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Children Looked After in Wales: National Needs Analysis to inform Commissioned Care and Placement Services 2025.

Helping develop the homes and care children need to thrive.

FOREWORD

The delivery of care to children looked after in Wales is significantly changing over the coming 5 to 10 years. The Health and Social Care (Wales) Act 2025 says registered care providers must in future operate under 1 of 4 business models if they are a provider of 'restricted services': foster care, residential care or Secure care. Since 2021 the development of the Act has largely served to pause investment by independent providers; in key areas this means the sufficiency gap and the mismatch between registered capacity and it's fit to meet needs, has grown, particularly for those children who require more complex care packages to effectively meet their needs. With the Act receiving Royal Assent, we are hopeful that commissioners and providers can now move forward with more certainty of the legislative context, to re-focus on developing the right services for children, available at the right time, and in the right location.

Public sector investment is growing to rebalance the level of commissioned services, so mitigating some risk from the Act, but this investment alone will not deliver sufficiency. We must work in improved partnership with independent providers who are able to meet the requirements of the Act in future.

Local Authorities want to work with independent providers to deliver complementary services, as a cohesive whole, to meet the needs of vulnerable children. In this report we examine the presenting needs of children, changing and emerging needs, explore national trends and highlight any regional variations in commissioned services. We look at what works well and available guidance to meet some of these needs, where we want to stimulate discussion and innovation in service models or models of care. We highlight the main gaps in sufficiency due to a mismatch between the service offer or lack of model of care to meet childrens identified needs profiles.

Much of the analysis in this report relates to a 5-year period 2020 to 2025, which includes periods of lockdown due to the Covid-19 pandemic. Where spikes in needs and referral types present as linked to the impact of Covid, this is noted. There is also reference to where a trend appears to be changing post Covid, but it is important to acknowledge the full impacts of the environmental and societal changes will require longer term evaluation. For many children their experiences during the pandemic have been life shaping.

As with all 4Cs' work the voice of the child is represented throughout the report, aligned to the child focused and outcome focused approach we promote, and celebrating the 4Cs' kitemark status of National Participation Standards. The Young Commissioners Group offer valuable insights to support learning and service improvement. In this report we refer to babies (0-3 years), children (4–13 years), and young people (14–18 years) in particular contexts or we use the term children to describe all children looked after (0-18).

If you would like to discuss this report in more detail, please do contact the 4Cs (the Childrens Commissioning Consortium Cymru) or sign up to attend one of our needs profiling events during 2025/26.

CONTENTS

WHO ARE OUR CHILDREN LOOKED AFTER IN WALES

At the end of March 2024 there were 7200 children looked after by Welsh Local Authorities (Stats Wales) with only minor fluctuations over 5 years, from 7165 at end of March 2020 (Stats Wales); the highest year being post-Covid in 2021. The number of children looked after on 31 March 2024 however was 28.4% higher than a decade ago. With a focus on ensuring the right children receive care and support at the right time in their childhoods, the number of children looked after remains relatively stable, at around 1.1% of the population under 18 living in Wales. Of the four UK nations, Wales continues to have the 2nd highest rate per 10,000 behind Scotland whose rate is decreasing.

The majority of children looked after are male, on average 8% higher than females, although the gap seems to be growing from a low of 7% in 2022 to a high of 11% in 2024. This trend continued into 2024/25.

The highest age group is 10+ years (4280 children (Stats Wales)) which has increased by 13% over the past 5 years. 39% were aged 10 to 15 and 20% were 16 years and over. The under 9 years (2910 children (Stats Wales)) has decreased by 14% over the same timeline. There has been a significant increase in males aged 16 to 18 (56%). This reflects the overall trend of children entering care older than in the 2010s.

The majority of children become looked after due to abuse or neglect; 54%, but the numbers are decreasing in this category. There has been a notable increase in children becoming looked after due to family in acute stress or dysfunction (64% increase between 2020 to 2024). This increase is in part likely reflective of more families and children being caught in poverty and increased deprivation. In Wales, 21% of working age adults and 31% of children were living in relative income poverty in FYE 2022 to FYE 2024, an increase from 29% (FYE 2021 to FYE 2023), and highest of the 4 UK nations.

Our care experienced population predominantly identifies as White Welsh and English speaking. Welsh speakers are twice as likely to speak Welsh every day if they have at least one fluent parent in Welsh, compared with those who did not have a fluent parent. (Welsh Government language survey 2020). The number of children looked after from Black/Black British/Caribbean/African, Mixed or other ethnic groups is disproportionately higher compared to the general child population. In 2023/24, 4.7% of children looked after were an unaccompanied asylum-seeking child, the highest recorded (Stats Wales).

In March 2024 68% are living in foster care, of which 34% are kinship care. The proportion in foster care has decreased steadily from a high of 79% in 2011, while within this figure the numbers placed with family and friends has increased. This is reflective of decreasing sufficiency in mainstream foster care. Adoption numbers continue to fall but Special Guardianship increase (51% difference 2020 to 2024). 12% of children are placed in residential homes, including Secure care, however the proportion of Secure has fallen due to lack of sufficiency and an increase in Secure settings either giving notice or declining referrals due to an inability to meet a child's needs. 51% of children leaving care returned home to family.

COMMONALITIES OF NEED, EXPERIENCE AND BEHAVIOUR

Here we consider the most frequently identified needs for children looked after in the 5-year period 2020-2024. Often in commissioning language we classify these as 'core' or 'standard' but this technical language does not capture the level of impact each can have on a child's ability to thrive or achieve best outcomes. Meeting these needs is the foundation of good care and support.

SUPPORT FOR FAMILY CONNECTIONS - 85% of referrals explicitly request providers support the child's relationships with family and friends, which reinforces the importance of maintaining relationships important to the child. Providers and carers are expected to promote safe and healthy family time in the best interests of each child, whether it be free time to visit, time spent out in the community or supervised time. Where a care plan intends the child to return home to family, the provider is central to relationship strengthening, building safety and resilience for the child. Over half of children looked after return to live with, or close to, birth family when they leave care, building the child's understanding of their care journey and relationships with family is an essential component to their resilience in young adulthood.

SUPPORT FOR POSITIVE PEER RELATIONSHIPS - 31% of children are identified as needing specific support to build and maintain healthy and positive peer relationships but further exploration of referrals indicates the prevalence is much higher than this. Children looked after are more likely to have moved house, moved school, have low school attendance, experienced bullying in school, have low engagement in after school activities and clubs, or experienced school exclusions, which are all factors impacting their opportunity to have established positive peer relationships. Relationships can help build resilience through connection; providers and carers are expected to promote opportunities for the child to build peer relationships and guide their understanding of healthy friendships and positive relationships, growing a support network into young adulthood.

LOW SELF-ESTEEM - 25% of children referred to providers are specifically described as experiencing low self-esteem, often linked to their experiences of neglect, abuse or trauma. Isolation and loneliness are common experiences which further impact sense of worth negatively and are explicitly described in referrals for care.

COMMUNICATION SUPPORT NEEDS – are identified across a broad spectrum and is a co-occurring need across many of the need profiles, for example, alongside speech and language therapy, neurodiversity, additional learning needs, alongside cultural identity, alongside anger management, mental health, emotional and psychological dysregulation. The ability to communicate, to speak and be heard and be understood is what all children want. Carers must nurture diverse, verbal and non-verbal, means of communication that make children feel safe.

NEURODIVERSITY - There are an estimated 20,000 (5%) children in Wales diagnosed with attention deficit hyperactivity disorder (ADHD) and 8,000 (2%) with autistic spectrum condition (ASC). With ASC, the rate may be higher for children looked after, Stats Wales indicating the percentage could be as high as 15%, equating to 1080 children in 2024. Stats Wales does not report the numbers of children with a care plan diagnosed with ADHD but,

NHS digital data shows that ADHD medication prescriptions increased 75% between 2010 and 2020 across the population, and reports from Welsh Government (2022/23) indicate growing waiting lists for ADHD assessments. If the over-representation of children looked after is mirrored for ADHD, diagnosed and undiagnosed, this is a significant needs profile. ADHD does present as increasingly common in referral numbers (average 10% of children over 5 years) and as a thread running through child pen pictures, which also note ADHD assessments pending.

Challenging behaviour – is the most frequent generic description of behaviours across all referrals for children in need of care (57%). This most commonly sits alongside; verbal aggression, physical violence, being missing from care, anger management, drug and alcohol misuse, and criminality. Those children and young people with challenging behaviour identified in the referral are 100% more likely to not receive a placement offer to meet their needs than the next highest needs category.

Cultural identity needs – are selected frequently by specific Local Authorities and refer to two distinct profiles across the samples; firstly, Welsh language and culture, commonly selected in Northwest and Southwest Wales, and secondly, for children placed away from their home area, whether that be Welsh children moving out of area, out of country, or the cohort of unaccompanied children seeking asylum.

These common needs are cross cutting a range of more distinct profiles, and where especially prevalent the specifics are explored in the report.

ACEs, TRAUMA AND WALES' TRAUMA INFORMED APPROACH

Adverse childhood experiences (ACEs) and **trauma** are not uncommon with an estimated 1/3 of children in England and Wales having been exposed to a traumatic experience by the age of 18 years and 1/4 of those develop post-traumatic stress disorder (PTSD) by age 18. These rates are higher in children receiving care and support. Children looked after in Wales are likely to have experienced complex or developmental trauma through prolonged and multiple experiences of trauma prior to becoming cared for. Almost all referrals for commissioned placements evidence multiple co-occurring ACEs and trauma for the individual child in need of care.

Research from Public Health Wales shows the link between ACEs and risk of poor health and social outcomes across a person's life where there are no protective factors, or accessible support. Of the ten ACEs, five relate to the child and five relate to the parents/household.

Physical abuse
Sexual abuse
Emotional abuse
Physical neglect
Emotional neglect

Household substance misuse
Household mental illness
Incarcerated household member
Parental separation or divorce
Household domestic violence

Support and further information on the expected approach in Wales can be found from these resources: ACE Hub Wales (training on becoming a trauma informed organisation) Wales Trauma Informed Framework and Traumatic Stress Wales (research, training and events).

Understanding how to support healing alongside building resilience and protective factors should be at the core of care. The frequency and acuity of need requires embedded practice across organisation's workforce to deliver child focused and outcome focused services.

Providers and carers are expected to understand and implement a consistent trauma informed approach to care and support in Wales, to meet these widely presenting needs of babies, children and young people looked after. Examples of these needs' profiles are captured below:

Menna, age 6, has a foster care ending due to emotional and behavioural challenges following the arrival of a new baby in the foster home. Long-term foster care is needed with a focus on 1:1 attention and emotional support.

Displays challenging behaviour that may result in physical harm to self during emotional outbursts. Can be physically aggressive towards other children or babies, especially when seeking attention or feeling excluded. Requires supervision around younger children. Rough and potentially harmful behaviour towards pets, incidents include a pet returning with a minor injury after being alone with Menna.

Needs: support with emotional regulation and anger management, development of secure attachments and self-esteem, consistent boundaries and nurturing environment, 1:1 attention to reduce attention-seeking behaviours. Social and developmental needs include opportunities to build healthy peer relationships, encouragement to develop hobbies and community involvement, stable and secure living environment with predictable routines

Educational needs are continued support with learning and emotional literacy. Improved school attendance and potential transition if placement changes. Health needs are monitoring of speech and language development plus routine health care (dental, vision, general well-being).

Illtyd is a 7-year-old boy. He has no formal diagnosis or medication needs but a history of glue ear and some behavioural concerns. His carers have queried Oppositional Defiance Disorder, though this is unconfirmed. His challenges are primarily linked to early trauma and neglect.

Current placement ending due to breakdown in relationship between carers and the children, particularly with his half-brother, despite support from specialist teams. Illtyd expressed a desire to leave the carers and remain with his brother, stating "brothers stick together."

Needs: a nurturing environment with consistent routines and boundaries; support to build self-esteem and emotional regulation, benefits from adult attention and physical affection, can be demanding of carer attention and may mimic his brother's behaviours to gain approval. Attends school full-time and is doing well academically, especially in literacy.

Enjoys outdoor play, board games, and digital play. Has a good peer group and is sociable, though can display silly behaviours to impress others. Needs help managing sibling dynamics and understanding appropriate social boundaries.

