

# The case studies

## How to use them

These case studies are compiled using the real experiences of different children in public care. They aim to give a flavour of the wide range of situations which cause problems for children and their carers. We provide one possible methodology, analysing the cases against the five key issues:

- Assessment of need
- Planning
- Placement stability
- Skilled interventions
- Caring for carers

There are many other possibilities. It may be that one particular study “rings bells” for your institution and throws into sharp relief issues about policy, staffing or communication. It might be that behaviours highlighted in the studies suggest parallels with children known to you. You may wish to concentrate on one study in detail or use the whole set. They can be used for group discussions or individual assignments. Please feel free to make use of them in any way which suits your training programme – and let us know how you got on!



**John**



**Susan**



**Andy**



**Kareena**



**Wayne**



**Kayleigh**

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### John: A six-year-old boy

John is six years old, and is the youngest of four children. The family have been known to children's services since the birth of the first child, as the mother is a registered drug user and alcoholic. Their maternal grandmother took on responsibility for maintaining the home as best she could until she became too frail two years ago when John was four years old.

When John's grandmother moved into sheltered housing, the family home quickly deteriorated. The children's always sporadic school attendance now stopped completely and a protracted period of frustration for education welfare services and children's services ensued. After some six months, entry was forced and inspection revealed the house to be in a state of foul neglect with the children malnourished and infested with lice. Remains of a birthday meal of baked beans was in evidence. Their mother was sectioned under the Mental Health Act and the children were placed in three different foster placements. John and his closest in age sister, who has severe learning difficulties, were separated for the first time.

The two elder girls lived together and went to school together but John went alone to his neighbourhood school. While the placements were stable for his siblings, John had problems settling and he developed speech and language difficulties, which manifested themselves as severe stuttering. He found it very difficult to make any significant friendships with peers and was frequently bullied. He withdrew from contact and would spend much of his time at school in tears, making contact only with his education liaison social worker. He was the only one of the children who refused to visit his grandmother, and he cut himself off from family contact.

John was assessed as having complex special educational needs with particular weakness in speech and language development. No SEN statement was, however, considered necessary.

It was difficult to persuade John to attend school, and when he was on site he would often truant from class and be found hidden in small spaces. He started to steal from school staff and his carers. Two placements broke down because of the difficulties arising from his challenging behaviour.

Recently, John was placed with new carers, with a placement contract providing considerable extra educational input. He was given a place on an out-of-hours literacy scheme run through children's services in collaboration with the school; this provides John with a variety of resources to use at home. He also has considerable time input from a speech therapist. John's foster carers have experience in caring for children with FASD (foetal alcohol spectrum disorder) and, in view of his mother's alcoholism and his particular needs, they have asked for a referral to a specialist team for assessment.

This latest foster placement is within walking distance from John's sisters, and the current plan is for him to join them in attending the same primary school next year. He has made one visit to see his grandmother. John is beginning to respond positively to this integrated approach to his complex needs.



### Susan: A 16-year-old girl

Susan is 16 years old. She is of mixed heritage and has been on a care order since she was two. Her mother works as a prostitute in a large city; she is a heroin user who has been in and out of rehabilitation units and prison on a regular basis since before Susan was born.

As a young child Susan was extremely withdrawn with significant speech delay. Between the ages of two and seven, she was placed with a succession of local authority foster carers but each placement broke down within two months because she would not communicate, consistently soiled herself and her surroundings, and was aggressive towards other children in the home. When she was with her mother, Susan displayed none of these characteristics, and indeed appeared to thrive – except that all school attendance stopped. She was placed on the Child Protection Register and regular social service visits were made to the home.

When Susan was eight, her mother was imprisoned for a 12-month sentence for GBH, drug dealing and soliciting. Susan went to live with her grandmother and started attending junior school regularly. She was compliant with all school procedures but very withdrawn, rarely offering any information. Despite this, she made rapid academic progress with literacy and numeracy skills, and cognitive testing confirmed that she was potentially very able. During this time, she disclosed that she had been subject to sexual abuse from a series of men while she had been living with her mother. Susan felt that this had helped her mother and made Susan herself feel grown up.

After her mother was released from prison, Susan started persistently running away from the home in order to be with her.

At age ten, Susan was placed out of county with an independent fostering provider. She initially appeared to settle well, but after six months she stopped eating and had to be hospitalised. Exhaustive counselling and therapy by mental health workers followed and Susan slowly began to thrive once more. There followed a period of settled calm, her mother was once again imprisoned and Susan was regularly in a school that she enjoyed.

