art) or to parental preference (for example for an external provider)
- increased intensity: funding more sessions or a fuller programme than would previously have been feasible

'Before the ASF created an external way to pay for this, we would have just had to offer [in-house therapy] on a less frequent basis. We would probably have provided it once every two or three weeks. We would still have offered an intervention, but I guess its

¹³ Equine therapy and reiki, not eligible within the national ASF, were also mentioned here

effectiveness would have been diluted. Having the ASF means that I could look for [an external provider local to the out of area placement] instead.' PROTOTYPE SITE LEAD

- layering therapies: commissioning more than one external provider to work concurrently, or external provision alongside therapy from CAMHS or the local authority adoption support service. (Independent sector providers had some concerns about this approach, as we discuss in Section 5.)

The extent to which the prototype local authorities identified additionality varied. As would be expected, where local authority leads were confident that they had been able to meet needs fully prior to the prototype ASF, there was less evidence of additionality. Where the ASF was largely used for in-house provision, additionality was mainly in the form of providing more sessions than would otherwise have been provided. But where it was acknowledged that there had been gaps in provision, there was much more evidence of the ASF being used to access provision that would not otherwise have been available.

The almost universal view of adoption support leads was that these service responses represented a more appropriate response than would have been feasible without the ASF. Their view was that more families were now getting access to more of the therapy they needed, and that this would have significant impact on the ability to sustain placements.

3.4.2 Shifting concepts of 'sufficiency'

Also striking was the impact that many site leads described on the adoption support team, particularly where previously access to therapy had been very constrained. Social workers were now able to respond to needs as they would have wished to, and speedily, and site leads observed higher levels of energy, enthusiasm, creativity and morale as a result.

'It's made a huge difference, really, feeling as if you can help these families and give them what they need rather than what is available, and respond to them quickly, which is what they need It's a huge sense of relief to a lot of the staff that we can just say yes, which is amazing It's made a huge difference. It's like working in a different team, or a different job.' PROTOTYPE SITE LEAD

An interesting nuance was that there appeared to be a shift, over the prototype period, in concepts of 'sufficiency' among the prototype site leads. As we noted, some were confident, before they began using the prototype ASF, in the sufficiency of local provision. However, even site leads who at Wave 2 made little use of the ASF and reported little additionality were, by Wave 3, describing changes in practice as a result of the ASF which they judged positive for families. In part this might have emanated from growing pressure on local authority budgets: over the prototype period there was less confidence that funding for additional provision previously secured would continue to be

available. However, underpinning local authority resource allocation is the need to manage service responses with finite constrained budgets and for an unpredictable number of families. Some prototype sites described the beginning of a change in *'the local authority mindset'*, since the availability of the ASF meant that the first service response could now be a fuller one.

'It makes you think even more creatively, rather than the first thing you think about being funding So you're very much focusing on the needs of the child in a different way.' PROTOTYPE SITE LEAD

Having the additional budget stream of the ASF meant that local authority adoption support services could now *meet* more needs, because a fuller response could be made without affecting the service's ability to meet other families' needs. But the comments made suggest that they also allowed services to *recognise and acknowledge* more needs. This may be indicative of the emergence of more shared understanding between parents and adoption support services and a better aligned conceptualisation of what is 'sufficient'. Viewed through a systems lens, which highlights that the alignment of objectives and values is an important pre-condition for effective systems, this is a more fundamental and propitious change.

3.4.3 Substitution

There was some evidence of the prototype ASF being used with a substitutional effect, that is, in place of equivalent services that would have been used had the ASF not been available. We have no statistical data on this, but the observations of site leads suggested it arose in a small minority of cases:

- where the ASF was used to commission external provision that would have been commissioned anyway: in some cases it was already being funded prior to the introduction of the ASF
- where the ASF was used to commission external provision in place of referring the family to CAMHS or where a refusal of service by CAMHS would, without the ASF, have been challenged by the adoption support service. As we noted in Section 2, adoption service leads were not always successful at obtaining CAMHS services. However, the ASF was used reluctantly here and it was viewed as an inefficient use of public money which *'lets CAMHS off the hook'*.
- where the ASF funded enhanced in-house provision, part of which would have been provided anyway. For example where the ASF funded 20 sessions but 12 would have been provided anyway.

To varying degrees, the prototype sites sought to avoid substitution through:

- continuing to look first to in-house adoption support services, CAMHS and other public services unless they were clearly unable to meet a therapeutic need

- not using the ASF for the local authority adoption support service unless what was provided was clearly different from and additional to the pre-ASF service response
- not using it to fund other public sector provision on the grounds that these were already funded
- not using it to fund independent sector provision that was already secured by an existing SLA or similar arrangement.

In the cases where there was evidence of substitution, it was generally felt that adoptive families had had swifter, smoother access to therapeutic provision. However, substitution will need to be monitored. If the ASF drives use of external provision in place of existing public sector services, an unintended consequence *could* be a loss of expertise, weakening commitment to supporting adoptive families, and dilution of capacity in the public sector. (As we note in Section 5, there were some early indications that might point to this.) There are also questions about efficient use of public funding, and about equity in the use of the ASF between local authorities. However, it is possible that using the ASF to fund public sector provision, and accepting a degree of substitution, is necessary to stimulate innovation and capacity development there – an issue we discuss further in Section 6.

3.5 Extending the scope of the ASF

The widening of eligibility criteria during the prototype phase was greatly welcomed by the prototype site leads. There remained, by the end of the prototype phase, a strong view among them and independent sector providers that the exclusion of pre-order support was unfortunate, although the rationale that local authorities have a duty to meet the needs of all looked after children was understood. There was also concern among these groups that the ASF could in theory create a perverse incentive to move earlier to an Adoption Order, although prototype site leads had seen no evidence of this and were confident that practice in their own service was sufficiently robust for this not to happen.

Prototype leads, independent providers and parents were also troubled by the exclusion of education-related therapy, both because the boundaries between education-related and other therapy are indistinct and because school is a key domain in children's lives. Prototype leads regretted the exclusion of funding for training for adoption social workers in therapy methods in the national ASF, particularly where the local independent market was limited and building in-house capacity was viewed as important. The introduction of an initial one-year limit on the duration of a therapy programme was viewed as a potential risk in the few cases where a more substantial programme was judged necessary. Finally, there was also a growing view that the specific focus of the ASF on adoption would be hard to sustain longer term, particularly as local authority adoption support services are increasingly reconfigured to include SGOs and other forms of permanence.

4. FAMILIES' EXPERIENCES OF THE PROTOTYPE ADOPTION SUPPORT FUND

Key messages:

- Families' experiences of the therapy funded by the prototype ASF were overwhelmingly positive. They felt therapists had a high level of specialist knowledge and expertise, and valued their supportive, partnership-based approaches
- Many had been at a point of crisis when they had accessed therapy, with deteriorating relationships between children and parents, and children exhibiting high levels of distress
- Most were at an early stage in therapy, and the process for some families was more difficult than expected, but the almost universal experience was of very significant progress already having been made
- Parents described children being better able to manage their feelings and behaviour, and more settled at home and at school. They described themselves as having a better understanding of their child and how to support them, and had modified their own behaviour and responses
- Several parents felt the therapy funded by the ASF had prevented the placement from disrupting

4.1 Families' experiences of ASF-funded providers

Of the 17 sets of parents involved in the implementation analysis, the ASF funded independent sector providers for 13, the local authority adoption support service for three, and the independent sector and a local authority service for one.

Families' experiences of these providers were overwhelmingly positive. In our small sample, this was particularly so where families had used independent sector provision. Therapy provided by the local authority adoption support service was also well received, and parents valued the continuity of relationships and the connection between the therapy and the advice and support they had previously had from the team. Parents using independent sector provision, however, found an approach that was often a striking change to their prior service use. They felt that therapists had a high level of specialist expertise and knowledge, immediately making sense of child's behaviours or distress within a framework for understanding the impacts of early trauma and adversity. Therapists quickly formed positive relationships with children and parents, connecting with children in a way that not all professionals had, making them feel comfortable, supported and not judged or blamed. For many parents, this was important validation of their own concerns, particularly if they felt these had been minimised by other professionals. They welcomed the re-focusing from parenting shortcomings to the particular needs of children affected by early trauma. There was a sense of enormous relief for those who had been struggling to get an effective service response.

'When we went to [ASA], it was like putting your dressing gown and slippers on. I just felt like we'd come home. It was just lovely. They completely filled us with confidence and they're delivering.' PARENT

Several parents commented on the child-centred perspective of their therapist, whether from the local authority adoption support service or an independent provider. The ability of the therapist to explain the child's behaviour from their perspective, and help the parents to see from this view point, was very much valued. Several also commented on the therapists' emphasis on the need to work at the child's pace.

'Social workers are always very good at putting themselves in the shoes of the child and playing that back to you as a parent So it's something about helping you to develop your own skills in doing that They have an incredibly child-centric view of the world.' PARENT

There was a strong sense of working in partnership, which for some parents was a new emphasis in relationships with professionals. Their own knowledge of their child was valued, the therapist actively sought their insights into the child and the key aspects of family life to address, and there was a strong sense of working together. Therapists were also valued for the constructive challenge they gave parents.

'Sometimes it's not what we want to hear, but she does deliver it in a manner where I'm quite happy to go back the next week She gives us advice in a way of 'I understand why you do this, but you might want to think about [an alternative approach]. So I guess she's just got a good way of going at things.' PARENT

Being able to contact therapists between appointments was really valued. Parents were impressed by the attention therapists had paid to historical reports and assessments: one therapist had met the child's birth mother so they could help the child understand how they came to be adopted, as part of their work with the family. Several parents were particularly struck by the family systems focus of therapists' work – an emphasis on wider family dynamics, impacts on and needs of siblings (adopted and older birth children), and the relationship between parents.

There were occasional exceptions to these very positive experiences. For one parent there had been long gaps between sessions because their sole practitioner therapist was ill. One parent whose therapy was provided by the local authority adoption support service and another whose child was seeing a local authority therapist were unsure that the approach was sufficiently specialist or intensive and that the practitioners involved had sufficient expertise.

It is important to stress here that in our small sample there were also positive experiences of ASF-funded public sector therapy. But this early evidence highlights the critical importance of systematic methods for feedback from parents on service experiences and outcomes to inform future referral decisions, and of ensuring intervention type and intensity are well matched to needs.

4.2 The outcomes sought by families

Many parents were at a point of crisis by the time they accessed support funded by the prototype ASF. Some had lost confidence in themselves and felt out of their depth, lurching from crisis to crisis, and failing to meet children's needs. This is reflected in the key issues that prompted their approach for help:

- children's rejection of the adoptive parents, an expressed preference to be with their birth families, poor relationships with parents, and allegations against parents which had led to child protection investigations
- children's anger, aggression and violence, mainly towards parents but also sometimes towards others
- behaviour seen as controlling and manipulative
- behaviours such as stealing, running away and self-harm
- children's high levels of anxiety, hypervigilance, extreme upset and unhappiness, poor sleep patterns
- children being insular, withdrawn and '*bottling up*' their feelings
- severe difficulties at school, including exclusion and actual or near breakdown of school placements

It was, understandably, sometimes hard for parents to describe the specific outcomes they sought from therapy. It is probably also fair to say that desired outcomes tended to be expressed primarily in terms of changes for children rather than changes for parents. This may reflect what independent and public sector providers describe as a tendency for parents, at least initially, to see children as 'the problem' rather than taking a wider family systems perspective. But it may also simply be that parents saw improvements for children as the ultimate objective of therapy. The key outcomes sought that emerged from the interviews were:

- **strengthening the family unit:** staying together as a family (many felt there was a high risk of the family breaking up), having positive family interactions rather than a feeling of '*constant battles*', children being settled in the family and positively wanting to be there
- **changes in children's emotional state:** for children to feel happier, safer, more secure and '*comfortable in their own skin*'; to understand themselves better; and to have an integrated sense of identity and family history
- **changes in children's behaviours:** for children to control their anger and aggression and to understand the impact of their behaviour

- **changes in their own parenting:** to have a better understanding of their child and what lay behind their behaviour or difficulties; to have strategies for addressing problems and defusing situations; and to have a better understanding of the support their child needed now and in the future.

4.3 Families' perspectives on early outcomes from therapy

The interviews with parents occurred at different stages in their work with therapists, and it was early days for some. Some had found therapy more difficult than they had expected, for themselves or for children, and they had experienced downturns as well as progress. This is an important point to note: it reinforces comments made by prototype leads about supporting families through therapy, and comments by providers about the importance of sufficient therapy intensity and duration. However, the almost universal experience was of very significant progress having already been made, even when the therapy programme was far from complete.

'The sessions have affected [daughter] – sometimes it feels like it's in a really good way and sometimes not so much, but I think we have to go through it to come out the other side Some weeks it's really good and some weeks it's really bad and she comes out of there really cross, and she's cross for the whole week So, yes, sometimes that is really hard but it has to be done.'
PARENT

Parents described children as having more insight into the immediate triggers and underlying causes of their feelings and behaviours, and as a result being better self-regulated, more able to manage their feelings and less likely to manifest them in anger, aggression and violence. Their behaviour was more settled in the family, at school and in other social interactions, and some noted a significant improvement in their child's learning.

'She'll say 'I've come off the trampoline because I don't want to hurt anyone or hurt myself, but I'm finding it a bit difficult at the moment' Whereas before she'd have hit the other children or hit herself. So she is coming on tremendously, she's learning to self-regulate and not lash out at people.'
PARENT

'For periods she [has been] great the whole week, there were no tantrums, she was quite calm, she was able to play nicely with her brother which we've just never seen, ever We've taken her to Brownies and she's made friends there and, again, it's early days but I wouldn't have considered taking her before, I couldn't have taken her to any club.' PARENT

For two parents, these improvements emerged not only directly from therapy sessions but also from additional services that the therapist had helped to broker, in one case leading to a successful medication intervention and in another to a diagnosis of Asperger's which had helped the parents to provide targeted support to the child.

Parents also described having a better understanding of the support their child would need from other services, particularly schools but also health services. Parents also highlighted changes for them, perhaps placing more emphasis here than in their earlier discussion of the outcomes sought. Even those at an early stage in therapy felt they had new insights and strategies based on a stronger framework for understanding their child. They had more insight into children's behaviours, what triggered them, and the underlying causes, and a richer understanding from the child's own perspective. They felt better informed and more empowered to act as an advocate for their child in the future. They also described a better understanding of their own part in difficult family dynamics, their own triggers, responses, and behaviours, and how to manage their own reactions differently.