No direct risk to self or others but requires supervision due to sibling rivalry and emotional vulnerability. No immediate risk from family, but both parents have complex histories. The father has a diagnosis of ADHD and a history of domestic violence allegations. Family time is supervised and infrequent.

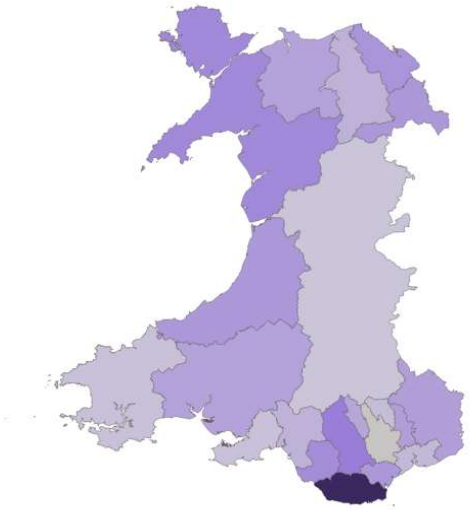
DISABILITY, ADDITIONAL NEEDS AND IMPAIRMENT

Local Authorities, alongside Welsh Government, are committed to the social definition of disability, which recognises people with impairments are disabled by barriers that commonly exist in society; however, data is often available based on the Equality Act 2010 medical definition of disability.

7.4% of children looked after on 31 March 2024 had a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. This proportion has been broadly stable in the last decade and is proportionate to the general population (Stats Wales).

PHYSICAL HEALTH NEEDS

The demand for commissioned care; foster, residential and supported accommodation, for children and young people with identified physical health needs has the below distribution for the period 2020 to 2024. The **3 most common needs are asthma, urine incontinence and faecal incontinence**.



Physical Health	Number of referrals
Asthmatic	243
Cerebral Palsy	39
Diabetic	24
Down's Syndrome	41
Encopresis or faeces incontinence	123
Enurises or urine incontinence	231
Epileptic	117
Medical nursing needs	32
Pregnant Girls Young women	25
Terminal illness	2
Visual impairment	58

Figure 1 - Map & Table geographical distribution of referrals with physical health needs - Source CCSR - 2020-2025 referrals data

The rates for these presenting needs are relatively stable year on year, a spike in urine incontinence post-Covid (2021/22) may partly link to widely reported concern regarding toilet training. In Sept 2024 an estimated 1 in 4 children starting school in the UK were not toilet trained (Ofsted).

Asthma is the most common long-term condition among the general population of children and one of the top ten reasons for emergency hospital admission in the UK. Deprivation is linked to a higher incidence of asthma in children and associated with poor housing (Royal College of Paediatrics and Child Health, 2024).

As a basic care and support need, carers should be able to recognise signs of undiagnosed asthma, support diagnosed asthma health management and support the understanding of the child to manage their own health in an age-appropriate way. NHS Wales have developed an app to support carers to monitor, manage, and learn about their child's asthma. Regular users of the apps report improvements in respiratory health, resulting in a reduction in GP and A&E admissions. Details of the App

can be accessed here Asthmahub for Parents – Health hub. The Asthma Hub hosts online events to support those with asthma as well as their carers. The increased risks posed by vaping and smoking should be discussed with young people to promote good health.

NIGHTTIME ENURESIS or bedwetting is common in the general population under the age of 5 years (up to 1 in 3 children) but decreases notably by age 9 (under 1 in 10). From referrals, however, a **significant proportion (48%) highlight this needs profile for children and young people in the older age range of 10-15 years.** This is disproportionate to the general population and correlates to reported experiences of trauma, neglect or abuse in childhood.

A workforce able to deliver care and support in a trauma informed approach should be trained on the best ways to manage enuresis and the embarrassment children and young people can feel, which may impact their emotional wellbeing.

> Smearing was identified on the referral. We did have a plan, but I wasn't prepared for how it made me feel. I really did struggle with the daily issues.
> Source: 4Cs foster carer feedback, 2022.

5% of children and young people with additional learning needs and ASC present with double continence issues. Faecal incontinence and smearing emerge as a factor in a small but distinct group of placement disruptions.

Providers should proactively consider and build strategies for carer resilience when managing these presenting needs and work closely with local health services to implement management strategies. Carers can access advice sheets and guidance on a range of continence topics at https://www.bbuk.org.uk/children-young-people/resources-for-children/ and https://eric.org.uk/ in addition to support from local health services.

20% of children with identified physical health needs were re-referred over the 5-year period which illustrates the challenges in identifying the right homes to provide stability of care to this vulnerable group. This is a known area of decreasing registered capacity across not only foster care but, unusually, also in residential care in Wales. It is an area of risk linked to the implementation of the HSCW Act and Local Authorities welcome new market entrants to offer greater sufficiency and service models to offer outreach and community support.

> **Carly's seizures have been well managed, resulting in a decrease of medication. She has a rare form of epilepsy and is registered with a local GP and with consultant nurse in respect of her epilepsy. She is supported by her carer to take her medication on time. The impact of the (carer's) support on Carly has been positive, she is attending and now engaging in all her appointments, including for hearing aids and glasses. Her carers have promoted and supported all of her health needs and Carly's carers have ensured that all relevant professionals are kept up to date of any changes or concerns.** Source: 4Cs QPA, 2023.

ADDITIONAL LEARNING NEEDS

In Wales, Additional Learning Needs (ALN) refers to children who require extra support to learn due to learning difficulties, disabilities, or other needs that make it more challenging for them to learn compared to their peers. This support is provided through Additional Learning Provision (ALP), which is detailed in an Individual Development Plan (IDP).

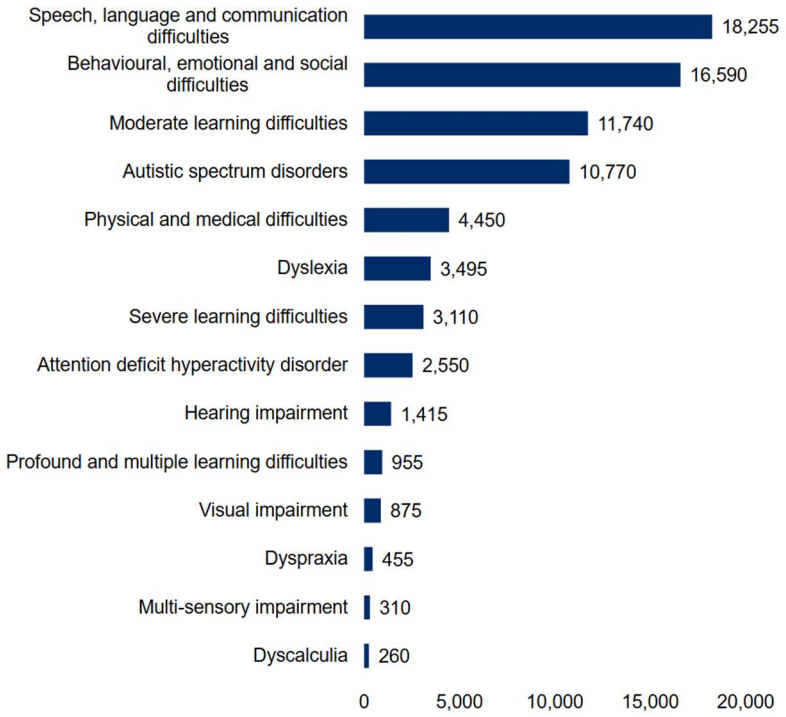


Figure 2 - Reports of ALN (and SEN) in maintained schools by type of identified needs – Source - School census, Jan 2024

The implementation of the current legislation was delayed due to Covid until 2021; therefore, the previous language of Statement of Educational Need (SEN) is evident in this analysis and impacts data. For example, the 52% decrease between 2022 to 2024 in identified SEN, is likely linked to implementation, as is a correlating increase of identified ALN (108% 2020 to 2024) and increase for learning disability (52% 2020 to 2024) with co-presenting needs evident within referrals. Use of SEN terminology is due to cease in August 2025.

My (education) plan helps because it explains how to help me to learn, if there's different TA's it's clear what help I need. I think it makes me happier, you know, less worried, so I don't mind going to class. Source: Young Commissioner, 2024.

COMMUNICATION NEEDS

are a key presenting feature of referrals for children looked after with learning needs. Largely the children looked after population mirrors the range of the general populations profile but with a higher rate.

The data further indicates **between Jan 2022 to March 2025, 40% of referrals for Secure Welfare care have identified ALN / SEN.**

Rhodri is 17, has additional learning needs, is diagnosed with anxiety managed by medication, and being assessed for autism. He has a history of breakdown in family relationships. Behaviours include verbal and physical aggression, sexualised behaviour and concerns about interactions with the community, including incidents of criminal behaviour and inappropriate social interactions. He is under CAMHS Outreach Team. Rhodri has an IDP for additional learning needs but is excluded from school. He's interested in studying barbering at college, enjoys dressing well and sometimes adapts his dress code to fictional characters. Rhodri's mental health is a risk if anxiety is not managed effectively plus a risk of social isolation. Collaboration by health, education, and social care is essential to support well-being and community integration. Referral case Study.

EDUCATION AND TRAINING

Based on a breakdown of 4Cs 2024 quality performance assessment (QPA) (Figure 3) data indicates the difference between children attending full time education in both foster and residential framework care settings. The numbers of children not attending school or with reduced timetable are significantly higher in residential care.

> **I have been encouraged through my time in my home, my carer is big on education and due to them I was able to pass GCSE's and get in college to do the things I love.**
>
> Source: 360 Survey, 4Cs QPA, 2024.

Lack of school attendance features regularly as a reason for foster care disruptions, as carer's resilience is impacted without the structure of consistent school routines. Foster care providers should focus efforts to assist carers with practical support to maintain resilience and minimise unnecessary disruption during gaps in education. Searches for residential homes with education integrated into the care package have shown an overall increase over the 5-year period with a peak in 2022.

In 2024, 73 individual children were newly referred for homes who had been permanently excluded from school. 64% of the co-presenting needs related to behaviours classed as harmful or disruptive to others, such as physical violence, while 36% of the presenting behaviours can be grouped as harmful to self.

The percentage of absenteeism across primary and secondary schools in Wales reached its highest in a decade, post-Covid (2022/23, Stats Wales). Recording of exclusions, fixed term and permanent, have changed and so are not available for the comparative period or post-Covid. Similarly figures for those receiving education other than at school (EOTAS) are not available post-Covid (Stats Wales). Analysis of referrals does indicate exclusions are a growing concern for children looked after.

Foster

Region	Full Time	Not attending school	Reduced Timetable	Total
Cardiff and Vale	172	20	9	**201**
Cwm Taf Morgannwg	96	5	4	**105**
Gwent	83	7	1	**91**
North Wales	180	11	1	**192**
Powys and West Wales	69	7	2	**78**
West Glamorgan	59	3	4	**66**
Total	**659**	**53**	**21**	**733**

Residential

Region	Full Time	Not attending school	Reduced Timetable	Total
Cardiff and Vale	41	21	19	**81**
Cwm Taf Morgannwg	35	23	21	**79**
Gwent	23	18	11	**52**
North Wales	20	25	50	**95**
Powys and West Wales	18	22	22	**62**
West Glamorgan	16	4	5	**25**
Total	**153**	**113**	**128**	**394**

Figure 3 - Summary of placement education attendance for Foster & Residential care by region - Source - 4Cs QPA 2024

The data indicates that **57% of referrals for Secure Welfare care, are for children and young people not registered with a school at the point of referral, due to fixed term or permanent exclusions, and awaiting outcomes of education panels** (SWCU, 2025). Without education routines, risk-taking behaviours can spiral quickly for children.

NEET rates for 16 to 24 year olds are 15% in Wales, the highest of the 4 UK nations, only the Northwest of England region has a higher rate at 16%. Males are more likely to be NEET than females (ONS Labour Force Survey, 2024). Care leavers in England were found to be over ten times more likely than their peers to be not in education, employment or training in their 21st year, based on analysis with care experienced young adults (Rees Centre, 2023) and this seems likely to be similar in Wales based on a sample of referrals for young people over 16 years, over the 5-year period.

Residential care providers who offer a clear model of integrated care with Estyn registered schools linked to their homes, are able to demonstrate re-engagement of children and young people in learning and with notable successes in supporting young people onto university or apprenticeships.

I'm encouraged to follow my dreams and have aspirations.
Source: 360 Survey, 4Cs QPA, 2022.