At puberty, Susan underwent a sudden and cataclysmic change. Her behaviour in the home and at school became aggressive and she physically attacked a younger girl. She was excluded from school and ran back to the city to be with her mother. She refused to leave and had to be physically restrained. Her mother at this point said that she didn't want anything more to do with Susan and that she was nothing but trouble.

Susan was placed with a new fostering agency and moved to a different part of the country. She refused to attend school and became clinically depressed – not talking, sleeping throughout the day, refusing to leave her room, cutting her legs and arms, binge eating so that she gained a huge amount of weight, and obsessively washing her hair.

This foster carer, however, refused to give up and after six months of careful work, using resources from many agencies, Susan agreed to begin an integration programme into a local secondary school supported by the Pupil Referral Unit (PRU) where she had made some positive relationships with staff.

She started with one subject, English. She found it difficult to stay in a classroom for a whole hour so was allowed to leave with a support worker, at any time. Her attitude towards teachers was often confrontational and she would abscond frequently from the school site. She would constantly challenge rules but all staff were aware of her problems and had agreed clear responses.

She was in the school for three years and in the end passed GCSEs in five subjects, gaining high grades in Art and English. The day she was due to start sixth form studies, she received a text message from her mother and returned to live with her.



### Andy: A 12-year-old boy

Andy was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) when he was eight years old. This was three years after his father had left home, after which his mother had moved her female partner and her partner's three-year-old daughter into the family home.

The diagnosis was arrived at during an assessment process after Andy had been permanently excluded from his junior school, and had been cautioned by police for taking and driving away a car and for sexually interfering with his young stepsister. He was taken into care and placed with local authority foster carers.

There was no full-time education available to provide for his needs, but Andy was provided with half-time schooling at a local PRU. Within two weeks Andy had set fire to the building, causing the unit to close. At home, he was not sleeping and was prescribed low-dose sleeping pills as well as Ritalin for control of the ADHD. The foster placement rapidly broke down when it was discovered that Andy was being overtly sexual towards another child within the home.

Andy was then placed in a children's home in a different area and integrated into a new junior school. He rapidly got into trouble with the police for setting fires and he returned under supervision to his mother's house, as she was now living alone. There followed a period where Andy was in constant trouble with the law. He was vandalising the estate, putting lit fireworks through neighbours' doors, setting vehicles on fire and drinking alcohol stolen from his own and other people's houses. He was finally taken back into foster care after assaulting his mother with a broken bottle. During this time, he did not receive any formal education, as no school would accept him on roll.

Transfer to secondary phase education took place with massive co-operation between the school and the local PRU. Statutory assessment procedures were started with the intention of providing Andy with a statement of SEN as a result of his extremely challenging behaviour.

Three foster family placements broke down over the three-month period, with Andy causing damage to the property in each place. Consistent schooling was maintained, however, with Andy being taxied into school from wherever he was placed in the local authority area. During the school holiday, he ran away from his foster placement and returned to his mother. She could not persuade him to leave the house, and therefore moved out herself to live with friends. Alone in the house, he trashed the building and was taken into secure accommodation.

He started the new term as a five-day boarder in a special school for children with emotional and behavioural difficulties, with weekends spent in a children's home. Andy survived and even flourished in this protective environment for two terms. On the last day of term he set fire to the school, and as he reaches 13 will be transferred to secure accommodation.



### Kareena: A 14-year-old girl

Now 14, Kareena is the second of four children, each of whom has a different father. Kareena's mother is of mixed Hindu Indian and white British heritage and grew up in care herself. Her father, whom Kareena has never met, is said by her mother to be Pakistani. When Kareena was seven, her mother formed her first long-term relationship with a man who moved into the family home as stepfather to the children.

He was racist and physically abusive to Kareena and her sister, whose father is African-Caribbean. All four children were made subject to a care order and accommodated when Kareena was eight. She spent time in two children's homes and five foster placements over the following three years. The final two placements broke down because of her violent behaviour towards younger children in the home. These changes of placement involved her in attending four different primary schools. There is no record of her ever taking SATs at Key Stages 1 and 2.

In the summer when she was 11, Kareena's stepfather was found dead in his lodgings. Kareena returned home to live with her mother and started attending the local secondary school. Within three months, she was on the verge of being permanently excluded for repeated violent attacks on her peers who, she claimed, were taunting her, saying she had had sex with her dead stepfather. Meanwhile, all her siblings remained in local authority care and, at her mother's request, Kareena was taken back to a new foster placement. She was admitted to a new secondary school. Within two weeks she had run away from the placement and was returned to a children's home.