Many described having modified their own behaviour, acquiring and putting in to practice better strategies for avoiding or responding to crises, managing their own responses in ways that helped the child to manage theirs, and making more space for positive family time together. There was a sense of parents having a more balanced perspective on the child and family, a better understanding of what is 'normal' and what is not, and a calmer reaction to some day-to-day challenges - alongside a heightened understanding of the significance of problems previously under-estimated.

As a result the family environment was calmer and happier for everyone. Family life was still challenging for many of the parents we interviewed, but difficult times could be managed more successfully so they did not escalate into 'war' and could be defused, with less significant implications.

'Perhaps it's like lots of little earthquakes, a lot more easy to cope with than to be in some sort of giant meltdown where things are being thrown around and punches are being thrown. So it's a lot more cope-able with for us, and more constructive for everybody, so that even if tempers do get a bit more hot or they get upset about things, we know that actually, do you know what, in half an hour or an hour's time we'll be friends again, we'll be able to work through this.'
PARENT

Perhaps most significantly, several felt therapy had interrupted a process they felt would likely have led to the adoption placement disrupting.

'There's no way that we would still be a family if [ASA] hadn't come on board We wouldn't be a family if it wasn't for the Adoption Support Fund.' PARENT

In the next section we focus on the prototype sites' implementation of the ASF, and its fit and alignment with existing processes surrounding adoption support.

5. IMPLEMENTATION OF THE PROTOTYPE ADOPTION SUPPORT FUND

Key messages:

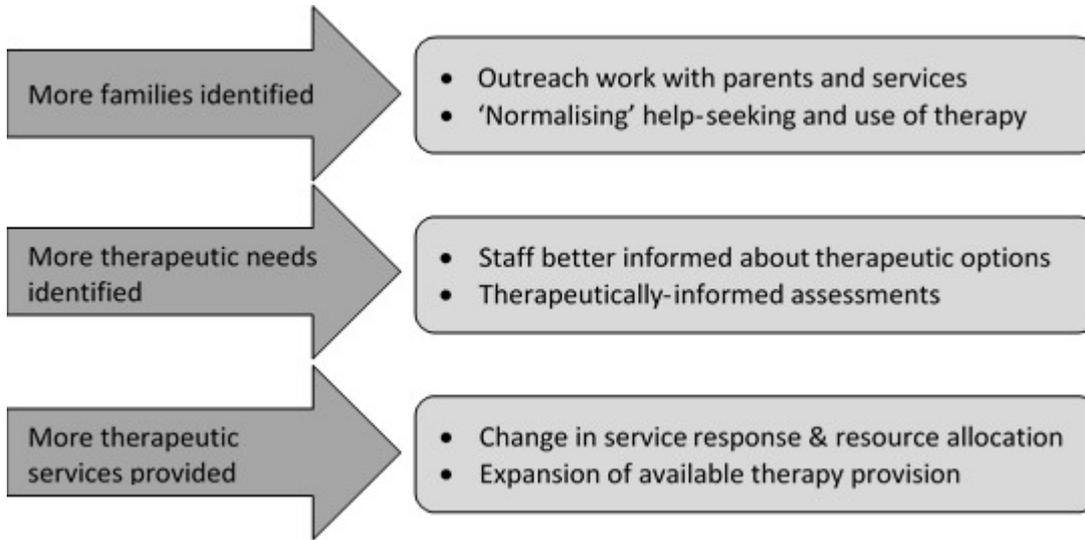
- The experiences of the prototype local authorities highlight areas where planning and strengthening of processes and infrastructure will be needed to get most value from the national ASF
- Sustained outreach work directly to parents and through other services is likely to be needed to reach more parents with unmet needs
- Approaches to assessment will need to be strengthened to support judgements about therapeutic treatments, requiring both capacity building in adoption services and more clinical input. A number of models for this were emerging
- Shared decision-making with parents may need to be strengthened as markets expand, to support parental choice about treatments and providers
- Joint work between adoption services and external providers was seen as important, but practices, expectations and cultures varied and more consistent arrangements are likely to be needed
- Strategic service planning, based on systematic analysis of local needs and provision, will be essential to support and optimise market development across the system. Active market stimulation is likely to be needed in many geographic areas
- Building market intelligence and establishing provider frameworks, locally or regionally, will be important aids to making full use of the ASF
- Many local authorities will need to consider how to introduce improvements and flexibilities to commissioning processes to strengthen the infrastructure for the ASF
- It is widely anticipated that the ASF will lead to more trading of therapy services between local authorities
- Monitoring of outcomes of therapy will need to be strengthened within local authorities and independent providers, and a data infrastructure embedded in the ASF for systematic data collection about needs, services and outcomes

In this section we describe the planning and other activity undertaken by the prototype sites to strengthen the organisational infrastructure for implementation of the ASF – with important implications for other local authorities.

Our analysis raises a number of issues concerning the alignment of the ASF with operating contexts and processes within local authorities. An implication of our discussion of additionality in the previous section is that adjustments are needed to processes and systems if the ASF is to add value to local provision. Identifying more families implies a need to improve outreach and normalise help-seeking. Identifying more therapeutic needs implies a need for developments in assessment practices. Providing more, and faster access to, therapeutic services implies a need to change

service responses and to scale up provision, which requires a whole systems focus to planning.

Figure 5.1 Preparing organisational processes to support the Adoption Support Fund



5.1 Raising awareness of the Adoption Support Fund

5.1.1 Promotion to parents

During the course of the prototype period, most of the local authority sites went to significant efforts to raise awareness of the ASF among parents and to encourage them to come forward to discuss their needs. This work used a range of media described in Figure 5.2.

Figure 5.2 Promoting the ASF to parents

<ul style="list-style-type: none"> adopter preparation sessions and other workshops the adoption panel ongoing casework the adoption service website Facebook regular newsletters and leaflets about adoption support 	<ul style="list-style-type: none"> writing individually to all adopters support groups social events events specially set up to promote and discuss the ASF council magazine or newspaper local press
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Local authorities also used case reviews and team meetings to identify cases where there may be therapeutic needs. Parents felt the most useful approach was for local authority adoption support services to write to parents directly with detailed information about what can be funded, eligibility criteria, how to access the ASF and examples of how it had been used for other local families.

Most prototype sites had taken a fairly cautious approach to promoting the ASF, fearing they might be *'inundated'* with requests, but on reflection judged that they had been over-

cautious. They reported a low level of response from parents to outreach work, and indeed some saw no increase in the numbers enquiring about support. Others were, by the end of the prototype period, beginning to see a rise in demand, most pronounced for one local authority that recognised there had been gaps in its pre-ASF therapeutic provision. Whilst this might suggest few needs that are unknown to services, it might also indicate that *sustained* outreach work is required to reach parents.

5.1.2 Promotion through other services

Adoptive families' difficulties may first become evident in other service areas, and so raising awareness of the ASF elsewhere is also important. Most of the prototype sites either had promoted the ASF, or planned to promote it to other services including: CAMHS; psychology and educational psychology services; the Virtual School and education service leads; other social work teams; Children's Centres and GPs.

Most leads recognised that there was more work to be done here by the end of the prototype period, but there was hesitation for two reasons. First, there was a reluctance to engage other services before the long term shape of the ASF was clear. Second, there was concern about unintentionally stimulating withdrawal of other services from supporting adoptive families. Two prototype site leads had observed disturbing early signals of this from CAMHS and schools, and one had had to challenge assumptions by the local authority resources panel for specialist services that adoption support cases no longer needed to be considered.

'It became a case of 'well, we don't need to discuss this because it's [appropriate for] the Adoption Support Fund' and [I had to say] 'wait a minute, no, it actually needs to go through this route because ... there may be other assessments and other pieces of work that are needed and it's not actually [just] about adoption Services should continue to be provided in the way that they would normally be provided.' PROTOTYPE SITE LEAD

This highlights the importance of engaging systems leaders across health, social care and education to ensure the ASF is incorporated into the local adoption support system in a planned and intentional way, without inadvertently incentivising withdrawal of existing public services. The prototype leads felt it would be helpful if central government supported this in its own policy development and communications about the ASF to other agencies nationally and locally.

5.2 Assessments and treatment decisions

5.2.1 LA assessment practices

It is not uncommon for the introduction of an innovation to expose existing weaknesses in practices and systems, and early implementation of the prototype ASF pointed clearly to a need to strengthen assessment skills and processes in most sites.

In the prototype sites, adoption support assessments were primarily carried out by the local authority adoption support service, although there was some use of generic family support assessments conducted by children's social workers. Approaches were generally based on the Assessment Framework. Use of standardised assessment instruments was limited although evolved somewhat during the course of the prototype. (A list of the assessment instruments used by local authorities and independent sector providers is shown in Appendix 2.) However, formal assessments were not always carried out. For example, if there was a recent assessment or support plan, if the family were already receiving an intervention, or if the family were at a crisis point, an assessment might be judged unnecessary or unfeasible.

There was concern among many (although not all) of the prototype sites about the capacity of social workers to make judgements about therapeutic treatment directions, and the adequacy of their assessments to support these decisions. Although this was, of course, part of local authority adoption support services' work before the ASF was introduced, the ASF brought an expectation of more cases and a wider range of treatment approaches and providers to consider. Local authority adoption support leads were more confident where staff were more experienced, had been trained in therapeutic methods, or where there was access to clinical expertise.

5.2.2 Emerging models for clinical input into assessments

Local authorities where there was ready access to clinical expertise routinised their use of it with the introduction of the prototype ASF. Involving clinical colleagues in all or some cases where there appeared to be a need for therapeutic input was seen as an important aid to effective implementation. Different models evolved during the course of the prototype:

- Involvement of clinicians as part of an integrated service or multi-disciplinary adoption support service. This was viewed as very effective, and other sites were considering incorporating a psychology post in their service

'I would say probably nine times out of ten [the psychologist is consulted I would struggle to see how people [in other local authorities] are asking for Therapy or DDP or whatever without that input.' PROTOTYPE SITE LEAD

- Involvement of CAMHS or other psychology services: However for several sites CAMHS capacity was insufficient, and attempts to secure more involvement had thus far not been successful
- Solihull commissioned an independent psychologist to work part time in the local authority adoption support service, drawing up initial treatment plans
- Commissioning assessments from independent sector providers (either as a standalone piece of work or as the first stage of treatment) or approaching them for informal advice. There was some unease about this. Although adoption service leads scrutinised assessment reports and recommendations, and certainly viewed providers as primarily driven by the interests of children, they recognised there was a potential conflict of interest and indeed had sometimes encountered treatment proposals they judged inflated. This was also a more vulnerable arrangement if the provider worked within a single or limited set of interventions, as many did.

'I'm not questioning their professionalism, but there's a [conflict of interest] because they are private businesses [who need to] maximise their income.'
PROTOTYPE SITE LEAD

Several of the prototype leads became more confident about the quality of assessment practice during the course of the prototype, as social workers undertook more assessments, underwent training, and learnt from working with independent sector providers. Our observations suggest there was some scope for greater clarity and consistency in when clinical input or review was sought, and most prototype leads felt there remained weaknesses in assessment processes.

5.2.3 Independent providers' perspectives on assessment

The independent sector providers we interviewed generally viewed therapeutic assessment as complex work, not easily divorced from the therapy process itself, and requiring skills and understanding of therapeutic interventions, which social workers could not be expected to have. Most fairly routinely received local authority adoption support needs assessments and reports from other social care and health services, found them useful (although sometimes of variable quality), and valued the insights of social workers working with families. However it was important to them to be able to carry out their own assessments. These generally involved observation and interaction with the family in more than one session and discussions with other agencies, particularly schools, where the child was sometimes observed. Some used structured instruments in assessments (see Appendix 2), others used dialogue and observation.

In most of the prototype ASF cases discussed, the local authority had liaised with the independent sector provider to discuss the scope of treatment before the application was made. Independent providers were generally uncomfortable with the idea of committing to a specific intervention, or a specific number of sessions, without carrying out their own

assessment, and emphasised that there needed to be flexibility in the early stages of their work.

Providers said that it was not at all uncommon to encounter problems in the early stages of referrals and case work. Drawing on their experience beyond the ASF, they described encountering:

- A lack of clarity, at the initial approach by social workers, about why therapy was needed, why a particular intervention or provider was being considered, and the key therapeutic needs.

'Normally the referral would come in terms of ... 'we think they need some therapeutic work, we're not entirely sure what, could you have a look at it?' ... There's normally a catalogue of difficulties that need addressing but in terms of a therapeutic plan, there isn't one.' INDEPENDENT SECTOR PROVIDER

- Families and children not being ready for therapy: more immediate issues (such as child protection allegations or a crisis regarding a school placement) first needed to be resolved, or there were too many other agencies involved with the family.
- Cases being more complex than suggested by social workers, which might mean that a different therapeutic approach or further assessments were needed, sometimes requiring a suspension of treatment.
- It was common for providers to be commissioned initially for a shorter period of therapy than they judged necessary. In part this might have reflected under-estimation of the severity of needs by social workers, but it also appeared to be an intentional contract management strategy. Local authorities tended to commission providers for a set number of sessions with a review at or before the end to consider whether more sessions would be needed. Although providers rarely experienced a contract not being extended if this was their recommendation, it could still mean uncertainty about whether to start working towards an ending, a hiatus in treatment, and reviews being held at a stage that was not necessarily clinically optimal.

Several providers highlighted that ASF-funded cases were a marked contrast to more common experiences, with notably faster agreement of funding and commitment to a higher intensity of treatment.

'Both of [the ASF-funded cases] are the fastest I've ever had in terms of trying to explain the long term nature of our work, and [the social workers] got it straightaway. They were able to organise finance really quite quickly and smoothly in a way that enabled us to take the children within weeks There was a sense of yes, we're all in agreement with this, which was so significant in enabling us to work with the children and trust there was a [long term commitment].' INDEPENDENT SECTOR PROVIDER

- Finally, providers were also sometimes concerned about cases where they had been commissioned to work alongside other therapeutic providers. Many had

encountered cases where they felt the work proposed was too intensive, and where the varied approaches of therapists were potentially in conflict. Some went so far as to see it as unethical to take on a case if another therapist was already involved.

These issues were also described by local authority adoption leads, and highlight vulnerabilities likely to surface in use of the ASF. Indeed, all the issues noted above were highlighted by prototype leads and independent sector providers in the discussion of ASF funded cases.