Local Authorities want all carers to be able to work in partnership with schools, to advocate for children and young people's fulltime attendance at school or college, and to be able to support children and young people to identify their talents and pursue further learning or training in their chosen fields.

Education and learning is a pathway out of poverty to improved independence and wellbeing which can help break generational cycles for children looked after. All providers and carers are expected to promote opportunities through education and learning. Active schemes to link young people with local employers and facilitating work experience opportunities to build their CV promote good outcomes and add social value in local communities.

I have regular meetings around my education and other things with everyone involved in my care to make sure we are all in the same page and working together. This includes, my carer, therapist, teacher and my family and sometimes others like my social worker and CAMHS.

There are daily handovers between school and my home to give an update on how my day has been. This helps everyone to stay up to date with what I am working on and what I need more support with. With everyone working together, this helps me to reach my goals in a positive way. I'm doing GCSE's now and I want to go to university.

Source: Young Commissioner, Social Care Wales Residential Childrens Care Conference, 2024

NEURODIVERSITY

Neurodiversity refers to the natural diversity in human brains. 1 in 7 people are estimated to be neurodivergent, many unaware and undiagnosed. Neurodivergence is the term for when someone's brain processes, learns, and/or behaves differently from what is considered 'typical'. Neurodivergent conditions include:

I'm neuro 'fizzy' things are always bubbling up. Source: You Said We Did Conference, 2021.

Dyslexia (affecting reading and decoding speech) dyspraxia (also called developmental coordination disorder, affecting movement and coordination) dyscalculia (affecting numbers and maths) attention deficit hyperactivity disorder (ADHD) and autism spectrum condition / disorder (ASC). These **conditions often co-occur, and symptoms overlap**.

Strengths of neurodiverse people:

Problems solving skills, empathy, creativity, innovative, practical skills. Source: PHW.

Increasingly there is recognition of the positive attributes of neurodiversity. With increased social understanding and recognition, children and young people tell us stigma is reducing, making them more comfortable in sharing their experience of, and the impact of, neurodiversity on their day to day lives.

There is still distance to be travelled, and many children looked after will require specific, tailored care and support plans to allow them to thrive with neurodiversity. Carers must remain up to date with the evolving research in these areas. The accessible series co-produced by the BBC and OU Inside our autistic minds and Inside our minds: ADHD and Dyslexia may be helpful alongside more tailored training packages.

Referrals that identify **DYSLEXIA** are significantly below the expected level (only 12 children in 5 years), however, providers should be aware this is likely under-reporting rather than under-representation in the looked after children's needs profile; carers may be instrumental in advocating for children to be assessed and supported with this need. Where dyslexia is identified it is most commonly alongside ADHD and additional learning needs.

The 3 main characteristics of **ADHD** are being inattentive, being hyperactive and being impulsive, with increasing understanding these present differently in females compared to males. Those with ADHD are more likely to experience mental health issues including anxiety, depression, self-harm or suicidal thoughts (NHS UK). These **main characteristics are prevalent across referral content in Wales**.

10% of referrals currently specify diagnosed ADHD as a need but the forecast is an increasing profile. Over the 5-year period 4% of children identified with ADHD were re-referred for a new placement, a notable proportion of these being a move from foster care to residential care. Reduced carer resilience is a feature of these re-referrals and foster care providers should proactively plan what additional support may be available if needed.

Waiting times for ADHD assessments is an important context for analysing needs profile in terms of identified and unidentified need. In Wales, as across the UK, there are significant regional variations, from a reported 5 weeks up to 5 years (ADHD UK, 2024).

Yet prior to this, children looked after may also experience referral later than the general population, linking to becoming accommodated later in childhood and lower school attendance, or may experience 'screening out' of referrals. Where screening is used for children on average 29% will be screened out, girls are 11% more likely to be screened out than boys, (ADHD UK, 2023) compounding the gender variation noted in NICE guidelines that women and girls are under-diagnosed.

Research on the relationship between **ADHD AND ATTACHMENT** is an area to watch for impact on practice guidance for improved care and support. Early findings suggesting a complex association; some studies indicating a higher prevalence of insecure attachment styles among individuals with ADHD, others note two-way influences between ADHD symptoms and attachment difficulties (ADHD Centre UK, 2024).

ADHD AND AUTISM share a common needs profile in referrals between 2020 to 2024 as illustrated in Figure 4.

ASD
1. Challenging behaviour
2. Additional learning needs (ALN)
3. ADHD
4. Statement of educational needs (SEN)
5. Learning disabilities
6. Communication issues
7. Self injury
8. Speech and language impairment
9. Physical violence towards adults
10. Anger management issues

ADHD
1. Challenging behaviour
2. Absconding
3. Verbal aggression
4. ASD
5. Physical violence towards adults
6. Anger management Issues
7. Self injury
8. Reduced school timetable attendance
9. Additional learning needs (ALN)
10. Drug / Alcohol misuse

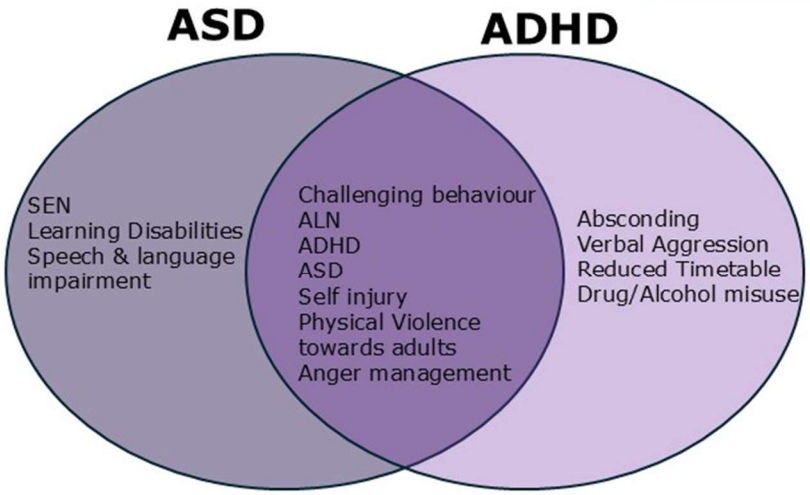


Figure 4 - Venn diagram highlighting the common behaviours, experiences and need for ASD & ADHD - Source - 4Cs CCSR referral data 2020-2024

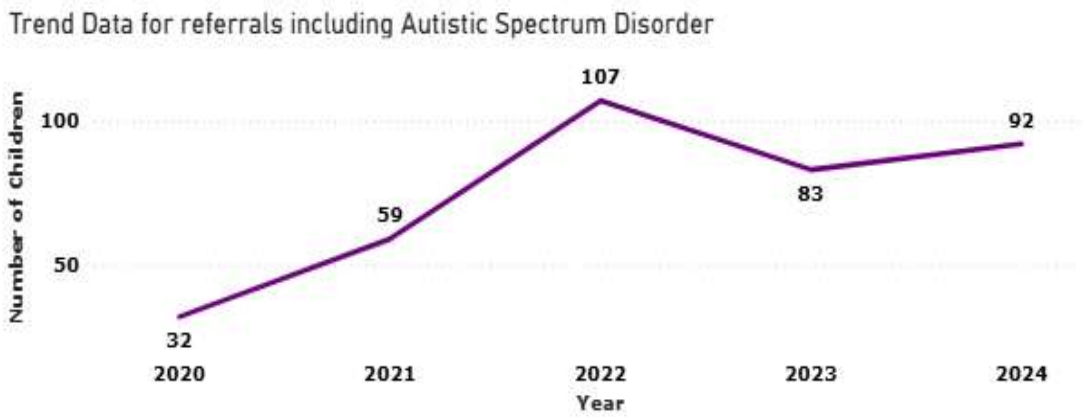


Figure 5 - Line chart - Source - 4Cs CCSR referral data 2020-2024

AUTISM is an **increasing referral trend in the needs profile and anticipated to continue into the next 5 years for foster, residential care and supported accommodation.**

Increased diagnosis of older children and young people with less profound autism may be influencing this trend, this echoes commissioner, social worker and health colleague feedback.

19% of individual children referred over this period were referred more than once, indicating their needs are not being met at the outset or changing needs cannot be supported by current carers. This is a relatively high level of re-referral.

With increased social and clinical understanding of the breadth of the spectrum over the last 10 years, we can see variation in the presenting needs of care and support. While referrals in the 2010s related primarily to needs requiring daily support, co-occurring health diagnosis often requiring medication, repetitive behaviours including rocking or hand flapping, and featuring personal care needs, as we move into the 2020s we are seeing more referrals where ASC requires less health intervention and more social care supports, such as social interaction, responding to social cues and forming appropriate relationships, communication needs and sensory sensitivity.

The children at the higher end of the spectrum often require integrated care, education and health packages. Social care is the main commissioner of bipartite packages with local education services, health offer resource funding in a small and decreasing number of packages. Where NHS and LEA services are not available Children's Services commission holistic packages from providers.

Demand is predictable in this higher area of the spectrum and relatively stable, so regional based capacity to match needs is an area where Local Authorities are keen to collaborate with providers to develop improved service availability and quality.

Sufficiency in this area of service is at high risk from impact by the HSCW Act 2025 and new market entrants or providers keen to diversify services are welcomed to approach us for further discussions. Some existing providers may be open to acquisition discussions with new entrants as key milestone dates for the Act implementation approach.

Alice is a 14-year-old girl who is biologically a boy, she is still exploring her gender identity, and professionals and family are supporting her. Alice has a diagnosis of ASC and ADHD. These diagnosed conditions present in her displaying literal thinking combined with the propensity to carry out threats of harm. Her behaviours have become more challenging with age, and she struggles with understanding her own and others' feelings and emotions. Alice can misinterpret situations which leave her to think that people may be doing her harm. This results in her becoming heightened and lashing out at people within proximity.

Due to the inconsistencies and instability she has experienced within her childhood, she struggles to regulate emotions and has issues with interpersonal relationships, she has also experienced childhood trauma that has an impact on her trusting adults and building positive relationships. She can be physically aggressive when unregulated.

Alice likes routine and likes to know what her plan is for the day ahead. She responds well and thrives with clear consistent boundaries. Alice enjoys taking part in creative activities such as art and messy play. Alice is very intelligent and loves to learn new topics and subjects, she especially likes learning facts to share with others.

The Local Health Board are part of ongoing care planning for Alice, and her care will include input from a CAMHS multi-disciplinary group consisting of a Psychiatrist, Psychologist, Speech and Language Therapist and Occupational Therapist professionals. As part of the care plan, the carers supporting Alice will need to have the specialist skills and knowledge to understand more about what she is experiencing and how best to support her. Specialist training and knowledge in approaches relating to trauma informed care will be provided to meet Alice's needs. The provider will need robust processes for supervision and support for their staff in caring for Alice.

Referral Case Study.

Rhiannon likes to be called Non; she's 13 and needs a long-term foster family. Non has a diagnosis of autistic spectrum disorder (ASD) and Polycystic Ovary Syndrome (PCOS), and she is supported by a weight management programme. She is not prescribed any medication. Her previous placement ended abruptly following a domestic incident involving her sibling and carer, which resulted in police intervention. Non has low self-esteem, anxiety (particularly around her parent's health), and has a history of self-harm (biting her arm when dysregulated). Her PCOS symptoms impact her physical and emotional wellbeing. She requires support with personal hygiene and body image. Non is academically capable but has sporadic school attendance. She attends mainstream school with additional support for her ASD diagnosis. Non is caring and talkative with familiar people, she engages well with trusted adults. She is passionate about art, cooking, gardening, anime, and music; she enjoys sharing her achievements. Non needs a safe, stable environment with minimal conflict, responding positively to structure.

Referral Case study.

SEXUALISED HISTORIES, EXPERIENCES, BEHAVIOURS AND VULNERABILITIES

Here we look at the current profile to be met by commissioned services when Local Authorities refer a child who is presenting with needs related to: experiences of sexual abuse, exploitation, or harmful sexualised behaviours. The NSPCC definition of harmful sexual behaviour is commonly used *'one or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults.'*

Children's sexual development is shaped by their environment, experiences and what they see. With children looked after their histories and experiences of abuse, neglect or trauma can impact their sexual development directly or indirectly. Children in the 2020s are more likely to see sexual images and videos at a younger age than the previous generation. This can be through films, music videos or online (further discussion in Online Harms).