Her attitude to school was initially polite and compliant. She showed quick interest in a variety of subjects, although testing revealed that her literacy and numeracy skills were two years below her chronological age. In her second week at the new school, Kareena physically attacked a girl on the way to school. Kareena claimed that the girl had been teasing her about her stepfather. She was excluded for five days and an interagency meeting called. As a result of this, Kareena was offered bereavement counselling and a psychological assessment from the Adolescent Mental Health Team.

On her return to school, a protracted battle began to get Kareena to go into classrooms. She would start off in a lesson, be apparently working well and then suddenly down tools and leave, often swearing loudly as she went. She would then hide herself under the stairs, in toilets or behind cupboards and wait to be found. At first, she would then return quietly to class for the rest of the day, but over a period of a month or so, her reaction to staff finding her became increasingly abusive. Finally, she would no longer return at all but instead walked off around the site.

A staff meeting decided to adopt a whole-school policy of not reacting to this, but if Kareena was seen out of class she would be asked in a non-confrontational manner to report to the support base. She started to stay in classes for whole days.

After three weeks, Kareena suddenly stopped attending and the school could not discover her whereabouts. Enquiries revealed that she had moved out of the area and been placed in a foster home at the other end of the county. After six weeks she re-appeared, having run away and returned to her mother's house. Despite the efforts of police and social workers, Kareena refused to return to the foster placement and her mother agreed that she could stay at home 'as long as she behaved'. Kareena now refused to attend any lessons, ran away from school, was caught on CCTV camera stealing from an office, and was verbally abusive to staff. The school referred her to the local PRU.

Over the next year, Kareena committed a series of acts of vandalism around the neighbourhood and was violent towards her younger siblings, causing one of them to be hospitalised. She was physically and verbally abusive to staff at the PRU and her mother freely admitted that Kareena was beyond her control. The Youth Offending Team organised a variety of different programmes, but Kareena never completed any of them.

Kareena was included on an NVQ catering course, but when she thought she might have to show her hands (which were discoloured with bruises and raw from biting), she ran away. She is now excluded from the PRU and is 10 weeks pregnant.



### Wayne: A 13-year-old boy

Wayne is a highly intelligent 13-year-old. He is an only child who lived with his mother and her partner until the age of five. At that point his father lost his job and left the family home. His mother started drinking heavily and three months later also lost her well-paid job as a secretary in a large firm. She became mentally ill, suffering from prolonged bouts of severe depression during which she self-harmed.

When Wayne was seven, his mother attempted suicide and was found unconscious in a pool of blood by her son when he returned from school one afternoon. He called the emergency services and her life was saved. He was taken into emergency care and placed in a children's home. He stayed there for six weeks but returned home when his mother was discharged from the psychiatric unit.

For a further year, Wayne lived at home where he took on many care responsibilities. The house was kept quite clean and tidy, clothes were washed, food prepared and bills paid. During the course of the year, the family social worker noted that Wayne was often at home when she called and the mother would say that the boy had been unwell. At the same time, the school had referred Wayne to the education welfare service for erratic attendance and the school medical service registered concern about the boy's slow growth rate. Wayne's teacher noted that academic progress had practically stopped. It was not, however, until a multi-agency meeting was convened that the pieces of the jigsaw fell into place.

It was agreed that Wayne should be taken into care and he was placed in an assessment centre. Full investigation of the home circumstances revealed that Wayne's mother was still drinking heavily and admitted that she was not able to cope with looking after herself and certainly not with looking after a child.

Wayne was placed with foster carers with weekly supervised visits to his mother. School attendance improved dramatically and he began to resume normal growth patterns. He achieved Level 5 in Key Stage 2 tests – above the national average. His foster family reported that he was well settled in the home and got on well with their two daughters, both younger than Wayne. He was told this would be a permanent placement.

Wayne settled quickly into secondary school and presented as a quiet and likeable youngster, eager to please and well organised. He made good academic progress and was placed in high sets for all subjects.

In the summer holidays at the end of Year 7, Wayne spent some time with his father who had re-married and had a ten-month-old baby. When he returned at the start of Year 8, aged 12, staff noticed that he was quite uncommunicative. He stopped attending the after-school technology clubs he had enjoyed the previous year and his homework record became very poor. He had had a growth spurt and became clumsy and uncoordinated. He developed a mild stammer and often refused to take part in PE lessons. Sometimes during afternoon lessons he appeared drowsy.