5.2.4 Implications for the Adoption Support Fund

Our analysis points clearly to a need to strengthen local authority adoption support service assessment processes. This will be important to ensure that families receive the most appropriate service and are able to make progress (and indeed are not harmed), and for the efficient use of public money. There are a number of ways in which this could be addressed. There is a need to continue to strengthen social work practice through training on assessments and on the appropriate use of available interventions. There is also scope to make more use of structured screening and assessment instruments, and a review of validated instruments and their application would be helpful.

Assessment practice would also be supported by a synthesis of international evidence on treatment effectiveness. Given that the evidence base is not fully developed, it would be unhelpful to define eligible therapies too narrowly, and continued innovation and experimentation are likely to be important, although oversight of this is essential. Further work to identify more confidently an appropriate range of interventions is planned by DfE. This would also usefully draw on professional insight and parents' and young people's experiences alongside conventional research synthesis methods.

It will also be important to strengthen the input of clinical expertise in assessments for therapeutic interventions. Continued innovation in service models will be helpful, particularly models that integrate different perspectives in a multi-disciplinary approach. Some prototype sites are working to this through collaboration with CAMHS or psychology services. Another model worth considering is a dedicated multi-disciplinary therapy assessment resource, which might be located in the local authority adoption support service, in clinical services, virtually, or regionally. The establishment of regional adoption agencies provides opportunities here. The prototype site leads generally preferred to see such a resource embedded in their team. However, several of the providers we consulted felt there was scope to scale up assessment models such as that provided by the South London and Maudsley NHS Foundation Trust and used in the 'It's All About Me' adoption service, and to deliver them through regional centres.

It would also be helpful if independent sector providers reviewed and strengthened their own assessment approaches.

There are also implications here for the ASF's operational processes. It was not intended that the ASF should quality assure local authority needs assessments: assessments are not included as part of the application for funding, and decisions about funding are made without scrutiny of whether treatment plans are appropriate to the needs identified. There were mixed views among those we consulted about whether such scrutiny is desirable. On the one hand, it was viewed as important that families' access to therapy was not delayed, and there was little appetite for any form of central monitoring of treatment plans. Monitoring of the outcomes of treatment was generally seen as a more appropriate way of identifying whether treatment was appropriate to families' needs. On the other hand, it was recognised that inappropriate use of the ASF could impact negatively on families. Prototype leads generally felt their own use of the ASF was sufficiently robust for further scrutiny to be unnecessary, but were concerned that when implemented nationally, other local authorities might use it inappropriately or inefficiently. Independent sector providers also shared these concerns.

There is insufficient evidence at this stage to determine whether additional scrutiny is needed, and if so what form it should take. Intelligence about the appropriateness of the interventions funded in national implementation will be important in determining whether the system needs to be tightened (for example introducing either further scrutiny or a requirement for clinical input in assessments), and designing a proportional response.

Since assessment cannot be entirely separated from treatment, there also needs to be some flexibility to accommodate adjustments in treatment plans. There may be value in a specific fast-track process for two-stage applications involving assessment followed by treatment, or for extensions of treatment.

Although prototype leads thought it appropriate that the eligible interventions were not narrowly defined, they also noted some 'grey areas' where the outcome of applications sometimes depended on the precise wording used. This was particularly true of interventions which were based on therapeutic methods but were not themselves specific forms of therapy, such as parenting support, life story work, youth work and counselling. This will be an issue to consider in further work on eligible interventions.

Ultimately the area of assessment and determination of treatment direction is of key importance to the effectiveness of the ASF, and our analysis suggests that both practice and the operation of the ASF may need to be strengthened.

5.3 Parents' involvement in decision-making

Increasing parental choice and involvement in decision-making is an important long term policy goal for DfE – perhaps more so than was understood by the sites during the prototype period. The site leads emphasised the importance of working in partnership

with parents in making decisions about the type of therapy and the provider to be used. They generally saw it as their own responsibility to identify options, offering a choice if viable. In one ASF funded case the social worker and parents had met with three external providers to select one, but this approach was highly unusual. Families occasionally approached the adoption support service with a prior view about a preferred intervention or provider: this was also rare. Overall, parents were seen as reliant on the advice of social workers.

'They have a say in it but most are happy to go with what we've recommended because if we said to them 'what do you think you need?' they haven't got a clue. They'd gone way beyond knowing what they needed. They just wanted somebody to sort them out and make them feel held.' PROTOTYPE SITE
LEAD

Parents were generally happy with the decision-making process they experienced. For most, the social worker had suggested a particular therapist and no choice had been offered. Parents had wanted information about what was being proposed and why, and a chance to respond, but generally felt they did not have the professional expertise required to be more involved than this. Most had not had a clear view about the help they sought – they just needed something.

'They did it really nicely. It wasn't 'You're going to have this'. They said 'We feel this approach would be worth trying first' and we just said 'Fine, whatever you've got'. They also said 'If this doesn't work, we will look at [alternatives]' We were also very aware she was the only [provider] locally.' PARENT

However parents would occasionally have preferred to have had a choice. This was true for two parents receiving therapy from the local authority adoption support service, one happy with that option, the other not. Some parents would have liked independent advice particularly from a therapist, particularly where relationships with the adoption service were poor. They generally felt it was important for alternatives to be offered if parents did not feel the proposed direction was right or involved unfeasible journey distances.

Fulfilling the aim of parental choice will require an active focus on market expansion (see Section 5.7 below). It also means local authorities will need clear policies on whether a choice of provider should be offered if appropriate public sector support is available. If parents become more informed and markets expand, there may be a gradual change in the dynamic of decision-making, with parents looking to play a bigger role. This may require different approaches and skills on the part of local authority adoption support services, and possibly more access to clinical or independent advice for parents.

Independent sector providers have an opportunity to be proactive in ensuring that local authority adoption support services are sufficiently familiar with their services to inform parents, and will need to be ready to support parents in considering alternatives and making choices about providers and interventions.

5.4 Direct payments and personal budgets

The Children and Families Act 2014 introduced a clause to require local authorities to offer a personal budget for adoption support services, but this has not been commenced by the Government. There was an early intention to test direct payments as part of the ASF, and the prototype local authorities established systems for this. However, the scope for direct payments within the ASF is limited, since decisions need to be made about intended provider and treatment before an application is made. By the final wave of implementation analysis interview fieldwork, only one case was reported where a direct payment had been used. We found strong, although not universal, reservations about the idea among parents, prototype leads and independent sector providers.

'Some adopters would be absolutely fine and they'd know what they want, and they would research. But I think some would need the help and support of the local authority to guide them through ... an array of services Adopters can be in a very vulnerable place, and desperate.' PROTOTYPE SITE LEAD

There was a little more interest among parents in the wider concept of personal budgets for pooled funding streams. They saw these as potentially helpful to reduce barriers to accessing services and to ensure a comprehensive service package, and particularly useful if trust in the social work team had been diluted. Parents felt they would need robust information and advice to make decisions, possibly from an independent service.

5.5 The decision to apply to the ASF

An interesting effect of the introduction of the prototype ASF was that it generally led to more devolved decision-making about the use of therapy, with decisions being taken by adoption service managers in place of panels or more senior post-holders. One prototype site continued to use its resource allocation panel to approve decisions to apply to the ASF. This was seen as important scrutiny for consistency across service areas and also meant that commitment to local funding was in place if the application were rejected by the ASF, or if the case needed both pre- and post-order provision. However, other sites no longer used the resource allocation panel for ASF cases, with decisions instead taken by adoption service managers. Delegation to a manager with more knowledge of the case was welcomed by prototype leads, and seen as speedier.

'The initial decision-making would be between a social worker and me Then I would discuss it with the service manager who would be the one who would agree the funding. I suppose she's told now rather than asked!' PROTOTYPE SITE LEAD

Parents generally had limited awareness of an application having been made to the prototype ASF, but the source of funding was much less significant than securing access to the right help for their family.

5.6 Joint work between local authorities and external providers

Liaison and joint work between local authorities and independent providers in funded cases was an important aspect of implementation, both to support positive impacts of therapeutic support for families, and to build expertise and capacity across the system. Families would not be well served by islands of excellence in provision which are disconnected from other professionals and from the wider system, particularly as they often need an integrated response across services.

The prototype leads generally emphasised the importance of high quality joint work with the external providers they commissioned. Cases remained 'open' in the local authority adoption support service, with social workers providing ongoing support. They viewed it as important to remain sighted on the progress of therapy, so they could support families; to flex and revise contracted arrangements if necessary; to provide follow-on support consistent with the therapy; and as an opportunity to develop their own expertise. Approaches included liaison with the family and provider at the start of therapy, attending a joint set-up meeting, attending therapy sessions (although this was rare), joint reviews, a handover meeting when therapy ended, and open communication with the provider and family throughout. There were occasional examples of independent providers being embedded in local authority adoption support services and of strong joint work in individual cases.

'With adoptive families and especially if you're working around attachment, it's really important to model close working within the professional network. Splitting is something we try to avoid. We think it's really important to model that we're working here as a team, not farming you out because you're really complex or difficult.' PROTOTYPE SITE LEAD

Providers similarly viewed keeping the adoption service sighted on their work as important, and they emphasised working closely with the whole support network, attending meetings and reviews, liaising with schools and other professionals.

'You've got your intervention, but you need the wraparound too, going to the LAC reviews, working in parallel with schools You've got to be containing the network, supporting the network to be thinking about the child's needs from an attachment perspective My job, I think, is to try and hold the network, hold the child, and do the therapy.' INDEPENDENT SECTOR PROVIDER

Parents described some extensive liaison work undertaken by independent therapists and valued this very highly.

'[The therapist] will attend meetings with me and for me, she's quite happy to liaise with people on my behalf Actually I think she swings a lot of weight. It's amazing what can get done when she says something or picks the phone up or attends a meeting, compared to what can get done when I do.' PARENT

In practice, the emphasis placed on joint work by providers and local authorities varied, suggesting that this is an area where practice development might be needed to strengthen the infrastructure for the ASF and help to optimise its value added. Local authorities found some external providers rather exclusive in their approach, which they attributed to promotion of the provider's own model and culture, or to commercial interests.

Equally, external providers found some local authorities (not particularly the prototype sites) disinclined to engage in their work with families. They mainly attributed this to time pressures, although it was also suggested that social workers need a better understanding of the methods used to provide effective liaison and consistent support.

Parents generally felt it was right that social workers should have some involvement with therapists, but some had not felt they needed ongoing support and wanted as few people involved and as little scrutiny as possible as they and their children went through a private and challenging process.

Overall, our analysis suggests that the appropriate liaison arrangements between social worker, therapist and parent are likely to vary, but that there was scope for more regularised arrangements and perhaps also for a shift in expectations on the part of both independent sector providers and local authorities. There was some evidence that the experience of the prototype was beginning to encourage this (see Section 6).

5.7 Strategic service planning and commissioning

5.7.1 Strategic service planning

We noted in Section 2 a sense of local adoption support systems having evolved dynamically, and not in an obviously intentional or systematically planned way. Strategic approaches to local service planning and configuration, across the local system, will be important for optimising the system to support the ASF and to achieve most added value from it. The numbers of families needing therapeutic support are relatively small and demand is uneven and hard to predict. Most areas identified a need for more therapy capacity in their local system, but it would be unrealistic to assume that, left to its own devices, the market will develop optimally, or indeed at all. Where this has not yet been done, our analysis suggests that systematic analysis of local needs and available provision is required. Such work needs to involve local system leaders, independent sector providers and parents, and could serve multiple purposes, aiding:

- more confident forecasting of demand
- identification of service expansion and innovation required and where in the system this would best be stimulated

- more contract-based commissioning and more sustained relationships with providers
- work across local authorities at regional or sub-regional level on service development and commissioning
- development of a bedrock of local strategic commitment to post-adoption support, and a shared vision across the local adoption support system.

Some of the prototype sites were at an early stage in reviewing services, either alone or within their consortium. Several prototype sites had already begun discussions and planning for collective commissioning with neighbouring local authorities and were enthusiastic about the potential, although noting that neighbouring systems need to be well aligned in terms of objectives, priorities and approaches for such approaches to have traction. As we discuss in Section 6, it was not clear that local systems leaders were yet fully engaged in support of this planned work.

5.7.2 Market stimulation and development

Strategic service planning and commissioning across local authorities would also provide a stronger foundation for market stimulation and development. Collaborative work across agencies and sectors is needed to expand capacity and innovate services. Some prototype sites were reaching the capacity of known providers by the end of the prototype period. However there was little evidence yet of work to stimulate or nurture new service development in either the public or independent sector.

'The only way the independent sector will know what the need is, is for local authorities to undertake collective needs assessments and publish them It's about statements of need, being clear about what outcomes you're looking for from the provision of those services, so defining the outcomes, and then asking providers to go away and to design services that would meet the defined outcomes.' NON-PROTOTYPE SITE LEAD

For most prototype leads, market stimulation was an unfamiliar area of work and it was not immediately clear how to take it forward. Independent sector providers, and to some extent local authorities, also said that there was not yet a strong culture of creative partnership and co-production between local government and the independent sector. Procurement processes were cited as a particular constraint, but this is an area where more fundamental cultural change may be needed to optimise the impact of the ASF on independent sector provision.

'The barriers are leadership and culture rather than financial.' INDEPENDENT SECTOR PROVIDER

Finally, independent sector providers have an opportunity to be proactive in initiating discussions with local authority adoption support services to develop a shared

understanding of local need and explore the scope for service and capacity development. We discuss this further in Section 6.

5.7.3 Market intelligence

At the start of the prototype period, a few of the local authority adoption leads were confident of their knowledge of the local market but most felt their knowledge was partial to very limited. They used a small number of external providers and were not generally aware of many more. During the course of the prototype period, most local authorities, either individually or within consortia or sub-regional groups, were gathering market intelligence through desk-based research, and liaison with other services and providers.

Several were developing approved provider frameworks, again either locally or with neighbouring local authorities or across consortia. The pace was fairly slow, and one prototype lead had been told by commissioners it would take a year to have a joint framework in place across the local authorities involved. Some 'soft marketing testing' had been undertaken to raise awareness within the independent sector of the types of services needed and to encourage providers to come forward. Gloucestershire had run two provider engagement events across children's services, and North Yorkshire were planning a joint event with CAMHS and health.