Data from referrals for foster and residential care 2020-2024 is perhaps surprisingly showing a decrease in demand in this needs profile, discussion with specialist providers echo a reducing and perhaps disproportionately low referral rate in Wales compared to England. It is at odds with general population data and safeguarding data. There is no specialist Local Authority provision, therefore we have to question whether needs are under-reported, unidentified or a focus on the main co-presenting needs and behaviours, are masking the true level of need.

Referrals have gradually reduced from 54 in 2020 to 37 in 2024 for sexually harmful or inappropriate behaviours. In contrast, referrals for Secure Welfare care have increased between 2022 and 2024 for both profiles; sexually inappropriate behaviours increasing from 44 to 62, and sexually harmful behaviours from 12 to 43. This may be an indicator of rapid escalation of need and vulnerability once identified, alongside an inability to meet needs in the current home.

Referrals identifying risk of sexual exploitation across foster and residential care saw an increase of 72% between 2020 and 2022 but a corresponding decrease 2022 to 2024 (down to 34 individual children). This spike in 2022 could be linked to increased identification of risk post-Covid but there is no clear evidence for the spike.

Secure Welfare referrals identifying sexual exploitation have reduced from 2022 to 2024 from 41 to 35, however, there has been a simultaneous increase in co-occurring criminal exploitation referrals, from 37 to 57 over the same period, with an overlapping profile. Again, the higher level of identification at point of Secure Welfare referrals may indicate late identification or rapid escalation of needs for these vulnerable children and young people.

> **I never saw myself as a victim. It started with friendship and (feeling) cared for, protection, presents and attention. Looking back, it changed really quickly, it got bad.**
>
> Source: Young Commissioner, 2022.

The profiles of harmful sexual behaviour and risk of sexual exploitation are most gender specific in 2024 across the need's continuum analysis, broadly; males classified with needs that are harmful or inappropriate, females classified as vulnerable to exploitation. The profile of searching for homes is distinct; demand for single gender settings, male or female, with only a minority considering mixed gender care settings.

More placements are made in mixed gender settings for females at risk of exploitation, compared to males displaying harmful or inappropriate sexualised behaviour. There is no evidence that supports the gender imbalance at a high level, but samples of risk management planning identify a higher perceived risk to females placed alongside males and the safety of single gender settings is preferred as mitigation.

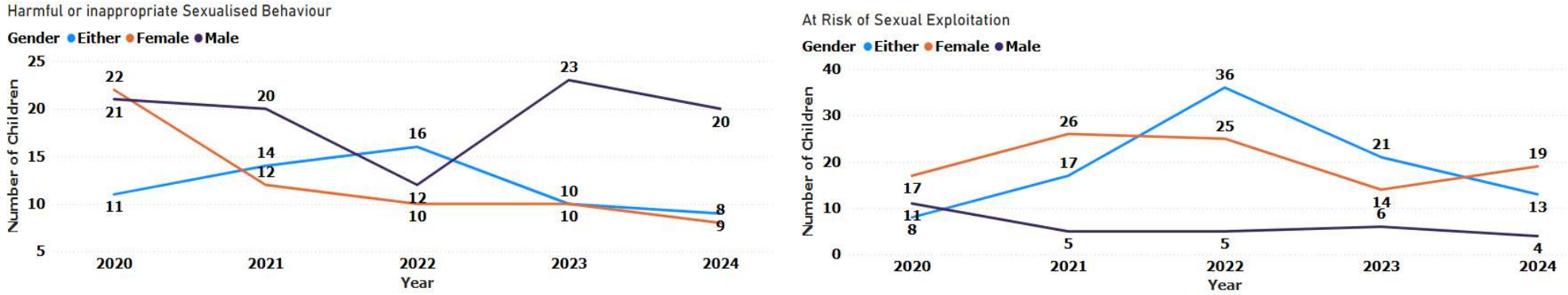


Figure 6 - referrals where gender preference is indicated for Inappropriate sexualised behaviour & Risk of sexual exploitation - Source - 4Cs CCSR referral data

There is sufficient, high quality harmful sexual behaviour settings for males in Wales, offering integrated services with evidence-based models of care, however, these are located in Mideast and Northeast Wales meaning a relatively high proportion of out of county placements. Local Authorities want to place children close to home where safe to do so, but this is balanced with the need for quality care. Inappropriate (rather than harmful) behaviours may be safely managed in a setting with a therapeutic approach (rather than high fidelity model of care) if providers offer robust workforce training.

There is a gap in specialised provision for females at high risk of sexual exploitation and/or displaying harmful behaviour across Wales. Many request out of county locations as a protective factor in exploitation.

The highest correlating needs across both profiles are the same: challenging behaviour, verbal aggression, physical violence, low self-esteem, absconding, ADHD, self-harm, and additional learning needs. Those at risk of sexual exploitation have higher risk of being missing from home but also have more reported substance misuse and reduced school attendance.

Physically the highest correlating needs across both groups are continence issues, mainly urine incontinence, a feature of the profile.

Emma is 15 and has experienced a number of placements during the 5 years she has been looked after, including 3 moves in the last 6 months. Emma has experienced significant adverse childhood experiences of witnessing domestic abuse, neglect, drug abuse and relationship breakdowns within the family. Emma has been let down by adults in her life and understandably finds it difficult to build trusting relationships. This has had a negative impact on her self-esteem and self-worth whereby she has been influenced by others and is vulnerable to child sexual exploitation (CSE) and missing episodes.

There was reduction in Emma absconding for several months in her current placement whilst she worked towards getting her phone back following an agreed period of positive behaviour, however following the return of her phone her behaviour has deteriorated resulting in Emma being missing on average once a week. Emma can be verbally aggressive and has been violent with her carers, including throwing items and damaging property. Emma is at risk of CSE, and concern is exacerbated when she has access to a phone because she will engage with strangers online. A recent example is when she met a young male online and absconded to London to meet up with him.

When missing from home, Emma is engaging in unprotected sex and expressed a desire to get pregnant. She has said that, by getting pregnant, she will be able to escape children's services, get a house, have a baby who will love her unconditionally. When Emma goes missing, she says she drinks alcohol and smokes cannabis.

Referral Case Study.

NICE Guidelines (2016) on harmful sexualised behaviours includes guidance for carers. Barnardo's guidance is helpful for providers and carers to assess sexual behaviours across the spectrum from normal through to violent using Hackett's Continuum of Behaviours 2010. Language matters and terminology in this area is important, carers may find the focused guidance by Barnardo's on this helpful.

Referrals for harmful sexualised behaviours are often for solo placements where risk is assessed as not manageable in a group home, however, specialist providers for males encourage individual risk management discussion rather than a blanket approach. Where there are bail conditions in place such as 'no unsupervised contact with children under 16' multi-occupancy homes can meet this need with planning or if bail conditions specify, they can't live alongside children under 16, this can be amended with police agreement if it's known the young person is moving to a HSB specialist.

Local Authorities have clear expectations of provision demonstrating models of care with an evidence base, embedding direct work with clinical input across the placement journey and realistic timescales for stepping down to foster, or stepping out to supported accommodation. Young people should be prepared for the expected engagement, approach to risk, or restrictions (free time and phones are common ones). School or college attendance may have a tension between social readiness and opportunity, academic ability and stage, with risk management approaches by providers more tolerant to risk than education. This is where integrated education models can overcome barriers and improve outcomes and mid-year academic moves are discouraged to maintain positive progress overall (Specialist provider feedback, 2025).

SUBSTANCE MISUSE

Recent research tells us children looked after are at increased risk of substance misuse, being 4 times more likely to use drugs and alcohol compared to their peers. They **start using drugs younger and are more likely to continue in adulthood**. Female children looked after are 8 times more likely to experience substance misuse than males not looked after.

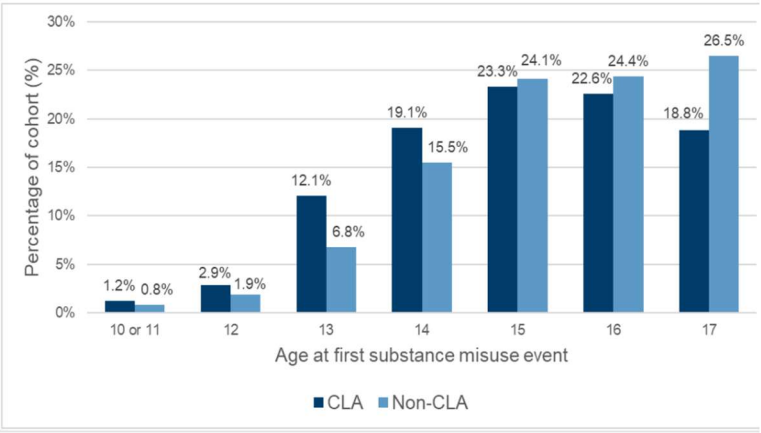


Figure 7 - % of children with substance misuse event by age, at first substance misuse event and CLA status – Source: The interplay between children looked after and substance misuse in Wales - March 2025

Drugs and seeing (others) doing drugs is unsafe, (should be) no drugs around children.

Source: Young Commissioner, 2024.

Some research indicates children in residential care settings are at higher risk of substance misuse, possibly influenced by age range not placement type. Research conducted in Wales showed secondary school students in foster care report higher rates of weekly smoking, binge drinking, and recent cannabis use than their peers. They were also significantly more likely to report mephedrone use, multiple substance misuse behaviours, simultaneously. Much of this research relies on surveys or qualitative methods. (*Government for Social Research: The interplay between children looked after and substance misuse in Wales March 2025)*

Challenging behaviour
Absconding
Criminal Behaviour
Verbal aggression
Social use of soft drugs
Anger management issues
Self Injury
Physical violence towards adults
Smoker
Suicide threats attempts
Sexually active
Child sexual exploitation
Fire setting
Inappropriate sexual behaviour
History of making allegations
Physical violence towards children
Bullying Others
Inappropriate social presentation

Figure 8 - List of common behaviours, experiences & need associated with substance misuse – Source 4Cs CCSR referrals data

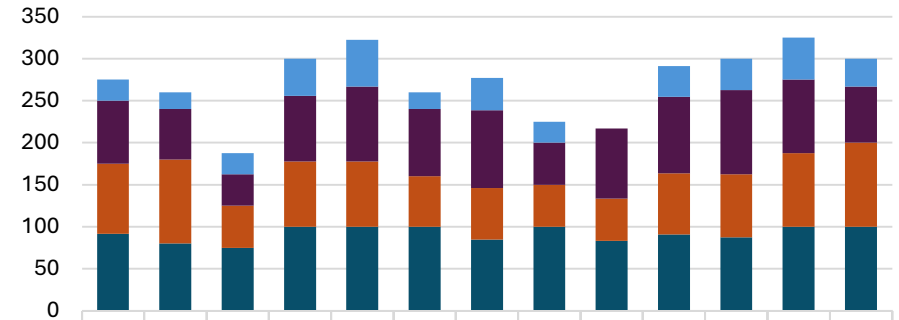
Many of our children and young people have parents who have misused substances, there were 4,960 children in Wales receiving care and support where parental substance misuse was a factor in 2022-23. The **number of children receiving care and support with their own substance misuse was 630**. *(PHW, 2024)*

An average of 85 children and young people are referred with a needs profile including substance misuse annually, spiking to over 100 in 2022. There are **correlations across the needs profile of substance misuse, neurodiversity and mental health.** 15% of individual children and young people referred between 2020 to 2024 were re-referred more than once, indicating for a proportion, their needs are not being met at the outset or changing needs cannot be supported.

Referral analysis evidence substance use both as a symptom and an initiating factor in a range of risk behaviours. The highest linked behaviours in common with substance misuse include challenging behaviour, absconding and criminal behaviour. They are identified at **higher risk of criminal exploitation and criminalisation, with 58% of children described as having criminal behaviour identified as misusing substances**. This correlates to the common feature in county lines drug supply by organised crime gangs (OCGs) where the exploitation of young and vulnerable people is prolific, and dealers frequently target children and young people. (County-lines-a-co-ordinated-welsh-community-response-to-child-criminal-exploitation CASCADE)

The County Lines - Strategic Threat Risk Assessment concludes the overall drugs threat has increased, with greater availability of cocaine and heroin, high production levels for cocaine and the emergence of powerful synthetic opioids such as nitazenes. When considering the County Lines, OCG's drug activity is predominantly crack cocaine and heroin supply, with 87% of external drug lines supplying these drugs.