There were a couple of incidents of absences where Wayne produced forged sickness notes and alcohol was smelt on his breath. One day, another pupil reported that he had seen Wayne taking some tablets. He was found in a disorientated state in the cloakrooms and taken to the accident and emergency department of the local hospital, having taken 15 paracetamol tablets.

Wayne's foster father came to a review meeting saying that his wife would not attend as she felt she had nothing positive to say about Wayne. Her two girls had revealed that they were now very nervous around Wayne and his foster mother felt that she could no longer talk to him. Wayne would not volunteer any information about what he was doing, just staring at her silently when she spoke to him. When she had grounded him in an attempt to manage his risky behaviour, he had climbed out of his bedroom window and been gone for some hours.

The foster placement broke down and Wayne was placed in a children's home. Wayne's behaviour continues to cause concerns over his health and safety. His attendance at school has dropped to about 50 per cent.



### Kayleigh: A 10-year-old girl

Kayleigh is 10 and at present in Year 6 at primary school. Her mother died suddenly when she was three, and she has clear memories of this event and how it affected her father. She was considered at risk of physical abuse from her older sister and taken into foster care. She was an aggressive child and three foster placements broke down in quick succession.

Finding a family able to offer long-term security proved difficult but a placement was secured when Kayleigh was five, which looked promising. She started school and made quick progress although she found it difficult to make friends and would often take things from others and protest loudly if challenged. She would bite and slap her peers, who avoided contact with her. She grew quickly and was the tallest in her class. She tends to be clumsy and has a moderately severe hearing loss which was not recognised until she was seven years old.

In the foster home Kayleigh got on very well with an older child, and was devastated when this young woman was killed in a road accident. This contributed to a further period of difficult behaviour with many incidents of soiling and bedwetting. She was excluded from school and again had to be found a new kinship foster placement with an aunt. Having moved in with her aunt, Kayleigh began to be more settled until an uncle re-appeared in the house, having served a prison sentence. Kayleigh was considered to be at real risk of sexual abuse from this man and had to be removed.

At the age of nine, and in her third junior school in another district, Kayleigh again enjoyed some stability in her fifth foster placement. But by this stage her behaviour in school was proving extremely difficult to manage. She was seeing support workers from children's services weekly and having considerable input from the behaviour support team in an attempt to provide some sustained schooling.

She complained regularly of being bullied by children at school and had no friends. Parents of other children complained that she was frightening their children by her "strange" behaviour and aggressive attitude. The school initiated statutory assessment with a view to providing Kayleigh with a Statement of SEN, but this was rejected by the local authority for lack of clear evidence. She was prescribed anti-depressants.

When she was just 10, her father committed suicide, and Kayleigh was hospitalised for three months having broken her arm when she pulled furniture down on herself during a tantrum.

At present, children's services are seeking a new foster placement for Kayleigh, and it is recommended that she attend a special school for children with emotional and behavioural difficulties when she reaches secondary school age.

# Key intervention points

Certain themes emerge from the case studies that indicate key issues or intervention points. These were:

- 1) Assessment of need;
- 2) Planning;
- 3) Placement stability;
- 4) Skilled interventions;
- 5) Caring for carers (see below).

During the lengthy piloting of this training material, practitioners have commented on changes they have observed at these key points when this approach is applied. Each of the key points is numbered, with subsections a, b, and c. In each case section (a) relates to the first section of the presentation, and invites the participant to reflect on the ways in which a deeper understanding of the effects of unmet attachment need and early trauma might make a difference to practice in this area. The (b) sections relate to the second section of the presentation, and encourage participants to reflect on the ways in which recognising and understanding the effects of secondary traumatic stress might have an impact on effective practice. And finally, the (c) sections suggest reflection on the effects on practice of having an approach to working with traumatised children that expects and promotes recovery and adaptation.

Participants should try and identify from the case study the key points at which increased knowledge and understanding might have produced different practice, or points at which practitioners showed skilled work in relation to issues of attachment and trauma. An example of a partial analysis is given with the case study of John.