Many of those involved in the implementation analysis interviews identified the need for a national register of independent sector providers, with information about services and organisations. A more ambitious vision was that this would also include information relevant to the statutory checks local authorities make when commissioning a provider not regulated by Ofsted, and details of other local authorities' use and evaluation of commissioned therapists. The national ASF application process included a drop down menu listing providers already funded by the ASF in different geographic areas, and it would be helpful in the national evaluation to monitor whether there are further information needs.

For the independent sector there is an opportunity for outreach and marketing activity to ensure local authorities are aware of the services they provide.

5.7.4. Commissioning and procurement processes

A recurrent issue among prototype leads, and providers, was that local authority commissioning processes were cumbersome, onerous, and led to delay in service provision.

'You can use the strict definition of procurement rules to almost make it impossible to get a service in time to respond to an immediate crisis You can very quickly lose sight of the child in the middle of all of that.' NON-PROTOTYPE SITE LEAD

'[With] some local authorities, we are now having to tender just for an individual piece of therapy I have massively reduced my therapeutic caseload because of the amount of time it can take just to respond.' INDEPENDENT SECTOR PROVIDER

The focus for prototype site leads during the prototype period was on finding short term strategies to work around these problems rather than to tackle them directly: negotiating a waiver to the usual procurement requirements or commissioning small blocks of therapy below the threshold for more formal processes. In many local authorities, there will be a need to consider how to introduce flexibilities and improvements to procurement processes, to strengthen the organisational infrastructure for the ASF.

For independent support providers, ensuring sufficient capacity to respond to procurement processes is clearly key, and several of those we spoke to also acknowledged a need for more work on pricing to enable rapid responses to tenders.

5.7.5 Trading services

Most prototype sites were anticipating making their own therapeutic services available to other local authorities to support incoming placements, with a focus on parenting programmes but also including therapeutic interventions by social workers. They were working to develop realistic costing strategies and some were beginning to develop marketing literature. There was a view that costs needed to be coordinated across local authorities for consistency and to avoid market distortion. The actual financial systems needed to pay and receive funds were not thought to be difficult to develop or adapt. It was expected that the ASF will stimulate more trading of services between local authorities. This was viewed as a valuable development that did not raise particular administrative challenges.

5.8 Monitoring, evaluation and the need for a data infrastructure

Finally, as we noted in Section 2.6, systematic monitoring of outcomes of therapeutic interventions appeared to be a weak point in the system. Local authorities were beginning to consider ways of strengthening these approaches. Local data will be an important driver of decision-making, and independent sector providers also need to develop their monitoring and evaluation. However, a robust data infrastructure also needs to be embedded in the ASF for systematic collection of data about intervention content, intensity and duration; providers; implementation quality; family satisfaction and clinical outcomes, with routinised data collection from providers and families including at a follow-up stage. The range of needs, interventions and intended outcomes makes this complex design work, but being able to demonstrate the quality and efficacy of interventions funded by the ASF will be important to its long term sustainability.

Continued improvements to the national ASF database and the national evaluation provide opportunities to take this forward.

Overall, our analysis highlights a number of areas where continued work, principally by local authorities but also by independent support providers, will help to strengthen the infrastructure supporting the ASF, and areas where there are opportunities to enhance the ASF's operational processes. In the next chapter, we look at early evidence about the impacts of the ASF on local adoption support systems.

6. IMPACTS ON LOCAL ADOPTION SUPPORT SYSTEMS

Key messages:

- By the end of the prototype period, the ASF was beginning to stimulate increased therapy capacity in local authority adoption support services. Social workers were being trained in therapeutic methods, capacity was being freed for therapeutic work, and parenting programmes were being expanded
- There were also early indications that the ASF was strengthening a tiered support offer encompassing universal preventative, early therapeutic and intensive support levels
- The ASF was stimulating demand for CAMHS provision and there were some promising early developments in some prototype sites. However there was not yet any evidence of CAMHS capacity increasing, and some early suggestions of the prototype ASF potentially incentivising withdrawal of CAMHS from adoption support. Our analysis highlighted some significant difficulties surrounding CAMHS: the transformation programme is a key opportunity to address these
- There was a clear increase in demand for provision from the independent sector. However, our analysis suggests that the ASF will not, on its own, stimulate more than small scale incremental capacity growth and that other investment in capacity is needed
- The prototype ASF was beginning to impact positively on system connections. It has clear potential to strengthen local authority adoption support service relationships with parents. It was already stimulating more collaborative work, both between local authorities and by local authorities with the independent sector, and making it easier to commission services quickly
- Regional adoption agencies offer an important opportunity to address fragmentation and to support more collaboration and integration across the system
- The ASF had also highlighted ways in which the systems supports and the infrastructure for adoption support could usefully be strengthened or better aligned, particularly local and national policy, systems leadership, funding, governance, workforce development, and data.

This chapter looks at the impacts of the ASF across local systems with a particular focus on whether it is stimulating an increase in therapy service provision. As we noted in Section 1, the interactions between innovations and systems are complex and involve both direct and indirect impacts, and both planned and unintended consequences. Where there are systems weaknesses, innovations often highlight them, and can create a constructive disturbance that stimulates change. We use the conceptual model we introduced in Section 1 to explore the dynamic between the ASF and the system at three levels:

- system components: looking particularly at the impact of the ASF on the scale and content of provision in different parts of the system
- system connections: the quality of relationships and interactions between systems components
- system supports: the wider infrastructure supporting the system and, potentially, the ASF.

6.1 Reviewing systems impacts at an early stage

Our analysis highlights some propitious early indications of the potential impact of the ASF on local systems, as well as identifying challenges that will need to be addressed. Systems effects were at an early stage of development at the time of our research. It would anyway be unrealistic to expect them to have manifested fully in this early stage of implementation, but there were some specific contextual factors which also point to systems responses being relatively immature. As we noted in Section 2, not all site leads saw obvious deficiencies in their local system or needs that were unmet prior to the ASF. They saw their own low use of the ASF as evidence of this, although it is also possible they were not aware of all unmet need. We also described in Section 3 evidence of a change in local authority 'mindset' around the sufficiency of support and of previous responses to needs, which may be only the beginning of a more profound cultural shift.

The future funding model for the national ASF was not yet known, and adoption service leads were concerned that funding levels in the prototype period might not be sustained, leading to expectations among families that they could not continue to meet. In addition, the prototype period was intentionally used as a development phase, and it took some time before some features of how the ASF could be used were firmly established, particularly the availability of funding for services for groups of parents and for in-house and other public provision.

We also highlighted in Section 5 ways in which some local authority processes needed to be strengthened to take full advantage of the opportunities offered by the ASF. Other public sector services were not yet responding actively to the opportunities presented by the ASF, and local markets remained constrained. Overall, if families' needs were previously under-recognised and under-met, it will take time before local service systems have adapted fully to address this.

Moreover, as we highlighted in Section 2, although funding is of central importance it was not the only form of weakness in local adoption support systems. The learning from systems thinking is that systems improvements generally require interventions which are designed and implemented with the whole system in mind (Ghate, 2015), intervening at multiple levels and on many or all the 'moving parts' of a system. Several of the adoption leads and providers we consulted were critical of the ASF in this respect, viewing it as an

additional source of funding to be spent within an ineffective system rather than an attempt to enhance or transform the system as a whole, and our analysis supports this critique to some extent.

Together, these issues point to systems impacts being at a very emergent stage at the time of our analysis, although there was nevertheless evidence of the ASF beginning to have positive impacts on local adoption support systems. Our focus in this chapter is therefore on the evidence thus far of impacts, the potential of the ASF, how to optimise its positive impacts on the system, and additional initiatives that might help to strengthen the whole system to better support the ASF.

6.2 Impacts on systems components

We begin by looking at early impacts of the ASF on the scale and content of **systems components**. As our discussion in Section 3.4 highlights, there was strong evidence of an increase in local authority demand for therapy services. But a key question is whether the ASF can also stimulate increased supply. Changes in demand and supply need to be broadly in equilibrium to avoid market distortion. If demand rises faster than supply, there is a risk of rising prices, or gaps being filled by low quality or other inappropriate provision. If supply rises faster than demand, there is a risk of falling prices and suppliers becoming unsustainable. The evidence by the end of the prototype period was that the ASF was beginning to stimulate an increase in supply in local authority adoption support services. There was little or no evidence, at this stage, of increased supply in CAMHS, other public sector services, or the independent sector.

6.2.1 Impacts on local authority adoption support services

Impacts on therapy capacity

Several local authorities trained or were planning to train social workers in specific therapies¹⁴, particularly Theraplay and DDP (mainly to Level 1), and with plans to explore other therapies that might be incorporated into in-house provision.

'I also want to spend a bit of time thinking creatively about how do we develop the service There's a real need for more knowledge around sensory processing and I think that if we could skill up our knowledge in that area or [use] someone who's external ... then we will be able to offer a much more holistic and better service So I suppose it's again creatively looking at how we can use the Fund.' PROTOTYPE SITE LEAD

¹⁴ Social worker training is not in scope for funding in the national ASF model but the costs of subsequent therapy provision are in scope.

Those with existing parenting programmes were providing them more frequently and considering developing new modules or programmes. Some which had not previously run a therapeutic parenting programme were now making plans for one. One site had established a children's therapeutic group, and others had similar plans.

There was also some evidence of more general in-house capacity development. There was a better understanding of therapeutic needs and of issues such as secondary trauma and hypervigilance, from initiatives to improve assessments and closer work with independent specialist providers. In addition, adoption service social workers trained in therapeutic work had sometimes had limited capacity to use these skills in longer term work. Being able to commission external provision for some families had released some of their own staff capacity for therapeutic work.

There was less evidence of an expansion in staffing resources. In North Yorkshire, a specialist adoption support service had been established with more capacity for adoption support. Leicester had made a temporary post permanent, and Cornwall had secured an additional social worker post and more psychologist capacity. The availability of the ASF had been influential on these decisions. Many of the prototype sites were watching the demand for therapy closely to identify whether a case could be made for more team resources. Some were considering joint capacity development with neighbouring local authorities, although discussions were at an early stage pending national implementation. The use of group-based applications to the ASF is likely to be particularly important here, but strategic work to forecast future demand will also be necessary.

In some sites there was more hesitation about expanding in-house capacity. Uncertainty about future funding arrangements for the ASF was a brake on expansion. But some sites also questioned whether expanding in-house therapy capacity was the optimal approach, both because only a limited range of models could feasibly be offered and because training is a long term investment, lost if staff subsequently leave.

Strengthening of a tiered support offer

We also observed early indications of a strengthening of the overall adoption support offer of social work-based support and activities. Having an additional funding stream from the ASF potentially released resources which could be re-invested. Savings (whether in the form of staff time or budgets for external expenditure) arising from the ASF were generally not yet visible to prototype leads, and some were unsure whether any savings would, in practice, do more than mitigate future budget cuts and any future local authority contribution to the ASF. But for others there was a stronger sense that resources could in future be reallocated for investment in the core offer of early preventative work, and occasionally a view that this had already begun to happen.

'We've got the skills to provide that therapeutic support, but ... it's long-term therapeutic support. In terms of team capacity, that ... reduces the capacity to do some of the preventative and early support work So if I can

[commission] the intensive therapeutic work, then we can focus on the preventative.' PROTOTYPE SITE LEAD

Thus the ASF appeared to be strengthening a more differentiated, tiered model of service, already existing in some local authorities and emergent in others, involving:

- **universal preventative services** for adopters including advice and direct support: more therapeutically informed as a result of the ASF and potentially enhanced through reinvestment of savings
- **an early therapeutic offer:** from within the team or from independent sector providers, particularly involving interventions such as therapeutic parenting programmes, play therapy and Theraplay
- **intensive therapeutic interventions:** increased access to independent sector provision for families at higher levels of need beyond the capacity of public sector provision

'The Adoption Support Fund has probably given us the opportunity to think about what's the windscreen of need? How do we manage that need? Where [is] the best place for that [level of support] to come from?' PROTOTYPE SITE LEAD

It was anticipated that expanded early intervention would, over time, reduce the demand for intensive intervention. This enrichment of support across the spectrum of need implies increasing scope to respond to individual families with a service offer well attuned to their specific needs.

6.2.2 Impacts on CAMHS

Increase in demand for CAMHS provision

There was clear evidence of an increase in demand for therapeutic provision from CAMHS by the end of the prototype period, in the form of input into assessments, specialist assessments, consultation and advice to parents and social workers, and supervision of social workers using therapeutic techniques as well as direct therapeutic work with children and parents.

However, there was little evidence at this stage of any increase in CAMHS capacity. In one prototype site, a new arrangement was put in place for monthly consultation sessions with CAMHS to get input into issues arising from adopter preparation, matching and support needs. (The ASF was not the only influence on this but had helped to make the case for it.) In another, the availability of the ASF meant that services for adoptive families had been given more clarity and profile in the CAMHS service re-specification. In another site there had been some early meetings with commissioners and CAMHS management to discuss the scope to extend the service offer to adoptive families.

However, none of the prototype sites reported any change thus far in CAMHS provision. Indeed, none had succeeded in using ASF funds to commission CAMHS provision for a family, with the exception of one application by Leicester involving a joint systemic family therapy project with CAMHS. Elsewhere it had only been possible to commission a CAMHS staff member in their capacity as an *independent* provider. In some sites, as we noted in Section 3.6, the ASF was also being used to bypass CAMHS altogether and go direct to external providers.

Barriers to increased CAMHS input

A number of barriers were identified to stimulating CAMHS provision. At the time of our final interviews, most sites were still in the process of re-commissioning CAMHS services and the resource available for adoption support was therefore unclear. In some local authorities it seemed likely to be reduced. CAMHS staff capacity remained constrained, and the availability of additional funding did nothing to change this. Prototype leads had been told that cases meeting the threshold would receive services and those below would not.

'I queried about funding CAMHS and what I was told ... - it was quite a brief discussion with CAMHS which actually probably I need to go back to, but their view was that that's never going to happen, because if it's a case they could deal with, they'd be dealing with it.' PROTOTYPE SITE LEAD

In areas where there was little or no specialist CAMHS provision for adoptive families, prototype site leads were sceptical that their CAMHS service was able to offer appropriate provision. Finally, two prototype sites had, as we noted in Section 5.1, seen early signs of their CAMHS service seeking to withdraw services in the light of the availability of the ASF and had had to intervene to stem this. Some site leads were confident in the commitment and continued collaboration of their CAMHS service, but the risk was also recognised by other sites.