% of those who misuse substances



	Jan - Mar	Apr - June	July - Sept	Oct - Dec	Jan - Mar	Apr - June	July - Sept	Oct - Dec	Jan - Mar	Apr - June	July - Sept	Oct - Dec	Jan - Mar
	2022				2023				2024				2025
Cocaine	25	20	25	44	56	20	38	25	0	36	38	50	33
Cannabis	75	60	38	78	89	80	92	50	83	91	100	88	67
Alcohol	83	100	50	78	78	60	62	50	50	73	75	88	100
Tobacco/Nicotine	92	80	75	100	100	100	85	100	83	91	88	100	100

Figure 9 - Substance misuse breakdown from 2022-2025 – Source - Secure Welfare Coordination Unit (SWCU)

Referrals from Wales for **Secure Welfare care shows a high correlation to self-harm and suicide attempts**, reflecting, but at increased prevalence, the referrals for foster and residential care, where self-injury and suicide feature in the top 10 co-occurring needs. (SWCU, 2025)

Analysis of the type of substance is detailed in Figure 9.

Local Authorities commissioning care for children at risk of or misusing substances expect providers to stay informed in terms of risks, links to other risk factors, and to their local context by engaging with police and regional safeguarding arrangements.

A frequently updated location assessment is a useful tool for residential and supported accommodation providers. CIW guidance on location assessments is available here as part of guidance on what a good care home should look like.

Regular training is needed for carers to help them identify misuse and to effectively manage health and social related risks. Information about children who use substances for... | Social Care Wales Child exploitation and children living in... | Social Care Wales

We have excellent connections with local police, 3rd sector drug and alcohol support groups, and the designated nurse.

The direct benefit for us is sharing of local intelligence in terms of safeguarding risks and access to comprehensive training for the team. We are confident we're aware of latest criminal activity locally, any new drug routes that impact us, and regularly update safety planning.

We're more confident we can offer a safe match to a young person who is misusing substances and crucially help manage any symptoms and health risks. Understanding it's rarely a direct or quick route to abstinence, the team encourage young people to talk about all experiences including lapses, without judgement, and try to reduce shame, focusing instead on positive strategies to stay on track.

Source: 4Cs Residential Provider Feedback, 2023.

Luke is a 13 year old young person who refused to engage in education, regularly absconded from school and his behaviour at his care home escalated. He was reported missing on numerous occasions, having to be located by police and found under the influence of alcohol. His behaviour included physical aggression towards staff resulting in the use of physical intervention. Luke was hospitalised for significant overdoses on 3 occasions.

Initially Luke was unsettled at the home, declining all emotional support offered from carers, stating he would do anything 'to break down' his placement.

His carers were trained in the Trauma Recovery Model. They made sure Luke has structure, rules and boundaries, making him feel safe and listened to. His carers undertook additional training to support Luke's needs including training enabling them to support with his substance misuse.

The home works in partnership with the local authority in reviewing the risks, putting strategies in place to best manage Luke's high-risk behaviour. This includes regular meetings, involving the professional team in his care including health and education, formulating safety plans to support Luke to remain safe in the community.

His carers remain consistent in their approach, providing emotional care to Luke even when he is not feeling responsive to the support offered. Although Luke engages with carers, he continues to say he does not want to remain. A significant reduction in notifiable events has occurred. Luke is more settled, re-engaging in formal education and able to manage time away from home safely.

Referral Case Study.

AGGRESSION AND VIOLENCE

Here we discuss referrals for commissioned services with a dominant aggression and violence profile, impacting 19% of total referrals over the period 2020 to 2024. Of the 19% the following specific needs present within referrals:

- **VERBAL AGGRESSION** (62%)
- **PHYSICAL VIOLENCE TOWARDS ADULTS** (46%)
- **ANGER MANAGEMENT ISSUES** (43%)
- **PHYSICAL VIOLENCE TOWARDS CHILDREN** (24%)
- **BULLYING OTHERS** (9%)

> **Things (anger) build up, I feel it in my belly and my shoulders and my head, so I get hot and uncomfortable. The therapist gives me ways of checking, stopping the anger spilling out.**
>
> Source: 360 Survey, 4Cs QPA, 2023.

The **5-year trend is a gradual increase in aggression and violence with a spike in 2022**. There is research on the impact of Covid on increased ACEs and violence at the Violence Prevention Unit Wales which correlates to this identified trend. This is **a trend forecast to continue** over the next 5 years.

There has been a gradual increase in referrals asking for male only placements to manage the presenting risk from males, potentially linked to an increase in male violence towards females and to younger children living alongside. The regional trend in 2023 and 2024 shows a majority of the gender specific placement referrals come from the Cardiff and Vale region, the Gwent region and Northeast Wales.

Reduced school timetable attendance
Abusive Violent relationship
Lack of social networks
Loss bereavement
Victim of physical abuse
Victim of sexual abuse
Trauma(inc War Torture)
Exclusion from day school

Figure 10 - List of common behaviours, experiences & need associated with Aggression & Violence – Source 4Cs CCSR referrals data

The most **common experiences evident in referrals with aggression and violence are linked to exclusions from education, isolation or loss, and experiences of abuse and violence, directly or in the household.**

Aggression and violence to other children or adults including carers, is the main reported reason in a sample of referrals for disruption of foster and residential care placements causing a move of home. Between 2022 and March 2025, level of aggression and violence was the 2nd highest reason cited for referrals to Secure Welfare settings being declined; 59 referrals from Wales across the Secure Estate in England and Wales (SWCU).

A small but consistent proportion of referrals for children and young people **link with neurodiversity, especially ASC, ADHD, or ALN**.

There is a small but increasing proportion of references to **GANG AFFILIATED** violence and **CHILD CRIMINAL EXPLOITATION** co-occurring with aggression and violence. These referrals are more likely to contain reference to **carrying or use of weapons; carrying knives is more evident in referrals from urban areas but not exclusively so**. There is a likelihood this needs profile will increase in future based on research and contextual feedback from YJS and police.

Commissioners would like all providers to have clear policies on violence prevention, consistent approaches to managing and de-escalating violence to support carers to maintain placements where it is safe to do so. Increased thresholds of risk management, robust safety planning and organisational supports to maintain carer resilience and wellbeing are required to be able to meet children and young people's needs in this increasing area. **Foster care providers must have robust Safe Care policies balancing their duty of care to the foster carer household with maintaining the carer child relationship and, where stability can't be maintained, a clear policy for positive endings and transition.**

For resources including how to engage men and boys in violence prevention visit Wales Without Violence here. Providers may also find the resources available at Media Academy Cymru on violence, criminality, the youth justice system, and child criminal exploitation helpful for workforce training.

A small but growing number of referrals with aggression and violence also identify **FIRE-SETTING** as a behaviour. This has a seasonal trend, late Spring into Summer, and a sample of referrals indicates this is largely linked to activity alongside peers in the community rather than in the home environment.

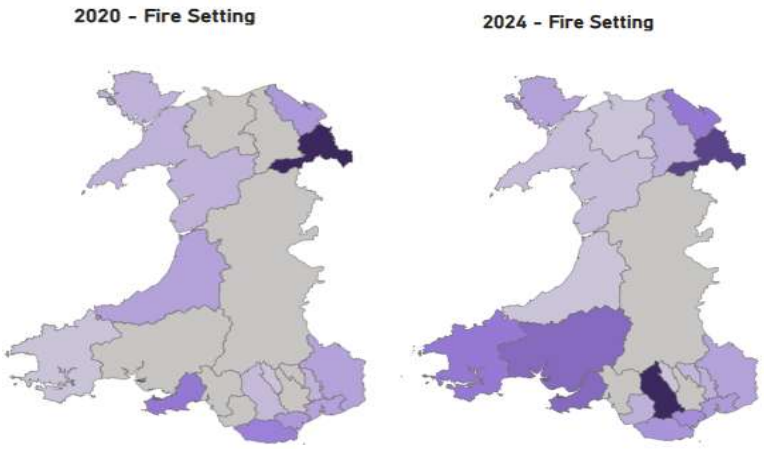


Figure 12 - Maps indicating areas with highest number of referrals for Fire Setting in 2020 & 2024 - Source - 4Cs CCSR referral data

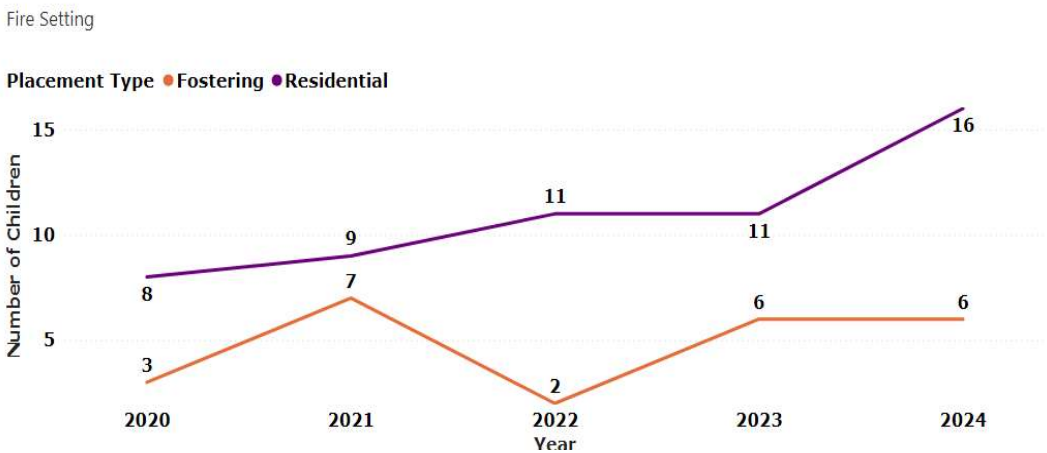


Figure 11 - Fire setting referrals by Foster and Residential Care - Source 4Cs referral data

The top 5 attributes alongside referrals that feature fire setting have remained stable across the 5-year reporting period (figure 13)

Other common profiles are reduced school timetables or exclusion from school.

Verbal aggression
Criminal Behaviour
Physical violence towards adults
Anger management issues
Physical violence towards children

Figure 13 - 5 most common behaviours associated with fire setting

The regional spread of all referrals featuring fire setting has changed between 2020 and 2024, as illustrated in the maps, and is now much more dispersed across Wales. This trend is more prevalent in referrals for Secure Welfare from Wales compared to England (SWCU).

Ryan is a 16-year-old male and is the eldest of his 3 siblings. He has had what appears to be a very a turbulent and difficult early childhood. He was removed from the care of his mother when he was 7, because of issues of neglect and domestic violence; concerns were also around mother's emotional dysregulation within relationships; attachment difficulties and mother's inability to care for her children. He has two younger brothers who were adopted, and he has no contact with.

Plans were made for Ryan to return to live with family members initially, but they withdrew from this plan, resulting in him going into a foster placement, which ended within a short period of time. Over a period of 3 years, Ryan was placed in 5 different foster placements and 2 residential homes, eventually returning to his mother's care.

Ryan was reported to Police for bringing a weapon into school and was again removed from his mother's care and placed in a supported living accommodation. Due to his behaviours within the accommodation, threatening staff and supplying drugs to another young person, he was again moved, this time to a placement in another area.

Ryan is open to CAMHS and is awaiting neuro and psychiatric assessments, which have been requested as urgent. He struggles with anxiety, has low confidence and low self-esteem. In terms of communication, Ryan is very changeable; he can have times where he barely wants to speak but once a relationship is established, he will engage better. He very much tries to direct conversation on an area of interest to him, which can sometimes be around weapons and violence which he sees on social media. Referral Case Study.

Young Commissioners raised concerns about exposure to aggression and violence when talking about where children looked after should live:

"We need safe places, avoid big cities, must have low crime rates". "Cities are too much". "No chavs, no violence, no stabbing, no arson". "(Not) too many people, violent neighbours arguing and anti-social behaviour".

The Young Commissioners believe the location of their homes should be in safe areas, with lower crime rates, and think use of a provider location assessment in residential care is very important. Source: 4Cs Young Commissioners 2023.

I used to get angry a lot. Now I got a little tent in my bedroom with lights in there and soft things I can throw instead of hitting the staff like I used to.
Source: 360 Survey, 4Cs QPA, 2024.

In Wales there is a strategic policy to increase **WELSH LANGUAGE** use across the general population More Than Just Words 2022-27 .