## 1 Assessment of need

- a) Understanding of issues of attachment and trauma can produce speedier, more child-centred assessments.
- b) Understanding of issues of secondary traumatic stress can help in screening out avoidance, in which the child is overlooked or blamed, or panic, in which the child is perceived as unduly dangerous or powerful.
- c) Belief in the possibility of recovery or adaptation, and understanding of issues of resilience, can reduce paralysis in the face of apparently intractable situations.

## 2 Planning

- a) Recognition of the disintegrative effects of trauma encourages all those with responsibility for the child to work together to ensure that plans are effective and do not perpetuate the disintegration.
- b) Recognition of the power of secondary traumatic stress to create conflict and reduce clear communication between the adults responsible for the child helps workers to stay calm and child centred while producing joined-up planning.
- c) Having a model for understanding the process of recovery and adaptation helps set a framework for constructing effective plans for the child.

## 3 Placement stability

- a) Care families who have been able to make sense of the behaviour of children placed with them in terms of issues of attachment and trauma are more able to survive and thrive.
- b) Social workers, teachers and other professionals who use a model of secondary traumatic stress to make sense of their work with care families are more able to sustain the family placement.
- c) Recognition of the nature and timescales of recovery and adaptation after trauma allows everyone responsible for the welfare of the child to be both more optimistic and more patient.

## 4 Skilled interventions

- a) Understanding the global nature of developmental and functional impairments after early adversity leads to a recognition that everyone around the child is contributing to the recovery process. This helps people to be motivated to build on their existing skills and to develop appropriate new skills.
- b) Applying the model of secondary traumatic stress promotes understanding of the de-skilling effects of living and working with traumatised children. This in turn leads to better mutual support and more clarity in the use of supervision.
- c) Having a model for the process of recovery and adaptation encourages the development of a range of appropriate skills for helping the child progress on the journey of recovery. It also promotes the recognition of a range of people who may, because of their particular skills, be helpful to the child at different points of the recovery process.

## 5 Caring for carers

- a) Traumatised children are often exhausting and frustrating people to be with. Everyone who cares for them – care families, teachers, social workers and other people who are part of the care network – may become exhausted and frustrated. Such experiences accumulate: people may

become less, not more, effective as they become more experienced. Knowledge and understanding can prevent such burnout.

- b) Secondary traumatic stress can lead to diminished ability to use supervision and support. Knowledgeable supervisors will expect this effect and find ways to continue to support those who care for the child.
- c) Strategies for recovery and adaptation are useful for everyone who ever experiences the symptoms that follow overwhelming stress.

*An example of a partially annotated case study, showing how these studies may be used to contribute to individual learning or group discussions.*



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mother's alcoholism and his particular needs, have asked for a referral to a specialist team for assessment.

This latest foster placement is within walking distance from John's sisters, and the current plan is for him to join them in attending the same primary school next year. He has made one visit to see his grandmother. John is beginning to respond positively to this integrated approach to his complex needs.

Highlighted section	Reference no.
Children's services	1a
protracted period of frustration	1b/5a
developed speech and language difficulties	4a
frequently bullied. He withdrew from contact	3a
refused to visit	4a
No SEN statement was, however, considered necessary.	1c
He started to steal from school staff and his carers.	4b
Two placements broke down because of the difficulties arising from his challenging behaviour	2b
with a placement contract providing considerable extra educational input.	3b
literacy scheme run through children's services in collaboration with the school; this provides John with a variety of resources to use at home. He also has considerable time input from a speech therapist.	2a/4a
foster carers have experience in caring for children with FASD (foetal alcohol spectrum disorder)	4a
This latest foster placement is within walking distance from John's sisters, and the current plan is for him to join them in attending the same primary school next year.	3c

# An example of a partially annotated worksheet

## Assessment of need

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1a Earlier intervention could have reduced developmental impairment

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1b Frustration leads to avoidance

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1c Belief in recovery

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## Planning

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2a Integrated multi-agency approach recognising effects of trauma

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2b Child's behaviour inducing secondary stress leading to breakdown

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## Placement stability

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3a Stress behaviour of the child partially recognised

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3b Recognition of needs of carers

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3c Ability to partially re-unite siblings starts long road to positive recovery

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## Skilled interventions

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4a Explicit developmental and functional impairments

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4b Stealing creating secondary stress - deskilling carers

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4c Recognition of the range of interventions

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## Care of carers

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5a Greater appreciation of effects of exhausting effect on carers can help prevent burnout

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# Case study worksheet

## **Assessment of need**

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## **Planning**

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## **Placement stability**

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## **Skilled interventions**

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## **Care of carers**

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