'We are getting CAMHS clinicians telling adopters they need to come to us ... and telling us that we should be applying to the ASF for [a specific service] and not using [an intervention provided by CAMHS] What we're finding is it's a way of them not picking up referrals for adopted children.' PROTOTYPE SITE LEAD

We did not interview CAMHS service leads or commissioners, so our intelligence on their response to the ASF is very limited. However, we interviewed a small number of independent therapists who also worked part time in CAMHS services, and they echoed the points made by prototype implementation leads. One painted a rather bleaker picture. They described the local CAMHS service being in a state of '*near freeze*' due to continued uncertainty about job security and likely substantial service reduction. They felt the service had limited understanding of adoption, attachment and the effects of early trauma and, perhaps most significantly, was not culturally disposed towards or ready for collaborative work with adoption services to expand or re-design provision.

This description clearly does not apply to CAMHS services in all prototype areas - some have strong relationships which could form the basis for joint work on service development. But it is likely to be recognised by adoption support services in other local authorities nationally, and raises concern about the readiness of CAMHS for service innovation and capacity development to meet a growth in demand arising from the ASF. For CAMHS to be in a position to be part of the response to the needs of adoption support, the good practice and collaborative working that is evident in other sites needs to be adopted more widely. The CAMHS transformation programme represents a key opportunity to improve the interface between CAMHS and adoption services, and the substantial restructuring proposed is a systems disturbance that could be leveraged in support of the ASF.

6.2.3 Impacts on other public sector provision

In terms of impacts on other public sector therapy provision, there was limited evidence of changes to the scale or content of provision at this stage. One prototype site was commissioning more frequently a parenting course provided by its educational psychology service; one had begun to refer adopted children to a new service which offered Functional Family Therapy (FFT); and as we noted in Section 5.2, there was some increased involvement of psychology services in assessments. Otherwise there was no evidence of increased demand for public sector therapy services or capacity development, and relatively little recognition among prototype leads that the ASF could be an opportunity to stimulate public sector service development and scale-up. There was also concern that a potential local authority contribution to the ASF might be at the cost of existing commissioning of psychology services. The early evidence suggests that strategic planning and the engagement of systems leaders will be necessary to stimulate development of public sector services.

6.2.4 Impacts on independent sector provision

There had clearly been a substantial increase in the demand for independent sector therapy provision, as described in Section 3.4. However, there was little evidence yet among those involved in the implementation analysis interviews of any change in capacity in independent sector supply in anticipation of, or response to, the ASF, and independent sector interviewees described little activity or planning for expansion.

It is possible that work had progressed, by Wave 3 of our interviews, among the providers interviewed at Waves 1 and 2. We were also aware of some developmental activity among providers that was not captured in our interviews. However, at all three waves our implementation analysis identified significant barriers to scale up that point to a concerning disequilibrium between demand and supply. The overall picture that emerged was that the ASF is unlikely, on its own, to stimulate more than incremental

increases in capacity in the independent sector, and that inadequate levels of supply pose a risk to the ASF longer term.

Financial barriers to scale up

The main barrier to scale up is financial: a *significant* expansion of capacity will require both capital investment and a degree of certainty about future income. The primary ASF funding model of releasing discrete budgets for individual families lends itself most obviously to spot purchasing (although the possibility of submitting group-based applications mitigates this to some extent). Unpredictable demand and uncertain funding, at a time when the ASF was untested nationally, made significant expansion high risk. Many providers are third sector or small private enterprises, with little or no reserves or other sources of investment capital. Indeed, the legacy of funding constraint meant that even larger providers had not yet, when we consulted them, invested time in planning for future expansion, whilst others had largely dismissed the ASF as too small and uncertain a funding stream to justify investment in business development.

'[We are] probably not [preparing] sufficiently. I think [we are] mostly just thinking oh dear, this is going to happen, we need to get ready for it, but finding the time to do that - I'm finding the resource to do it quickly is proving difficult Investing in getting staff on board, getting people trained up, getting the costings clearer, getting the marketing, the profiling, of the service out there - we should be doing that now, whereas we're quite busy doing what we're doing. So we are conscious that we really need to, if possible, get some investment and do it.' INDEPENDENT SECTOR PROVIDER

Many of the organisations and sole practitioners we interviewed felt they could expand *incrementally* on the basis of spot purchase. Indeed, there was occasionally an active preference for being funded on this basis and a resistance to SLAs or block contracts because they were seen as undermining the scope for tailor-made, entirely personalised therapeutic intervention. However, the clear message was that some combination of guaranteed income in the form of grants to fund innovation and expansion, together with block contracts or SLAs for service provision, was required. These forms of funding had been essential for substantial growth in organisational capacity in the past and the view was that without them, expansion in capacity would be limited, uneven and potentially unsustainable. They were viewed as a stronger financial model for co-designing service development with local authorities and for joint case work, monitoring and evaluation, and quality assurance.

'I absolutely feel spot purchasing is not the answer. It's contracts. If we had contracts with local authorities for adoption support work, we could invest so much more in terms of staff. The difficulty we have is that we don't know when the phone is going to ring It's only because we're getting busier and busier that we're now thinking, okay, we need to expand. But there's an element of risk because ... what about next year? So I do think if you're wanting national investment in adoption support services, I think security and contracts is the answer.' INDEPENDENT SECTOR PROVIDER

'We've seen what's happened with the VAAs stepping up in terms of recruiting a number of parents and then the numbers of children [placed for adoption] has dropped, so they're now vulnerable. Market forces is a really dangerous place to operate unless you've got some guaranteed funding The ASF provides the security ... that there will be a demand for services that will be met by a fund So it's opened that door a lot more. But ... how do you expand with just spot purchase? There needs to be some money coming into the sector for new provision to be developed.' INDEPENDENT SECTOR PROVIDER

None of the prototype sites, during our fieldwork period, had entered into new block contracts or SLAs with providers. In fact, we observed an unexpected and perhaps perverse consequence of the ASF in occasional decisions by prototype sites *not* to renew existing contracts, in favour of either developing services in-house or spot purchasing. Some were also aware of other local authorities having done this in anticipation of national roll-out. In-house services were preferred here as representing better value for money and a more integrated service offer; spot purchasing provided more scope to commission an intervention more precisely tailored to each individual families' needs. Because over-reliance on spot-purchasing could undermine providers' financial sustainability, this highlights the need for strategic planning to manage capacity growth across the system based on forecast needs.

Other barriers to growth

There were some further barriers to scale up of independent sector capacity. Few of the providers we spoke to had the infrastructure, in terms of regional offices or widely dispersed staff, for significant scale up. Sole practitioners and more informal partnerships were reluctant to formalise their corporate status and become employers. There were also concerns here about sustaining and assuring quality, which was often heavily dependent on the senior lead. Several of the sole practitioners or small partnership providers we spoke to were at later stages in their careers with little appetite to take on new responsibilities. Finally, being regulated by Ofsted was viewed as expensive and onerous. Although local authorities can commission providers that are not Ofsted registered, the lack of clarity surrounding this and the requirements of registration dissuaded some smaller providers from expanding.

Possible forms of scale up

This is not to say that there is no scope for scale up. We explored several specific potential forms of expansion with the independent providers.

Figure 6.1 Potential forms of expansion of independent sector capacity

- Capacity expanded by growing staffing or associates
- Geographic reach extended by operating in new localities
- Diversification of provision through the incorporation of new therapeutic approaches
- Diversion or repurposing of therapeutic capacity from other service areas to adoption support
- Partnerships with other providers
- New entry into the adoption therapy market

There was generally strong interest among larger organisations in **expanding capacity** by taking on more staff, although only incrementally, and much more hesitation in smaller partnerships and sole practitioners.

The feasibility of **extending geographic reach** depended on the operating model. For providers operating from a single or small number of locations, it would require substantial investment; where the operating model was a network of self-employed or largely independently operating therapists it was more feasible. A suggestion made was that large providers might operate an 'umbrella' model, distributing work and providing quality assurance, training and management support to sole practitioners.

There was some interest in **diversifying provision by incorporating new therapeutic approaches** although again this would require either investment in training or expansion of therapist capacity, and none of the providers we spoke to had formulated plans for this.

There was some scope to **divert therapeutic capacity from other service areas** such as foster care support. For some providers this might yield a substantial increase in capacity, although likely with investment requirements. Reducing the offer to other populations was not in itself a particularly attractive proposition although it is reasonable to assume that providers would respond to a shift in demand.

There was most interest in **collaboration and partnership** with other providers. For some organisations this had been an important part of expansion so far and was the preferred growth model for the future. Partnership work would not necessarily produce a net increase in sector capacity, but it has potential to extend geographic reach, spread methods and provide economies of scale.

Finally, growth in sector capacity could take the form of **new market entry**. There was a general view that there was under-utilised capacity in the system, in the form of independent therapists who would move into working in adoption if constraints relating to funding and Ofsted regulation were removed; public sector social workers and therapists who might set up independent practices providing adoption therapy; and ASAs, VAAs and other health and social care agencies that would develop an adoption therapeutic service. However, encouraging new market entrants was not viewed as particularly propitious. There was real concern about quality and sustainability if the ASF brought non-specialists into the market who lacked the necessary depth of understanding of and expertise to meet the particular needs of adoptive families.

'My concern is adoption support, specialist therapeutic adoption support is different from other types of therapy So if you've got a music therapist, they might be a great music therapist, but in order to be helpful to adoptive families

they need to have the additional knowledge of adoption and why adoption requires a different type of therapy intervention. [There are] very specialist issues that are unique to adoption and long-term fostered children and families.'
INDEPENDENT SECTOR PROVIDER

Overall the picture that emerged consistently across the three waves of research was that the ASF is unlikely to simulate more than incremental increase in independent sector capacity without other parallel supporting activity, and particularly a source of investment income. Although, as we discuss below, there are potential strategies to address this, the main funding model of the ASF is not well aligned with what the market needs to be able to scale up. There was widespread concern that, left to market forces alone, the ASF will distort the market, providing a disproportionate growth stimulus to some segments only. There were diverse views about which segments might be favoured – sole practitioners, the 'big five' providers¹⁵, or larger private sector and non-specialist organisations with reserves or other income sources but which are not necessarily the centres of expertise in adoption therapy. But the point is that, without careful planning and intentional local management, the financial stimulus of the ASF alone will be insufficient to drive sustainable market growth, and might lead to market development that is not well aligned with the needs of adoptive families.

6.2.5 Impacts on families as active partners in local systems

Families are, as the model we showed in Section 1.6 highlights, an important part of the adoption support system. We have noted that both parents and prototype site leads felt the ASF had the potential to sustain placements that would otherwise be at risk of disruption. Site leads also felt that the increased access to therapy had the potential to make adoption feasible for more children, particularly those who are harder to place. These are very promising indications of the potential of the ASF to support adoption.

'Longer term, what I'm hoping is that there are going to be adopters out there that will be more willing and more able to adopt some of our harder-to-place children because they will be confident that the support ... will be there I'd like to think that this would go a long way to helping the children [for whom] the permanence of adoption [is appropriate] to get it.' PROTOTYPE SITE LEAD

Our analysis suggests that some further strategies are needed to support parents as active participants in local adoption support systems. There was a lot of diversity among the parents involved in the implementation analysis interviews in confidence in understanding of the underlying dynamics of adoption and effective interventions. Some were well networked with adoption support organisations, attended conferences and local authority training, had read widely, and had relevant expertise from their own professional backgrounds. Many were not in this position. As we noted in Section 4, few

¹⁵ Generally identified as Adoption UK, After Adoption, PAC, Coram and Barnardo's

parents felt confident about their ability to make decisions about treatment directions and therapy providers without professional support and information. Strategies to strengthen the capacity for parental involvement, among both parents and professionals, might involve:

- Information resources about therapeutic interventions and their application to different issues and needs
- Advice and support for decision-making about treatment directions: whilst local authority adoption support services are likely to play a key role, some parents will prefer to get advice from outside the team, either elsewhere in the public sector or in the independent sector
- Developing the capacity of professionals to work in partnership with parents and to support them as active participants in the system: in local authority adoption support services and elsewhere in public sector services. For some professional groups there will be a need to strengthen understanding, and address misconceptions, about adoption, the impact of early trauma and disrupted attachment
- Parents should also be involved in strategic work on reconfiguration of local systems and service design, reflecting the value of their unique perspectives on the system
- Finally, we have also noted the value of their involvement in work to consolidate learning, from evidence and from practical experience, about the effectiveness of therapy interventions and their appropriate deployment.

6.2.6 Strategies to strengthen impacts on system components

Our analysis suggests a range of strategies are needed to strengthen the ASF's impact on system components and to stimulate the capacity growth needed to support the ASF:

- First and most importantly, our analysis highlights the need for strategic planning across the adoption support system to identify areas where capacity needs to be developed. In many localities there will be a need actively to stimulate new service development or diversification, involving co-design and collaboration across the agencies and sectors involved and with parents.
- This would aid prediction of future service demand and enable more contract-based commissioning. However, it is likely that local authorities will need to work in regional or sub-regional groups to achieve the scale of demand necessary to stimulate new service development, whether in the public or independent sector.
- Regional adoption agencies could potentially provide an important opportunity here, stimulating collaboration between local authorities and with independent sector providers.

- Our analysis highlights that more support will be needed, at national and local levels, for service development by the independent sector, involving:
 - raising awareness about the ASF, its scope, operation and intended impacts
 - investment grants or exploration of other investment models
 - access to expertise in strategic business development and implementation
 - work with sector leadership bodies such as CASA, CVAA, professional bodies such as the British Psychological Society and those connected with individual therapies, to explore how the ASF can be used to stimulate capacity growth
- Clarification of the requirements surrounding Ofsted registration will also be helpful, although as we discuss below there is a wider question about appropriate governance and quality assurance arrangements for therapeutic interventions.

6.3 Impacts on system connections

The second aspect of our conceptual model of systems is **system connections**: the relationships and linkages between system components. So a critical aspect of the impact of the ASF on adoption support systems is the extent to which it was strengthening, relationships and connectivity within local adoption support systems. Our analysis here is more tentative since one would expect changes in connections to evolve indirectly, and over time, from use of the ASF. However, even at this early stage we found promising evidence about the *potential* impacts of the ASF in a number of areas.