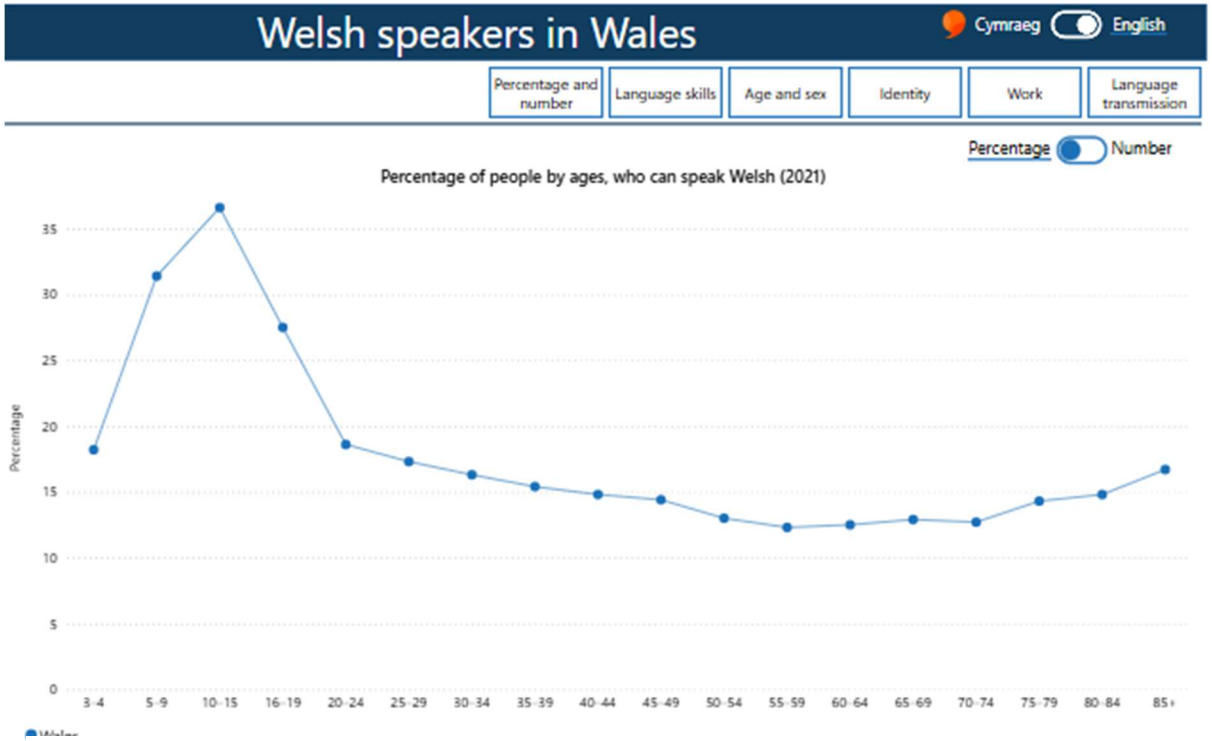


Figure 14 - Source - ONS census Data 2021

Children and young people aged 5 to 15 years are more likely to report they speak Welsh than any other age group, but this doesn't equate to fluency or preferred language.

3% of children looked after are estimated to have Welsh as their first and preferred language (Stats Wales, 2023/24).

There is a shortage of carers able to speak fluent Welsh, or converse in the preferred language of children where that language is Welsh.

Social Care Wales provides workforce language data across registered care workers for all age services, but it is difficult to accurately identify the capacity across children's services to include foster care, residential care, Secure Welfare care and supported accommodation.

More data in this area would help us assess the gap in service provision.

Focus groups of children and young people aged 11-16 stated the importance of health and care services through the medium of Welsh, particularly for fluent Welsh speakers (Welsh Language Commissioner, May 2025).

Recent analysis in the Isle of Anglesey demonstrates the size of gap in predominantly Welsh speaking areas in foster care (2025). Local Authorities would like all providers to support carers to learn Welsh where they are keen to do so to meet a range of children's needs.

23% of children and young people receive education through the medium of Welsh. (School Census, Jan 2024).

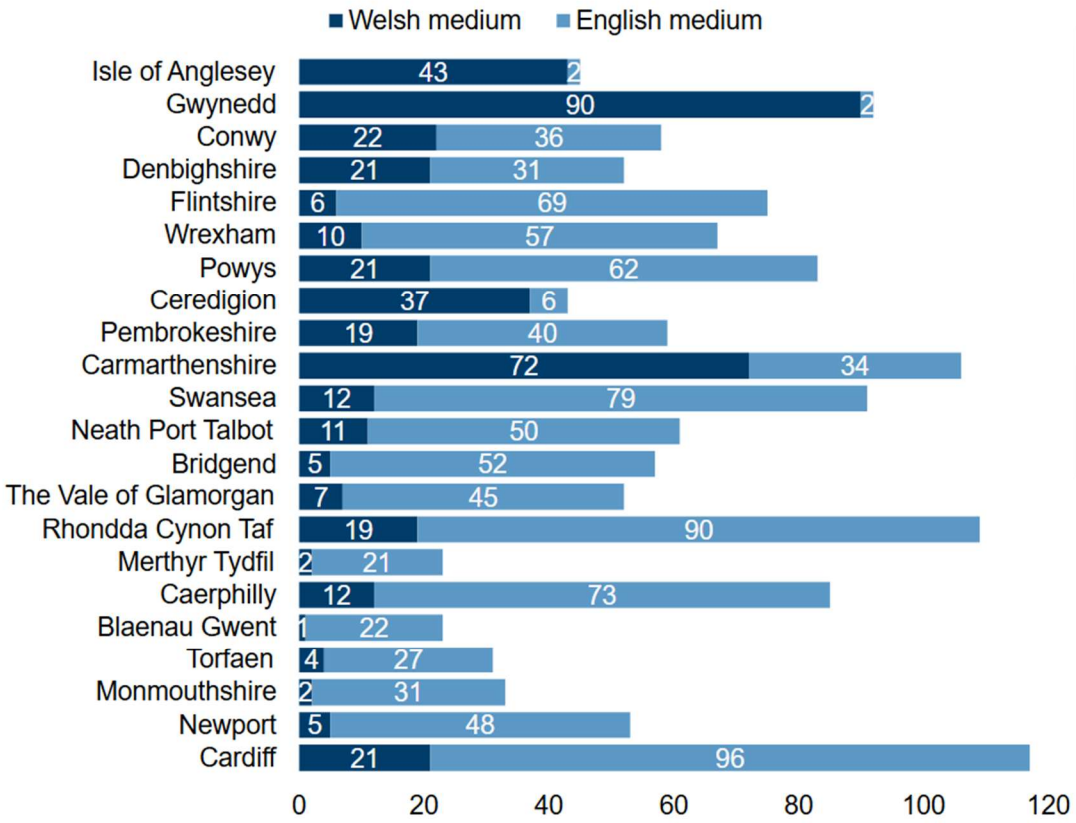


Figure 16 - Number of maintained schools by local authority and medium – Source - School census Jan 2024

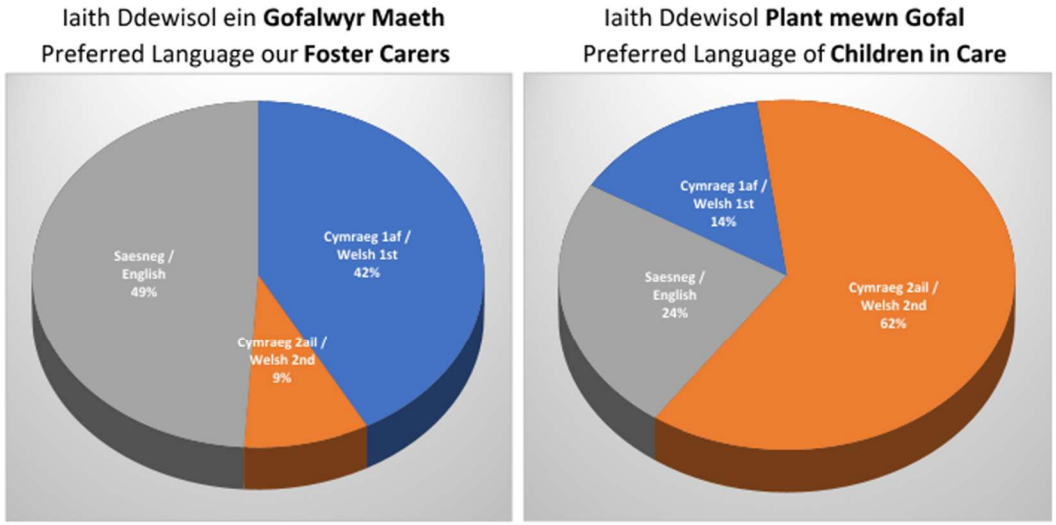


Figure 15 – Preferred language of foster cares and children - Source – Isle of Anglesey CC

Foster carers who may not be fluent, but live close to Welsh medium schools and have supported or are able to support children to attend Welsh medium schools, are also needed across Wales but especially in Anglesey, Gwynedd, Ceredigion and Carmarthenshire.

Residential care and supported accommodation should be able to deliver the Welsh Active Offer and where only a minority of carers are able to confidently communicate in Welsh, **all workforce should aspire to offer basic greetings and common phrases**. This basic level of Welsh language supports cultural ties which are strong for children looked after even if Welsh is not their preferred language or they do not consider themselves a Welsh speaker. Providers can access the Welsh Language Commissioners latest report on use of Welsh by children and young people here for further information along with the Welsh language strategic plan 2025-2030.

A common need for young people in referrals is having the confidence to express INDIVIDUALITY, such as choosing their style of clothing, hair style or colour, often aligned to cultural, music, film interests. They tell us overall carers are good at supporting them to develop their own identity.

My staff are Muslim; they help me with my religion. Some of the staff showed me mosque where I can pray if I want to and I am happy to express myself here.

I practice my religion peacefully and the staff respect my view. Staff always encourage me to join new communities. I cut my hair the way I like and wear what I want, and staff encourage me.

Source: 360 Degree Survey, 4Cs QPA. 2024.

CULTURAL IDENTITY AND LINGUISTIC SKILLS for our non-Welsh children looked after are equally important and all carers are expected to upskill their workforce in response to the specific needs of children they support. Children looked after tell us how important this is not only to their identity but to strengthening relationships with the carers.

RELIGIOUS IDENTITY may be entwined with a child's cultural identity, and again it's an area where we want to see carers develop child specific knowledge and understanding to promote and celebrate diversity. A new market entrant residential provider in 2024 has successfully recruited and trained workforce to meet a local presenting need in terms of culture, religion and language, which has proved positive in terms of overall care but also managing a specific safeguarding risk from criminal exploitation. Supported accommodation providers have had notable successes in tailoring services to meet this profile of need.

SEXUALITY, aligned to developmental stage, is well supported by a majority of carers, children and young people tell us they feel supported and accepted to make their choices in this aspect of identity. Gender identity is discussed in detail on page 33.

Rezan first came into our care under the National Transfer Scheme in 2022. He is a Kurdish-Iraqi national and was 16 years old when joining the UK. Rezan initially arrived in London, and we were informed he was a highly challenging young person, and the placing authority was worried about foster carers being able to manage his behaviours. Rezan was repeatedly threatening to abscond. Rezan became looked after by the Isle of Anglesey and was cared for by experienced foster carers on the island whilst we got to know him more. During this time, it became clear what Rezan needed was safe, stable care which allowed him to deepen a connection with his new home, given his traumatic early life experiences.

Rezan thrived on the Island, attended a local comprehensive school in which he studied Welsh and English and was welcomed into the wider Welsh community. Rezan continued to live on the Island until he was supported to be cared for by his aunt who was also a refugee living in the North of England. By the time Rezan left the Island he could hold some simple conversations in Welsh, which assisted with his integration into the local community, making friends locally.

Rezan continues to visit the Island and still thinks of it as his home, he carries with him a connection to his time here and speaks of it often.

Case Study, 2024.

UNACCOMPANIED ASYLUM-SEEKING CHILDREN

Wales is a Nation of Sanctuary for those seeking asylum.

Spontaneous arrivals in Wales over many years centred on the South Wales cities along the M4 corridor and to a lesser extent at the 2 main ports. In 2021, the National Transfer Scheme (NTS) re-launched by the Home Office, as the legal mechanism to transfer statutory responsibility for unaccompanied children from one Local Authority to another. The NTS became mandatory in 2021 with the 1st cycle of referrals in April 2022.

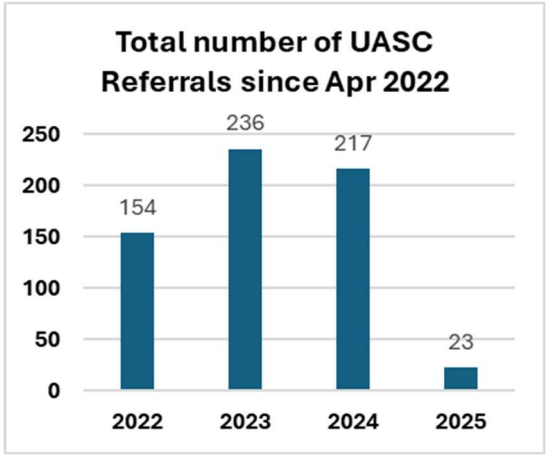


Figure 17 - Total number of UASC referrals since April 2022 – Source NTS data

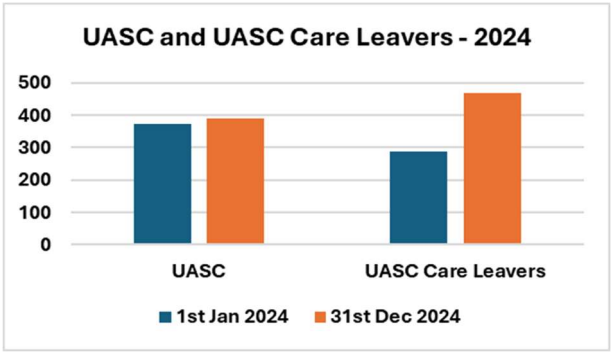


Figure 18 - UASC & UASC care leavers 2024 - Source NTS data

Approximately 630 unaccompanied children's referrals have been received by Welsh Local Authorities since April 2022.

The majority are male with a very low number of referrals for females (3%). The majority are over 16 years old (73%), the under 16s include referrals for UASC as young as 13 years (1%). On average there are 18 referrals per month, but levels vary considerably based on factors such as weather.

At the 1st Jan 2024, 373 unaccompanied children under the age of 18 were in care of Welsh Local Authorities and a further 289 care leavers. By the 31st Dec 2024, there were 389 under 18, not a substantial rise, however, care leavers rose significantly to 470. In 2024 all Local Authorities cared for a minimum of 5 unaccompanied children, the first year where numbers were **geographically dispersed across the whole of Wales.**

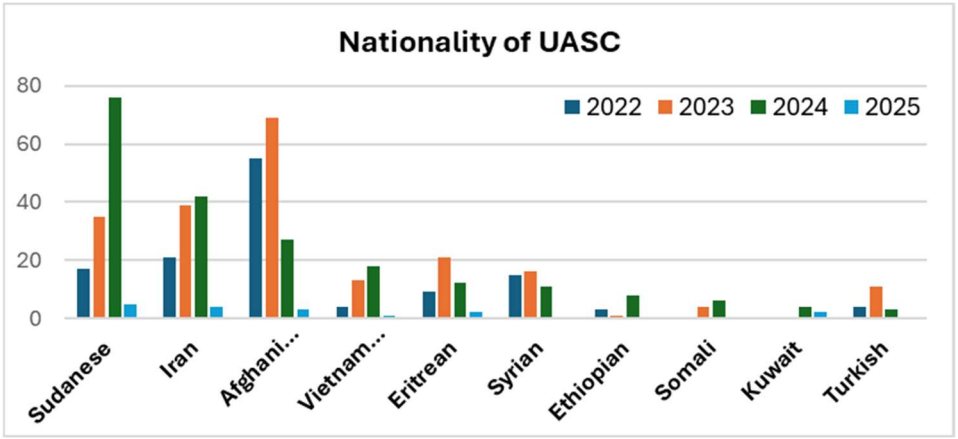
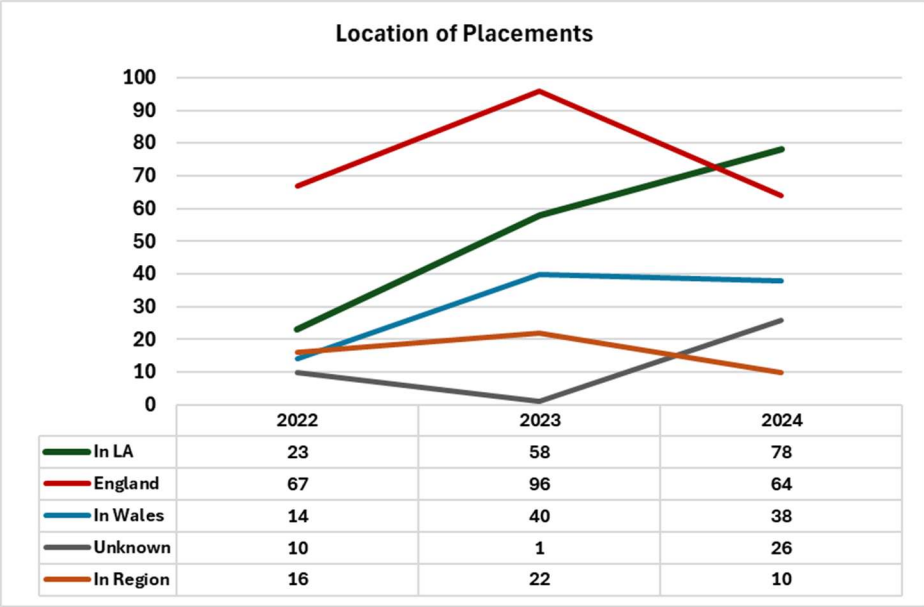


Figure 19 - Nationality of UASC 2022 - 2025 - Source NTS

Of the top 10 nationalities of referrals received in Wales since Apr 2022, young people from Sudan form the largest majority and the number has been increasing annually. Other countries where there are a low number of unaccompanied children travelling from include Egypt, Yemen, Iraq, Albania, Libya, Morocco, Palestine, Tanzania and Tunisia. The nationality of arrivals is often

impacted by war and conflict, unless there are legal entry routes supported by UK Government schemes specific to these geopolitical factors, for example, the Ukraine settlement schemes. Where new legal schemes or international agreements are introduced, there may be a notable reduction, for example, Albania where there were 12 referrals during 2022 reduced to 1 during 2024.



	2022	2023	2024
In LA	23	58	78
England	67	96	64
In Wales	14	40	38
Unknown	10	1	26
In Region	16	22	10

Figure 20 - UASC Location of placements - Source NTS

The referrals received since Apr 2022 indicate that the main languages spoken were Arabic (178 UASC, 28%), Kurdish (120 UASC, 20%), Pashto (117 UASC, 19%), Vietnamese (40 UASC, 6%) and Dari (36 UASC, 6%).

The increased number of NTS referrals makes it difficult to source care and support locally, in the region and in Wales. The graph opposite shows the actual location of homes.

From Apr 2022 to end of Dec 2023 the majority of young people were located out of country, however, the trend is changing positively with more Local Authorities developing 16 plus supported accommodation within their area; a total of 78 placed in area as at end of Dec 2024, compared to 64 out of country. The number placed in Wales has also increased since 2022 due to development of regional provision. The main gap in sufficiency is for foster carers and for care leaver accommodation.

Referrals from the reception centre in Kent has minimal detail on individual needs. Little is known about young people on arrival into the country, they have often travelled over a long period of time, sometimes several years, not knowing where they are going and often experiencing violence and exploitation; sexual, financial and criminal. Presenting health needs can include untreated injuries or wounds, infectious diseases such as scabies, lack of oral health and a lack of vaccination history.

Prior to the mandating of the NTS 66% of referrals for commissioned placements were for foster care. Since Apr 2022, there have been 238 searches for individual unaccompanied children, of these 44% have been for foster carers, with the majority for supported accommodation.

There has been a positive response since 2021 by supported accommodation providers based in Wales to expand services to meet this demand, and many work in effective collaboration with Local Authorities to provide local or regional services. In North Wales more supported accommodation in

region is needed as a notable proportion is on or just over the border in England, however, this has met the needs of young people who have benefitted from the diversity of cities, especially Liverpool. 4Cs accessed funding from the Welsh Strategic Migration Partnership (WSMP) in 2022/23 to offer training opportunities to providers of services of unaccompanied asylum-seeking children with positive engagement. For signposting to training and support, providers can access resources via WSMP. In terms of sufficiency foster care providers are encouraged to respond to Local Authority demand by recruiting for diversity and encouraging existing carers to consider fostering this vulnerable group of young people.

Challenges in caring for unaccompanied children are; fear of not being able to meet their cultural and religious needs, their lack of English and also not understanding Welsh culture. While they are adjusting to life in the UK, they are having to address the impact of trauma they may have experienced within their own country and throughout their journey to the UK. **Identified key areas of support needed include; being able to meet emotional, social, religious, and educational needs, improving communication, building peer relationships, and enhancing self-esteem.**

Trauma(inc War Torture)
Lack of social networks
Loss bereavement
Victim of physical abuse
Reduced school timetable attendance
Victim of sexual abuse

Figure 21 - Most common behaviour, experiences or need associated with UASC - Source 4Cs CCSR referral data

Experiences shared help us learn their stories; they have told us they left home due to war, some being forced to fight as child soldiers, and their family not being able to support them due to poverty. Some have told us that they have experienced persecution for their beliefs, their parents' beliefs, their sexuality or because of their ethnic or social group. Some have seen adults they loved murdered, or tortured, and may have had family members disappear without warning.

Other experiences include age disputes and applying for the right to remain. Support is needed in navigating the age assessment process, alongside the legal processes of establishing a right to remain, and the anxiety linked to administrative process milestones.

I looked young but my voice was deep. They said, "you have so much confidence in you, the way you speak you don't skip words", and I was like, it's because I have been living on my own since I was 12. I've been going to work, come home, feed myself, what do you expect?

We need a real person who is help us. I can't repeat myself again and again. I'm tired mentally, physically, everything. I'm absolutely changed, I can't drink, I can't eat, it closed my appetite.

Source: Lost childhoods: the consequence of flawed age assessment at the UK border (The National Refugee Council, March 2025)

The number of age disputed referrals received in Wales increased from 58% of all referrals during 2022 to 60% during 2024. Of the age disputed referrals received in 2024; 29 claimed to be under age 15, 72 age 16, and 31 age 17 years. Local Authorities with adult asylum seekers living in temporary accommodation in their area, also receive emergency referrals where a young person is identified through safeguarding processes as having been incorrectly deemed an adult on arrival, this includes incidences in Cardiff, Newport and Flintshire.

A study undertaken by Helen Bamber Foundation (2024) found the children seeking asylum whose ages were disputed showed higher levels of psychological distress compared to those who were not. The **young people that took part in the focus group spoke of the direct mental health impact of the age dispute process and the impact of prolonged uncertainty and isolation**.

> Ayah was placed with a foster carer under the UASC transfer scheme, he does not speak English and is suffering trauma from family separation and his journey to the UK. His foster carer is trauma informed, experienced with supporting UASC and has experience of teaching English as a second language.
>
> Ayah is not yet ready to address his trauma directly but has been provided with support from Consultant Psychotherapist who has helped him to develop understanding and strategies to begin to understand his trauma and prepare him for education.
>
> Despite very limited formal education, Ayah wants to learn English, aspires to work in IT and has a desire to learn. The foster carer has managed the process of enrolment to college and arranged additional tuition to accelerate learning. A plan to build other learning opportunities has been developed and implemented to aid his progress and adjustment to Welsh culture including independent travel, budgeting, recreational activities, social opportunities, using a mix of different apps, and infographics as well as the spoken word to communicate.
>
> Referral Case Study.