6.3.1 Connections between parents and local authority adoption support services

The most significant potential we observed was for the ASF to strengthen relationships between adoptive parents and local authority adoption support services. We noted in Section 3 that several prototype leads said the ASF allowed a change in approach, from a response that was realistic and equitable given finite budgets and unknown future demand, to being able to provide a needs-led, creative, even '*generous*' response. Our analysis also suggests that the ASF has the potential to stimulate a sharper focus on maintaining and sustaining relationships with adoptive parents. It was anticipated that the availability of the ASF and a potential strengthening of a tiered core offer will help to encourage families to come forward more quickly when problems first start to emerge.

'It feels to me [currently] that parents almost need to reach a breaking point or a 'can't cope' point before they're coming forward for support. If we can change that so they come earlier and have that support then, that would be brilliant I think the ASF might [help to achieve this].' PROTOTYPE SITE LEAD

Overall the ASF appears to have potential to ease relationships between parents and local authority adoption support services, removing the financial constraint that has

previously been a real source of conflict and difference, helping to build parents' confidence in the adoption support system, and bringing a closer alignment in goals, expectations and understanding.

6.3.2 Connections between adoption and other public sector services

There was also some evidence that the ASF had the potential to strengthen relationships between local authority adoption support services and other parts of the public sector. As we have noted, the ASF had stimulated more systematic arrangements, in some prototype sites, for the involvement of CAMHS or other psychology services in decisions about treatment directions. However, better alignment of CAMHS provision and thresholds with the ASF is needed to support closer relationships.

There was only modest potential for the ASF to strengthen connections between local authority adoption support services and education, since 'education support' is explicitly excluded from the scope of the ASF. However, some funded ASF applications have involved school-based assessments or work to strengthen schools' support for adopted children, and independent support providers emphasised the importance of their liaison with schools. Certainly it would be helpful for local areas, in considering how to expand service capacity, to look at therapy provision in education and how it links with services within scope for the ASF.

It is also important to highlight that there are areas where the ASF could lead to tensions or undermine relationships with other public sector services, with early signals of CAMHS (and schools) withdrawing adoption support and of prototype sites explicitly '*bypassing*' CAMHS services. Without careful management and strategic partnership work, there is a risk of parts of the public sector system 'pushing back' against the intentions of the ASF.

6.3.3 Connections among local authority adoption support services

There was clear early evidence that the ASF had stimulated more collaborative work within regional consortia, sub-regional groups or between neighbouring local authority adoption support services. As we noted in Section 5.7, work had been undertaken to share market intelligence, develop a framework of approved providers, and discuss the scope for joint commissioning. It was widely anticipated that the ASF would support more trading of services between local authorities. Some prototype sites were also at early stages of discussions about the scope for joint service development. The ASF also has the potential to bring a significant easing in arrangements for out of area placements, enabling swifter provision of support in situations where responsibility would previously have been disputed between services.

6.3.4 Connections between local authority and independent providers

There was also clear evidence of the potential of the ASF to strengthen connections between local authority adoption support services and independent support providers. Most of the prototype sites had undertaken work to develop their knowledge of local providers, there has been a substantial increase in commissioning, and many new relationships have developed. Perhaps most significantly, the easing of previous financial constraints means that local authorities have been able to commission, more often and more speedily, what independent support providers regard as an appropriately scoped programme of work.

In addition, some prototype leads reported their teams' understanding of therapeutic needs and interventions having been extended through work with external providers. There are early signs of an emerging better alignment between local authority adoption support services and independent support providers in goals and understanding of issues such as the severity of impact of trauma, abuse and neglect and the complexity of resultant needs. The ASF appears overall to have the potential to create incentives for closer working and to ease commissioning between independent sector providers and local authority adoption support services.

6.3.5 Strategies to strengthen systems connections

Our analysis suggests that the most vulnerable systems connections are those between local authority adoption support services and other public sector services. Addressing this requires strategic work, at national and local levels, to align priorities and goals and create a shared vision for adoption support, and to develop local services. Effective connections with independent sector providers would be supported by their active engagement in local and regional strategic planning, by the initiatives we outlined in Section 6.2 to support market development, and by strengthening joint working.

There remains however a much larger question about whether the adoption support system is currently optimally organised and structured to support system connections. Although the ASF has scope to ease within system transactions significantly, the system remains highly fragmented: between social care, health and education; between the public and independent sectors; between 152 local authorities, and to some extent also between different tiers or levels of support. Regional adoption agencies offer an important opportunity to develop here, and our analysis, and the views of some of those we interviewed, suggest that they may be a promising direction for bringing together public and independent sector providers in better integrated work.

Finally, there are currently diverse conceptualisations of therapeutic adoption support needs and services between, but also within, different components of the adoption system. In local authority adoption support services, attachment theory was probably the

dominant theoretical framework, with the sometimes uncomfortable overlay of statutory responsibilities for child protection. The focus in many CAMHS services on standardised diagnostic criteria provides a very different framework for understanding needs and services. Independent sector providers of more intensive interventions often cited developmental trauma as a dominant model for their service, and although attachment theory was also highly relevant there were often quite different expectations surrounding needs than in social care. Some attention to exploring the implications of these diverse, often contradictory, frameworks and theoretical underpinnings would aid stronger within-system connections.

6.4 Impacts on system supports

The third element of our model of systems is the **system supports** that aid the effective functioning of the system. Systems thinking suggests that there needs to be a good *alignment* between the ASF and existing system supports, that system supports need to be *actively engaged* in support of the ASF, and that system supports may also need to *adapt further* to strengthen the infrastructure for the ASF.

These are the most elusive of the three types of systems impacts we have considered, furthest from being the target or focus of the ASF and most likely to evolve organically over time. Our brief analysis therefore primarily highlights issues for future consideration.

6.4.1 Local and national policy

It is beyond the scope of our study, but an analysis of policy drivers across social care, permanence, education, CAMHS and health and their interaction with the ASF, if not yet undertaken, would be helpful to explore the quality of alignment in support of the ASF. As we have noted, future directions for CAMHS will be particularly important here

6.4.2 Systems leadership

Optimising the impacts of the ASF requires purposeful engagement and leverage of systems leadership, across service areas and sectors, at local, regional and national levels (Ghate et al, 2013). The prototype site leads generally described local social care leadership (Directors of Children's Services and second tier leaders) as being aware, interested and supportive, and they have sought briefings and meetings about the ASF. More active involvement of local systems leaders during the prototype period was rare, but our observations suggest its importance may not yet have been fully appreciated. Significant systems improvement necessarily engages systems leaders, and they would be central to work to align objectives and resources across agencies, to reconfigure local provision and to identify where and how to stimulate market growth. It was not uncommon for prototype leads to describe local leaders as sufficiently involved but also to highlight local systems weaknesses (such as inadequate CAMHS provision or a need

for market development) which realistically can only be addressed with their fuller engagement.

Similarly, the prototype sites were beginning to consider how to leverage the support of regional Adoption Leadership Boards (ALBs): some early discussions had happened or were shortly expected. Some prototype leads did not see an obvious role for their ALB, although others felt they would be critical to supporting the ASF.

'I think it is important that the [regional] Adoption Leadership Board is a driver for the Adoption Support Fund, has a good understanding and takes that whole systems approach So it links in health partners, education partners ... so, yes, I do think it does sit there.' PROTOTYPE SITE LEAD

6.4.3 Funding

It will be important to anticipate, and monitor, the effect of further public spending cuts on the ASF, since they could lead to disinvestment in current provision and greater reliance on the ASF in place of it. There is a need for better alignment between funding streams for therapeutic provision, particularly across CAMHS, social care and education, including reviewing the scope for pooled budgets.

6.4.4 Governance and quality assurance

Quality assurance of therapy services will be key as the therapy market expands. The current system for regulation is seen as fragmented and insufficient and the regulatory role of Ofsted in relation to ASAs and VAAs poorly aligned with the system as a whole. ASAs and VAAs constitute only part of the independent market, and Ofsted regulation is viewed as not well oriented to either clinical services or small scale providers. A more clinically informed model of regulation covering qualifications, training, accreditation, supervision and clinical oversight, as well as more oversight of the specific intervention models used, would provide better support to the ASF. The Health and Care Professions Council (HCPC) was seen by some of those we interviewed as better positioned for this role. It would also be timely to consider the scope to develop a national service framework for therapeutic adoption support, to support consistency in the help available across geographic areas and clarification of the scope of the ASF.

6.4.5 Workforce development

As we have noted, the ASF had stimulated some skilling up of local authority adoption support service social workers in therapeutic methods. There were early indications that training provision will need to expand rapidly if this demand is replicated in other local authorities, since prototype leads reported finding it difficult to locate training courses. Continued workforce development initiatives across service areas will help to support more widespread understanding of the difficulties faced by adoptive families, and might help to improve responses across services and aid collaborative and integrated work.

6.4.6 Data and information

Finally, the ASF has the potential to stimulate improvements to data and information systems. It has prompted recognition that local monitoring and evaluation needs to be strengthened, more interest in the use of standardised instruments in assessments, and strengthening and sharing of market intelligence. However, a number of other initiatives would help to strengthen the data infrastructure for the adoption support system:

- Local needs analysis, shared with public and independent sector providers, to shape the review and redesign of service configuration and the role of the ASF within it. This would usefully be supported by collation of national level data on adoptive families and their needs
- Coordinated national work to map and analyse the independent support sector comprehensively and systematically
- Synthesis of existing international evidence about the effectiveness of therapeutic interventions and when they are clinically indicated, drawing also on professional wisdom and service users' experiences. DfE are progressing work in this area
- Further development of the evidence base through robust evaluations of the effectiveness of treatments and analysis of the implementation requirements for high quality delivery
- Development of the ASF data infrastructure collecting rigorous data on interventions, implementation, service users' experiences and outcomes.

The ASF is beginning to impact on system components and system connections. Our analysis suggests that these strategies would help to strengthen the whole system and its support for the ASF. The final section provides a summary of key issues identified in the implementation analysis and draws out national and local implications.

7. KEY MESSAGES AND NEXT STEPS

Key messages:

- The ASF has potential to increase adoptive families' access to therapy, and families were very positive about the services they had used. Improved data systems and a stronger evidence base will help to assess the quality, appropriateness, cost-effectiveness and sustainability of services. We also highlight ways in which the operation of the ASF could be strengthened
- There is an urgent need to expand therapeutic provision, and our analysis suggests that other initiatives alongside the ASF will be needed to achieve this and to strengthen the whole system of care. Further work by DfE to strengthen the infrastructure surrounding the ASF would be valuable, including data and information systems and strategic work across the public and independent sectors
- Local authority leaders will play an important role in reviewing and strengthening local systems, recalibrating them and ensuring the potential of the ASF is realised
- Commissioners' roles will support work on local needs analysis, service specification, market intelligence and market stimulation. Review of procurement processes, commissioning cultures and readiness for an increase in traded services may also be helpful
- For adoption service leads, the ASF presents a key opportunity to advocate for better provision for adoptive families. The key operational processes that need to be aligned with the ASF are outreach work with parents and through services, assessment processes particularly clinical input, resource allocation processes, monitoring and evaluation, and staff development
- The CAMHS transformation programme and the ASF together create an opportunity to strengthen the role of CAMHS in adoption support and for diffusion of the good practice found in some areas. There is otherwise a risk of CAMHS services, in some areas, being bypassed
- Independent sector providers, sector leadership organisations and professional bodies should also ensure that the opportunities the ASF presents are recognised and developed

The ASF was intended to be a catalyst for improvement in adoption support systems, highlighting shortcomings and incentivising change. Our analysis has highlighted the progress made by the prototype sites, their learning through the experience of the prototype, early responses to challenges, and opportunities for the future. In this final section we review the potential of the ASF and key messages for DfE; local authority leaders, commissioners and adoption service leads; CAMHS; and the independent sector.

7.1 The potential of the ASF

It would be unrealistic to expect more than the earliest impacts of the ASF to have emerged during the prototype phase, particularly given that some core components (such as of the specification of within scope services and interventions) changed during that period. But we can summarise the evidence so far about the *potential* of the ASF in relation to its key objectives.

Does the ASF have the potential to increase adoptive families' access to therapy?

The evidence from the prototype local authorities clearly indicates that the ASF was increasing families' access to therapy. There was little evidence yet that more families were being identified, but this may change as awareness of the ASF increases across the system. However, there was evidence of more therapeutic needs being identified by the prototype sites, and more therapy provided: therapy was now available where previously it would not have been, or where a more limited therapy intervention would have been offered. The ASF has strong potential to achieve its key objective of increasing access to therapy, although this will be inhibited if service capacity does not expand.

There was limited evidence of service substitution. However, it may be necessary to accept some substitutional use, particularly to catalyse public sector service development. This needs to be monitored and managed to ensure efficient use of public money.

Does the ASF have the potential to increase access to high quality, appropriate, cost-effective and sustainable therapy?

The evidence here was more limited. The families interviewed were very positive about the quality and appropriateness of the therapeutic services they were using. However the evidence base for the effectiveness of many of the specific interventions, particularly their appropriateness specifically for adoptive families, is under-developed. In addition, systems for monitoring outcomes were not well developed in the prototype local authorities, and the approaches used by many independent support providers could be strengthened.

There was some concerning evidence about the variable capacity in prototype sites for assessing for therapy interventions. This is a crucial element of using the ASF well and it will need continued focus by DfE and by local authorities. More work is needed to explore whether there are significant or large scale disparities between needs and the services funded, and if so to design a proportional response involving some combination of quality assurance and scrutiny within local authorities and/or by the ASF, as well as staff development.

Does the ASF have the potential to develop capacity in local systems for therapeutic services?

Longer term, increased access to high quality appropriate therapy can only be achieved if therapy capacity expands. If capacity does not expand, there is a real risk of ASF funding being used sub-optimally, and this is a key area of potential vulnerability of the ASF. The evidence of capacity development during the prototype period was limited to therapeutic provision in local authority adoption support services. There was clear evidence of increased demand, but not yet of capacity growth in CAMHS, other public sector services and the independent sector, and some early signals of potential for negative impacts.

Local authorities own adoption support services are clearly a key part of local systems for therapy. Their role in capacity expansion will vary between local areas depending on prior investment, which in some areas has been substantial. However, their optimal contribution is likely to be in relation to preventative support and early therapy needs, rather than higher level needs where specialised and intensive interventions will be required. This highlights the importance of capacity expansion being based on needs analysis and systematic review across all parts of the system.

The main constraint on the ASF as a catalyst for capacity expansion is the funding mechanism of discrete budgets for individual families, which seems unlikely to be capable of stimulating more than incremental growth. This could be mitigated by a combination of local strategic planning for capacity growth; collaboration across local authorities; and applications to the ASF based on interventions for groups of families rather than individual families. However, the evidence suggests that some form of investment capital will be needed for *significant* growth in the independent sector.

Does the ASF have potential to improve the ‘whole system’ of adoption support?

The ASF was not primarily designed as a whole systems intervention (as we discussed in Section 6.1) although it was intended to catalyse systems improvement, and it has not yet been operationalised with a whole systems focus by the prototype sites.

Strengthening its impact across the system is likely to need further strategies led by DfE (see Section 7.2) and strategic planning across agencies, partners and local authorities to ensure it is used to stimulate or strengthen a coordinated and integrated local system of care. There is otherwise a high risk of uncoordinated responses which could weaken the system. The opportunity presented by regional adoption agencies is important here and could stimulate strong integration between public and independent sector provision across local authority boundaries.

7.2 Key messages for the Department for Education

7.2.1 Strengthening the Adoption Support Fund model and operation

We have highlighted several areas where further refinement of the ASF model and its operational processes is needed. The first is a data infrastructure embedded in the national ASF for the systematic large-scale collection of data on interventions and outcomes. This will be critical information to demonstrate the overall impact and value of the ASF. The second issue is the importance of clarity, as soon as possible, about the future funding model. We have also identified a need to consider strengthening the application process in a number of ways:

- reviewing whether there should be a requirement for clinical input into assessments or other quality assurance, at least above a certain level of intensity or cost, or whether this can effectively be managed by monitoring the effectiveness of the treatments funded
- considering the need for scrutiny of treatment plans and their fit with assessed needs beyond that provided by local authorities
- a possible need for a fast-track application process for ‘top-up’ funding to extend therapy, or to vary the intended use of ASF funding

Finally, ongoing work to specify further the therapeutic services in scope for ASF funding will be important. It would also be helpful to clarify the relative priority of different policy intentions. In particular the aim to increase parental choice and involvement in decision-making is *potentially* in tension with the aim to avoid substitution of services. It would also be helpful to clarify whether expanding provision in the independent and the public sector are policy aims with equal weight.

7.2.2 Strengthening the infrastructure for the Adoption Support Fund

We have suggested a number of strategies through which DfE could strengthen the infrastructure surrounding the ASF:

- collecting national data on the population of adopted children and prevalence of needs within scope for the ASF: an important aid to local needs analysis
- continued work to provide systematic information about therapy providers in the independent sector: the VAA is also undertaking work in this area
- synthesis of international evidence about the effectiveness of specific therapy methods, incorporating the insights of practitioners and families
- a review of standardised instruments for assessment and their application
- sustained work with the independent sector, via sector leadership and professional bodies, to raise awareness of the ASF and stimulate capacity development

- investment funding for growth, coupled with strategic business development support, technical assistance and implementation support. The grant programme for development of regional adoption agencies is a partial response here
- quality assurance: further work is needed with regulators and other professional bodies to identify options for strengthening quality assurance of adoption therapy
- analysis of the alignment of policy drivers and funding streams across social care, permanence, education, CAMHS and health would be helpful, in particular to strengthen the interface between CAMHS and adoption support. Addressing what many see as chronic under-funding of CAMHS will be central to this
- continued work to raise the profile of adoption and post-order support needs, and to create a shared platform and vision for adoption support at national and local levels. Developing a national service framework for therapeutic adoption support, integrated across agencies and departments, would be helpful here
- continued workforce development initiatives to strengthen understanding of adoption and support needs across professional groups

7.3 Implications for local authorities

7.3.1 Local authority leaders

Our analysis suggests that opportunities to engage local authority leaders across health, education and social care might not have been fully exploited in the prototype areas, and highlights the importance of the engagement of leaders in strategic work to support use of the national ASF. Key areas for their input are:

- working with partners to create a shared vision for adoption support (and perhaps support for other forms of permanence) in the local area, with consistent understanding and prioritisation across agencies
- reviewing areas where local policies and strategies can be strengthened and the alignment between service areas and funding streams improved
- coordinating work, with systems leaders and in collaboration with partners, practitioners and families, to assess needs and existing provision and to determine the appropriate local configuration of support across the system, identifying where capacity growth and new service development is needed. In many areas, improved data for needs analysis may be required
- reviewing the role of local Adoption Leadership Boards and Health and Wellbeing Boards in leading whole systems improvements to adoption support
- reviewing funding, service specification and joint work with CAMHS, in the context of the children and young people's mental health transformation programme

- reviewing opportunities for joint service development and commissioning with other local authorities, in the context of regional adoption agencies and more widely
- reviewing the strength and flexibility of commissioning processes and the sufficiency of commissioning resources, and where necessary strengthening cultures supporting commissioning and partnership working
- reviewing how services to support adopted children, and the opportunities presented by the ASF, might be leveraged for the benefit of children in other permanence placements

7.3.2 Commissioners

Commissioners will also have important roles to play, particularly given the mixed economy model of the ASF. Our analysis suggests this may involve:

- local needs analysis and mapping of local provision to review whether support needs are sufficiently met in current commissioning arrangements
- ensuring the needs addressed and opportunities presented by the ASF are integrated into commissioning, particularly in reconfiguration of CAMHS provision
- identifying where market stimulation and development activity is needed
- reviewing the sufficiency of commissioning resources, proportionality and suitability of procurement processes, and strengthening commissioning cultures and understanding within service areas
- considering the scope to work with other local authorities to develop common provider frameworks, joint commissioning and joint service provision
- supporting service areas in identifying and costing services that could be traded with other local authorities, and ensuring processes for trading are in place
- reviewing the scope for strengthening monitoring and evaluation systems to support commissioning.

7.3.3 Adoption service leads

Our analysis suggests that the key organisational processes that need to be aligned with, and engaged in active support of the ASF, are:

- developing local strategies for the use of the ASF, including identifying relevant cases and provision, determining how the ASF should be used alongside other provision and other funding streams, and establishing systems for monitoring applications, the outcome of applications, and subsequent service use
- analysis of the needs of adoptive families and how far they are met by current provision, advocating for better alignment of existing services and for service

development where further capacity needs to be developed further

- outreach work with adoptive parents and across service areas to develop sustained relationships, support the early identification of problems and identify needs of which the local authority adoption support service is not aware
- assessment processes: a key area where systems may need to be strengthened, with training and information resources for social workers and arrangements for access to clinical expertise
- resource allocation processes: reviewing how existing decision-making systems sit alongside the ASF, and how to ensure decisions are in place for aspects of service need not covered by (or deemed ineligible by) the ASF
- systems for monitoring and evaluation of commissioned and in-house provision
- staff development: our review suggests that many local authorities will need to strengthen capacity and skills particularly in assessment practice; the delivery of specific therapy interventions; understanding of therapeutic interventions and their appropriate use; and partnership work with independent providers and parents.

7.4 Implications for CAMHS

The ASF has the potential to stimulate demand for CAMHS provision and collaboration with local authority adoption support services. However, the ASF has highlighted key challenges here. There clearly are examples of good practice, specialist services or teams and strong partnership working, and our analysis highlights the need for diffusion and wider adoption of effective practice in these areas. In other areas, there will be a need to review and strengthen significantly staff skills, the interventions available, service models and the quality of relationships with other parts of the adoption support system, and this work requires wider cultural change. There is a real risk that if weak CAMHS provision for adopted families is not improved, the ASF will be used to commission other services in its place. The CAMHS transformation programme offers an important platform to take this work forward, but it needs to be supported by a significant increase in funding if shortcomings in current provision are to be addressed.

7.5 Implications for the independent sector

There are widespread concerns within the independent sector about planning expansion based on the ASF, but there may also be a risk that the opportunities the ASF presents are not fully recognised and exploited. There is scope for individual agencies and providers to:

- review the alignment of their services to the ASF, the scope for ASF funding and the opportunity for further diversification of provision
- strengthen approaches to assessment, partnership working with local authorities, monitoring and evaluation
- ensure local authorities are well informed about their services and capacity
- get involved in work with local authorities to review and reconfigure local provision, including within the context of regional adoption agencies
- identify other potential funding sources for scaling up and diversification
- review the need and scope for strategic support for business expansion, technical assistance for implementation of therapeutic models, and business operational support for issues such as costing

Sector leadership bodies including CASA, CVAA, bodies representing therapists in different professional settings and organisations supporting specific interventions and approaches also have an important role to play in increasing the readiness of the sector to engage with the ASF, and providing strategic support to service development and reconfiguration.

The ASF is a 'systems disturbance' that has helpfully highlighted how adoption support systems need to be, and could be, strengthened. It presents important opportunities for building capacity, improving integration and collaborative working, and developing the evidence base. There is scope for DfE to strengthen the ASF model and its potential impact on the wider system through other strategic initiatives, and for local authorities and other partners to use the disturbance strategically, to develop, reconfigure and enrich local adoption support systems for the benefit of adopted families.

APPENDICES

APPENDIX 1. Glossary of therapeutic terms

This table provides a brief description of the therapeutic interventions referred in the report.

Figure A.1 Glossary of therapeutic terms

AdOpt	Group-based 16-session programme for adoptive parents, developed by DfE in collaboration with the Oregon Social Learning Centre (Phil Fisher) and delivered by trained group facilitator and adoptive parent. Informed by attachment theory, neuroscience and social learning theory; intended to be used in the first two years of a placement.
Animal therapy (or animal-assisted therapy)	Therapeutic approaches which incorporate the involvement of animals as a form of treatment including pets, farm animals and horses (also known as equine therapy or hippotherapy)
Attachment-based therapy	Range of therapeutic approaches applying interventions and practices based on attachment theory. Includes manualised programmes such as Child-Parent Psychotherapy, Circle of Security and Attachment and Biobehavioural Catch-Up. These approaches need to be distinguished from 'attachment therapy', also known as 'holding therapy', which involves restraint of children and is strongly criticised
Dialectical Behaviour Therapy (DBT)	Therapy intervention which aims to change problematic patterns of behaviour such as self-harm, substance abuse and risky behaviour. Involves individual and group work; focuses on mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Developed by Marsha Linehan
Dyadic Developmental Psychotherapy (DDP)	Psychotherapeutic approach for families where children have experienced trauma, neglect and loss, developed by Dan Hughes. Based on attachment and attunement. Aims to create safe setting for child to explore and integrate early experiences and the feelings they evoke. Uses principles of PACE (playfulness, acceptance, curiosity and empathy)
Eye Movement Desensitising and Reprocessing (EMDR)	Psychotherapy method developed by Francine Shapiro to treat symptoms of post-traumatic stress disorder. Includes controlling eye movement during recall of distressing images and replacing negative cognitions with positive ones
Enhancing Adoptive Parenting	Parenting programme for experienced adoptive parents where children have challenging behaviour, in first year of placement. Developed by Alan Rushton, delivered by trained adoption or family support workers. Ten-session programme, delivered one-to-one in adopters' own homes. Based on attachment and behavioural approaches, with further optional sessions on specific issues e.g. bedwetting, sibling relationships, sexualised behaviour

Family therapy	Range of psychotherapy approaches focusing on interactions between family members and systems within families
Filial Therapy	Form of play therapy involving structured training programme for parents in use of child-centred play. Developed by Bernard and Louise Guerney
Functional Family Therapy (FFT)	Manualised family therapy intervention designed for treatment of young people with behavioural and conduct problems. Aims to reduce problem behaviours and accompanying family relational patterns and increase family's resources for support. Developed by Jim Alexander
It's a Piece of Cake	Six-day parent support group developed and delivered by Adoption UK's adopter-trainers, aimed at adopters with children with challenging behaviour from one year into placement. Based on attachment theory and effects of early trauma
Non-Violence Resistance (NVR)	Approach that applies the principles of non-violent resistance (as a form of political activism) in psychological intervention for parents and carers of children with aggressive behaviours. Aims to help parents de-escalate, plan effective forms of action, resist controlling behaviour and develop support networks
PACE	See DDP
Psychotherapy	General term for therapeutic interventions by psychiatrists, psychologists or other mental health providers with focus on exploration of thoughts, feelings and behaviour. May involve child, parent, both or family. Includes specific approaches such as psychoanalysis, gestalt therapy, cognitive behavioural therapy, play therapy
SafeBase	Parenting programme for adoptive families developed by After Adoption and delivered by trained social workers. Designed for any stage from pre-placement to risk of disruption. Based on early childhood trauma and impacts on child development and attachment. Involves family observation and feedback, followed by 4-day group-based parenting course which includes use of Theraplay
Sensory Attachment Intervention (SAI)	See sensory integration
Sensory Integration	Approaches based in part in occupational therapy that aim to address sensory processing difficulties related to e.g. adopted children's intolerance of certain sounds, tastes or sensations, poor body awareness and motor control. Includes Sensory Attachment Intervention developed by Eadaoin Bhreathnach, which used enriched sensory experiences and child-led play to enhance children's self-regulation and co-regulation between parent and child
Solihull Approach	A model of working for care professionals to promote emotional health and wellbeing in children and families, based on a framework for understanding children's behaviour and parent-child relationships which integrates containment, reciprocity and behaviour management. Also includes a range of parenting courses. Developed by Hazel Douglas
Systemic family therapy	Range of methods for working with families based on understanding problems and developing responses and capacities within the context of family systems rather than focusing on the behaviour of an individual regarded as problematic

Theraplay	Form of play therapy which helps parents (and other care givers) to use play to build children's attachment, self-esteem and trust, based on structure, engagement, nurture and challenge. Developed by Phyllis Booth and Ann Jernberg
The Thrive Approach	Approach aimed to support all children's social and emotional wellbeing and engagement with life and learning, involving relational, play- and arts-based activity (one to one or group-based). Used in schools, homes and other childcare settings and supported by training and mentoring for professionals and parents. Developed by four UK social workers and psychotherapists.
Video Interaction Guidance (VIG)	Intervention that uses video feedback in a coaching relationship to help parents become more sensitive and attuned to children's emotional needs and to enhance communication and interaction. Used by a wide range of practitioners: educational psychologists were particularly influential in bringing it to the UK

APPENDIX 2. Assessment instruments

The following instruments were cited as being used in assessments and monitoring of outcomes by the independent sector agencies and local authority adoption support services involved in the interviews.

- Adaptive Behaviour Assessment System
- Assessment Checklist for Children
- Beck Youth Inventories
- Behavioural Assessment of the Dysexecutive Syndrome
- Behaviour Rating Inventory of Executive Functioning (BRIEF)
- Bruininks-Oseretsky Test of Motor Proficiency
- Carer Questionnaire
- Child Behaviour Checklist
- Child Disassociative Checklist
- Clinical Outcomes in Routine Evaluation (CORE-10)
- Consumer Health Inventory
- DAWBA (Development and Wellbeing Assessment)
- Emotional Literacy Assessment
- Expression of Feelings Questionnaire (EFQ)
- Mindfulness Attention and Awareness Scale (MASS)
- Neurosequential Model of Therapeutics metrics (Bruce Perry)
- Parenting Stress Index
- PHQ-9 depression module
- Self Compassion Scale (Short Form) (SCS-SF)
- Sensory, Attachment and Child Development Questionnaire
- Sensory Profile Caregiver Questionnaire (SPQ)
- Strengths and Difficulties Questionnaire (SDQ)
- Signs of Safety and Wellbeing assessment
- Story Stems Assessment profile
- Test of Everyday Attention for Children (TEA-Ch)
- Thinking About Your Child Questionnaire (TAC)
- Trauma Symptom Checklist for Children
- Wechsler Intelligence Scale for Children (WISC-IV)
- Wechsler Pre-School And Primary Intelligence Scale for Children (WPPSI)

APPENDIX 3. Research methods

1. BACKGROUND PAPERS

We produced three background papers (provided to the DfE but not published) which informed refinements to the ASF prototype before its launch, and our implementation analysis approach. The first (Lewis, 2014a) was a rapid review of the literature on the needs and experiences of adoptive families. It summarised evidence about the difficulties faced by adopted children, the needs identified by parents, the take-up of different types of services, families' experiences of help-seeking, what we know about the effectiveness of interventions, and implications for the prototype ASF.

The second rapid review (Lewis, 2014b) summarised evidence from the major personal budgets initiatives piloted or evaluated in England. This included direct payments and individual budgets in adult social care, the In Control individual budgets initiatives, individual budgets for disabled children, personal health budgets, and SEND personal budgets. The paper summarised the key initiatives to date, evidence about the implementation of personal budgets, evidence of outcomes, and implications for the ASF.

The third paper (Lewis, 2014c) took a different focus. It was a brief desk-based mapping exercise to provide early information about the part of the market for therapeutic adoption support represented by ASAs and VAAs registered with and regulated by Ofsted. The sample was identified from the Ofsted website, and triangulated with membership listings for CASA and CVAA. We reviewed the latest Ofsted inspection report and organisational websites to collect information as systematically as possible about providers and their therapeutic services, although there were many gaps. The mapping exercise identified 56 providers and described them in terms of size, location and therapeutic provision.

2. THE ASF NATIONAL SURVEY OF ADOPTION SUPPORT PROVISION

The aim of the survey was to provide a systematic description of key aspects of the post-adoption support system across England. It collected data on the extent and types of therapeutic provision for post-adoption support within local authorities, Tier 3 CAMHS and commissioned from independent providers. In relation to commissioning, we also collected data on the types of providers involved, contracting arrangements and some data on expenditure.

Survey interviews were carried out by telephone by a professional independent survey organisation, IFF Research. All local authority adoption services in England were invited to participate (142 in total¹⁶), and respondents were adoption team or service managers, or a colleague to whom they delegated for this purpose.

The focus of the survey questions was on support known by respondents to be provided by local authority adoption teams; other local authority services; Tier 3 CAMHS; and independent providers (organisations and individuals, and whether or not registered as ASAs and VAAs). The questionnaire covered: the use of out of area placements; the services available in different parts of the local system; the number of children accessing services provided by CAMHS and commissioned from the independent sector; spending on commissioned services; contractual arrangements; and ratings of the quality and sufficiency of support provided by the local authority adoption service, CAMHS and independent providers.

The questionnaire was sent in advance, by email, with a letter explaining the purpose of the survey, to enable participants to prepare. Interviews took place between 10th July and 26th August 2014. Of 142 local authority Adoption Teams approached for interview, 101 provided data, a 71% response rate. This is a high response rate for a telephone survey, particularly given that advance preparation was required and the timing of fieldwork over the summer period. Analysis of the characteristics of the 29% non-participating local authorities shows that they did not differ in any systematic respects from the responding authorities. Data were analysed using Excel. A report summarising the findings was sent to all participants and was published by The Colebrooke Centre for Evidence and Implementation (Lewis and Ghate, 2014)

3. IMPLEMENTATION ANALYSIS INTERVIEWS

3.1 Sample selection

Local authority adoption service leads

In the prototype sites, we approached the individuals identified by Mott Macdonald as the lead for implementation of the ASF. Several involved another colleague in the interview. The individuals interviewed were generally adoption team managers; service managers for adoption, fostering and adoption, or permanency; heads of service; adoption support team managers and Adoption Support Services Advisers. There was some variation in precisely who took part in each of the waves but at least one person remained consistently involved across all three waves in all sites bar one. In this site, the individual

¹⁶ A small number of local authorities have merged their adoption services.

nominated at Wave 1 was replaced by two colleagues who both took part in the two subsequent interviews.

The five non-prototype local authorities (interviewed at Wave 1 only) were selected to expand the coverage of the prototype sites in terms of region and local authority type. Two had already indicated to DfE their willingness to take part, and DfE asked us to include them. We also reflected variation in the number of ASAs and VAAs operating in the local area (drawing on the mapping exercise described above). Our selection was also informed by Ofsted reports and Adoption Scorecard data sets, to reflect local authorities placing different numbers of children for adoption. All those approached

Table A.1 Local authority sample for implementation analysis interviews

	Prototype sites n=10	Other local authorities n=5
Region		
South West	2	0
South East	2	1
London	1	1
East of England	0	1
East Midlands	1	0
West Midlands	1	1
North West	1	0
Yorkshire and Humberside	1	1
North East	1	0
Type		
County council	5	2
London Borough	1	1
Metropolitan	3	1
Unitary	1	1
ASA/VAA therapeutic provision¹⁷		
High	4	3
Medium	5	0
Low	1	2
Number of adoptions from care¹⁸		
High	6	1
Medium	3	2
Low	1	2

¹⁷ Number of agencies in local authority area, based on desk-based mapping exercise

¹⁸ In 2012-13, based on DfE data

agreed to take part. One participant was the lead for the regional consortium and so gave an overview of arrangements within the region rather than from the perspective of a single local authority. One local authority lead also involved the head of their clinical psychology service in the interview, previously based within CAMHS but recently brought into the local authority.

In total 24 local authority representatives were interviewed at Wave 1, 14 at Wave 2, and 16 at Wave 3.

Independent sector providers

The approach to selecting independent sector providers varied between Wave 1 and subsequent waves. The prototype ASF had not yet been launched when the Wave 1 sample was selected. A sample of ASAs and VAAs was selected using information from the desk-based mapping exercise. We sampled purposively to include agencies of different sizes (including sole practitioner therapists), and agencies with different degrees of specialism in therapy and in adoption. We also aimed for as much coverage as possible across the nine regions, and for half the sample to be located in or close to prototype local authorities since we expected to see more activity in response to the ASF here.

Table A.2 Independent sector provider sample for implementation analysis interviews

	n=10		n=10
Focus of work		Region	
Therapy only	20	South West	7
Wider services, only/mainly adoption	5	South East	6
Wider services, not only/mainly adoption	3	London	3
Size of organisation (all staff)		East of England	1
Sole practitioner	8	East Midlands	2
2-5 staff	4	West Midlands	3
6-10 staff	2	North West	2
11-20 staff	6	Yorkshire & Humberside	1
21-50 staff	4	North East	2
51+ staff	4		
Organisational type		Whether funded by ASF	
ASA	9	Yes	18
VAA	6	No	10
Both	3		
Neither	10		

At Wave 2, the sample was selected in two ways. First, from the ASF Prototype Database we identified a sample of providers funded by the ASF but who had not previously been interviewed. We aimed for as much diversity as possible in terms of the prototype site through which funding had been secured, the type of provider (size, degree

of focus on therapy and on adoption, and whether an ASA/VAA), and type of services, provided both generally and in the funded case/s. In addition we interviewed two organisations who were among the most significant providers of adoption support, based on market intelligence, but who had not at that stage been funded by the ASF. At Wave 3 our sample selection was entirely providers who had been funded through the ASF, purposively selected for diversity as above. At each of the three waves, one provider approached was unable to participate and was replaced with an alternative. The individuals interviewed were either sole practitioners or senior representatives (generally the chief executive, director, or director of adoption services). At Wave 2 and 3 we also interviewed the practitioner or therapist involved in the ASF funded case/s if the senior representative had not been involved.

Parents

The sample of parents was generated through the prototype sites. We asked each site to contact, at Wave 2, the parents involved in the first four approved applications made since the launch of the ASF and, at Wave 3, four sets of parents involved in applications made between 1st October and 15th December 2014. We prepared an information sheet and letter to parents for sites to send on our behalf inviting parents to take part in an interview. Parents were asked to indicate their willingness to the local authority, and to give the local authority permission to pass on their contact details and to provide us with either brief background information or the ASF application number. (This approach was needed to provide information for sample selection, but reflected the fact that some parents might not know their support was funded by the ASF.)

Sampling via the prototype sites was not the optimal approach, but since the ASF Prototype Database does not collect family contact information it was the only feasible method. Sites lead indicated that there were some potentially eligible parents whom they thought it inappropriate to approach, for example where safeguarding issues were being investigated or where they were aware the family was in a particularly vulnerable situation, and so there was some selectivity in their approaches. This may have biased the sample towards parents with more positive experiences, and it is possible that making contact via local authorities may have discouraged some parents from coming forward.

Some prototype sites were unable to provide us with contact details for any parents, at either Wave 2 or Wave 3 or both, and the scope for selection overall was very limited indeed. We also decided not to interview more than one parent using the same provider, to maximise the coverage of our small sample. In selecting parents, we aimed for diversity in terms of the age and sex of children, the type of provider funded, intervention type, and the ASF budget. The sample came from seven of the ten prototype sites at Wave 2, and from only four at Wave 3.

Table A.3 Parents sample for implementation analysis interviews

Parents sample			
Characteristics of children for whom funding received		Characteristics of provision funded by ASF	
	Children n=25		Parents n=17
Sex of child		Provider funded	
Male	12	Sole practitioner	5
Female	13	Independent sector organisation	9
Age of child now		Public sector	3
0-5	2	Services funded	
6-10	12	Therapy for child/ren only	2
11+	11	Therapy for parent/s only	1
Age of child at placement		Therapy for child/ren and parent/s	11
0-2	10	Assessment only	3
3-5	11	Value of ASF application	
6+	4	Under £5,000	11
Placing authority		£5,000-10,000	1
LA within area	9	£10,001-£20,000	3
LA out of area	11	£20,001+	2
VAA	5		

In total, 17 sets of parents were interviewed (in three cases, both parents took part in the interview). In addition, at Wave 3 we wanted to re-interview parents interviewed at Wave 2 to explore the outcomes, so far, of therapy. We decided to focus on those whose therapy had begun after the introduction of the ASF since there would be richer learning here about the impact of the ASF. We chose not to contact two families where we were aware, from the prototype site, that they were in a particularly vulnerable position, and we were unable to make contact with one. Overall, three parents were re-interviewed. Since some parents had had ASF funding for services for more than one child, the interviews covered a total of 25 children.

3.2 Data collection

Interviews with prototype leads were conducted face-to-face at Wave 1 and by telephone at Waves 2 and 3. Those with other participants were conducted by telephone (with the exception of two independent sector organisation leads interviewed face-to-face). Interviews followed a topic guide which listed areas for inquiry, but the style of interview was flexible in both structure and questioning, exploring issues raised as relevant by each participant and probing for depth and detail. Interviews with prototype leads lasted up to two hours at Wave 1, and around 60-90 minutes at Waves 2 and 3. Those with other local authorities, independent sector providers and parents lasted around 60-90

minutes. All interviews were digitally recorded, with permission, and transcribed verbatim for detailed analysis.

The key issues explored evolved over the course of the study. With local authorities, at Wave 1 our focus was on understanding context and readiness for the ASF, looking at the therapy services available from across the local system; views about barriers and enablers of growth in the independent market; overall assessments of quality and sufficiency of provision; perceptions of the possible impacts of the ASF; and planning and readiness for its launch. At Waves 2 and 3 we explored changes in contexts and views. We looked at how the ASF was being used both generally and in specific cases selected from the ASF Prototype Database; aspects of implementation that were emerging as key; service and systems changes stimulated by the ASF; and perceived impacts of the ASF for families and the local system.

With independent sector providers, we collected information about the organisation and its work; referrals and funding; dynamics of the adoption support market and their own development plans, views about key features and likely impacts of the ASF, and readiness for the ASF and a potential increase in demand. At Waves 2 and 3 we also explored the ASF funded case/s, looking at liaison with the local authority, how decisions about interventions had been made, appropriateness of referral and progress thus far.

The interviews with parents explored experiences of service use before the ASF application; liaison with local authority around the ASF application; experiences of funded services, progress and outcomes; views about personal budgets; and views about key features of the ASF.

3.3 Analysis

Analysis was carried out using the Framework method (Spencer et al, 2014) which involves summarising interview content in a series of thematic matrices, where columns represent different topics and sub-topics, and rows represent different participants. This allows the range of views on each issue to be reviewed, whilst maintaining the integrity and context of each individual account.

4. ANALYSIS OF THE ASF PROTOTYPE DATABASE

The final element of the methodology was our analysis of the ASF Prototype Database. The database was designed and administered by Mott Macdonald and set up in Excel. The latest version of the database was made available to us at various points during the prototype phase, and we used it to inform sampling and interview coverage as noted above. Since the database had not been designed for research, we needed to do some data preparation and cleaning, for example making adjustments for unfunded or partially funded applications and to enter information systematically about budgets and providers.

We added new data categories for the type of funder (local authority adoption support service, other public sector, independent sector sole provider, independent sector organisation, and whether ASA or VAA), drawing on our knowledge of the market, internet searching and in one case contacting a prototype sites for clarification. We then analysed the data in Excel.

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Any enquiries regarding this publication should be sent to us at:

gail.peachey@education.gsi.gov.uk or www.education.gov.uk/contactus

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