> Edris, first arrived in the UK in March 2023. He arrived with a National ID card and an identity document from a third country on his phone. Edris confirmed to Human for Rights Network (HFRN) when they first met with him that Immigration Officials had not allowed him to access his phone to present the photo of his ID(s) as his phone had been confiscated upon arrival. Edris was detained in Dover for around 24 hours, then moved to a Short-Term Holding Facility, where he was detained for a further two days.
>
> Edris was sent to a Home Office hotel, where he stayed for three months and shared a room with an unknown adult male, he felt very unsafe and unable to sleep. At one point, Edris left the hotel and took himself to a local police station to seek help with resolving his age, as he felt desperate.
>
> HFRN then referred Edris to a local authority. Shortly after this, he was visited by social workers. The local authority accepted Edris's claimed age, 17 years old, without the need for a full 'Merton compliant' age assessment.
>
> Source: Lost childhoods: the consequence of flawed age assessment at the UK border (The National Refugee Council; March 2025)

GENDER IDENTITY

A small but growing proportion of children and young people looked after, have needs related to gender identity (health colleagues may refer to gender dysphoria). **These children and young people often present alongside other mental health needs and often are in receipt of, or waiting for, health services through clinical pathways**. In known case studies, multiple emotional and health needs include depression, anxiety, OCD, ADHD and PTSD. There is an increasing trend of these multi-faceted needs in referrals. The way gender identity affects young people in adolescence is thought to be different pre-puberty; a majority of the presenting need for in Wales is in adolescence; 13 years or above.

Referrals for individual young people where gender identity is specified in the needs profile increased notably from less than 10 per year up to 2020, to a relatively stable trend average of 21 between 2021 to 2024. There is a high re-referral rate for these young people, indicating their needs are not being met at initial match, they are experiencing disruption of care and needs escalate. **The most common behaviours identified in conjunction with gender identity needs are self-injury (24%) and challenging behaviour (21%).**

From research, and reflected in Welsh case studies, we know young people affected commonly feel:

- their gender identity conflicts with their biological sex,
- comfortable only in the gender role of their preferred gender identity,
- a strong desire to hide or be rid of physical signs of their biological sex, such as breasts or facial hair and a dislike of biological genitals,
- they may feel lonely or isolated from others, face pressure from friends, family or peers to behave in a certain way, or they may face bullying and harassment for being different.

I want to live in a home that accepts me as Tom, that's who I am.

Source: 360 Degree Survey, 4Cs QPA, 2023.

Having or suppressing these feelings, can significantly affect their emotional and psychological wellbeing; they need carers who can recognise their needs and provide timely sensitive support.

The regional pattern of referrals is variable across years, so local specialised care are unlikely to be sustainable if the current level of demand continues as forecast. Instead, we want all providers to upskill workforce in this area, in particular to be able to spot emerging or changing needs linked to gender identity, to respond with sensitivity and support young people to access local services which work for them.

The Cass Review (April 2024) made recommendations on the future of gender identity services for children and young people across England and Wales https://cass.independent-review.uk/home/publications/final-report/. The Review notes rates of depression, anxiety and eating disorders are reported as higher in the gender clinic referred population, than in the general population, with ASC and ADHD also prevalent. Although robust clinical data is recognised as limited by the Cass Review, high rates of ACEs, trauma, and time looked after are noted. The NHS Wales Joint Commissioning

Committee (NWJCC previously NCCU and WHSSC) are the lead for specialist gender incongruence services for children and young people in Wales. Referrals to the waiting list for gender services are made by CAMHS. Since 2014 referrals for gender identity services have increased significantly not just in the UK but internationally, and **greatest demand for support services is from young people registered as female at birth, identifying as male during adolescence**. Research is ongoing to identify the best ways to support and care for children and young people with these needs.

Jack identifies as a gender fluid and is a biological girl aged 14. They have short dark brown hair and describe themselves as 'emo' and tall. Jack's current preference is male pronouns. Jack has struggled with their sexuality and has had relationships with both boys and girls. Jack struggles to have platonic relationships with peers and relationships often quickly progress to boyfriend/girlfriend status. Jack has experienced multiple ACEs.

Jack can be heightened by time spent with their family and struggles with regulating their emotions which may increase their likelihood of risk-taking behaviour including self-harm, running away, using explicit language, damaging the house and refusing to come home. Jack has assaulted staff by punching them to the head when they have been trying to calm them down. Jack has made verbal threats to other young people and staff. Since being looked after, Jack has been observed to have episodes of binge eating and vomiting, which can be self-induced or involuntary, they have ongoing monitoring for this. Jack has made several suicide attempts including overdosing and ligaturing.

Jack is a very vulnerable young person and there has been concerns of potential CSE. Jack has sent/received pictures from other young people online and dated people online, one from Scotland who was nearly 18 years old. Jack previously developed an unhealthy relationship with another young person in his home quickly, which escalated to both the vulnerable children being boyfriend and girlfriend and presenting with challenging behaviour.

Recommendation in term of therapy, is Jack needs active therapeutic intervention and in the longer term the immediate family may need to join some form of family therapy. Jack needs individual work before family therapy could take place, including:
- support for Jack's vomiting disorder; this may be more usefully addressed with the wider context of their anxiety, low self-esteem and vulnerability to exploitation.
- therapeutic life story work using the Richard Rose technique, this is a lengthy undertaking which is likely to extend over 6 – 9 months.
- conclusion that Jack does not require therapy at present aimed at gender fluidity although this may need to be considered at some point.

Jack has been referred to and is being supported by CAMHS. There are regular multi-agency meetings where their needs are reviewed, and key agencies are encouraged to attend these meetings to think about any progress that has been made and any issues.
There is an expectation that a new placement will provide therapeutic support to Jack and the staff will be appropriately trained in the Trauma Recovery Model and trained appropriately in all areas to meet Jacks individual needs. Referral Case Study.

SELF-HARM

The total number of individual children with referrals relating to self-harm over 5 years is 428 with 74 (17%) experiencing placement movements in different years. When we report on the self-harm profile it includes **SELF-INJURY** (350) and **SUICIDE THREATS OR ATTEMPTS** (197). 26% of children have both detailed in referrals.

Referrals including a profile of self-harm have **increased by 34% between 2020 and 2024**. There is no forecast of a reduction in this profile, and it increasingly **presents alongside: aggressive or violent behaviour, challenging behaviour, neurodiversity with communication needs, risk of sexual exploitation and absconding, a history of making allegations and reduced timetables at school**.

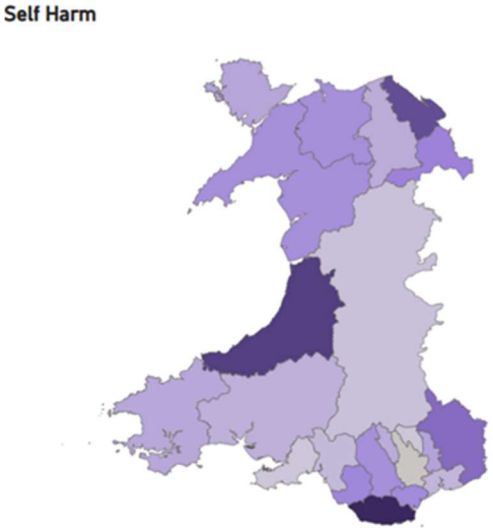


Figure 22 - Self-Harm referrals Map – CCSR referral data 2020-2024

Substance misuse is a key trigger. **Online harm is a trigger factor** increasingly reported by children and young people themselves, and by their carers.

More females are within this needs profile than males, approximately 3 times more likely, for non-suicidal self-injury. Research indicates females report cutting themselves more than males. Young people with this needs profile are likely to have multiple searches for foster carers prior to placement in residential care or referral to Secure Welfare settings or inpatient care.

Vale of Glamorgan, Ceredigion and Flintshire have the highest proportion of referrals (including re-referrals) with this needs profile for commissioned placements.

The profile of need for self-harm closely replicates the profile for young people with mental health needs requiring integrated care packages.

At the higher end of the continuum examples of non-suicidal self-injury include inserting objects such as paperclips, staples or other sharp objects into veins, into the skin or under nails, use of ligatures, hitting themselves, repeated picking at skin, or burning skin. Further consideration of **referrals highlight elements of negative reinforcement attached to the injury, so to stop themselves feeling bad, angry or anxious**.

I veer between being happy and settled and then anxious, unhappy and am unable to express myself, I am not sure I understand how to express how I am feeling. I need support.

I have been given 'emotion cards' in hospital and use these to express my feelings, rather than relying on words. I want to continue to use these when I move to a new home.

Source: 360 Degree Survey, 4Cs QPA, 2024.

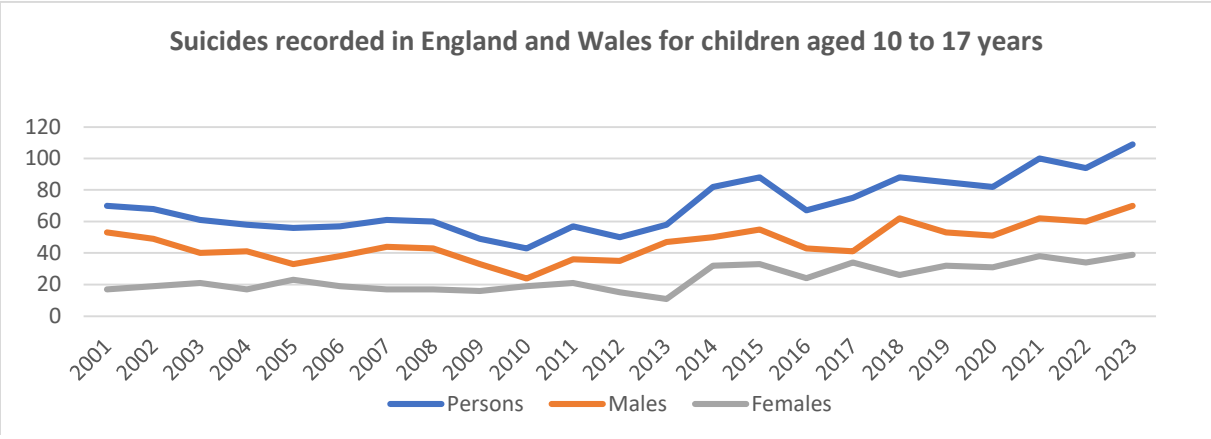
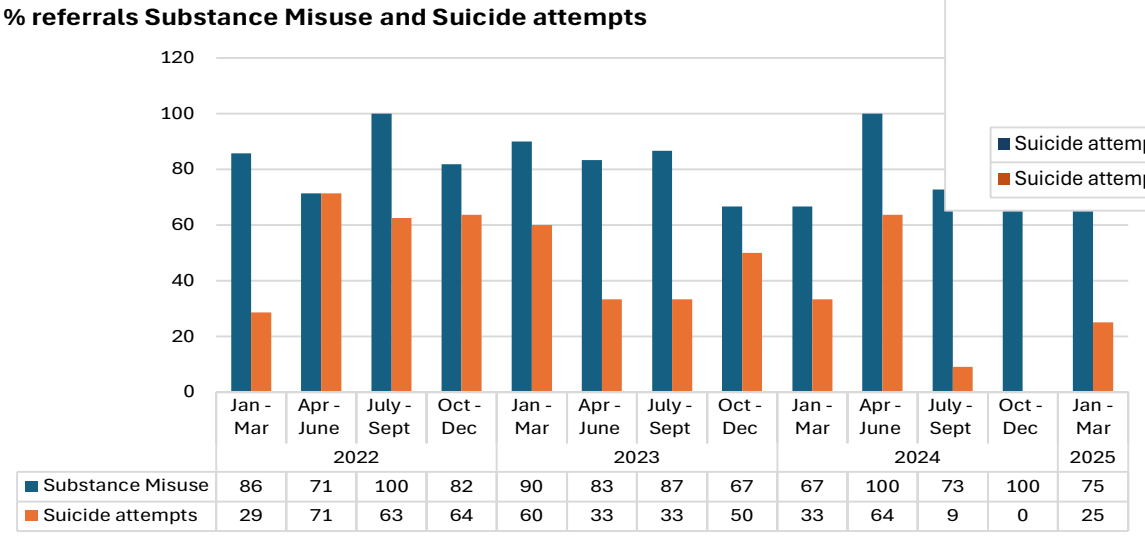


Figure 23 - Suicides recorded in England & Wales for children 2001-2023 – Source - Secure Welfare Coordination Unit (SWCU)

Attempted suicidal self-injury examples between 2020 to 2024 include a growing proportion of young people running into traffic, trying to access trainlines, or trying to exit moving vehicles, these are often in the context of a highly emotional episode or crisis. The more common referral trends pre-Covid linked to use of ligatures or overdose through substance misuse, and this continues to be apparent. The general population statistics of deaths by suicide is recorded as higher in males rather than females (ONS, 2024), but the overall trend is an increasing one.

Referrals from Welsh local authorities for Secure Welfare care from 2022 to March 2025 strongly identify **self-harm behaviour; the most frequently recorded was the tying of ligatures.**



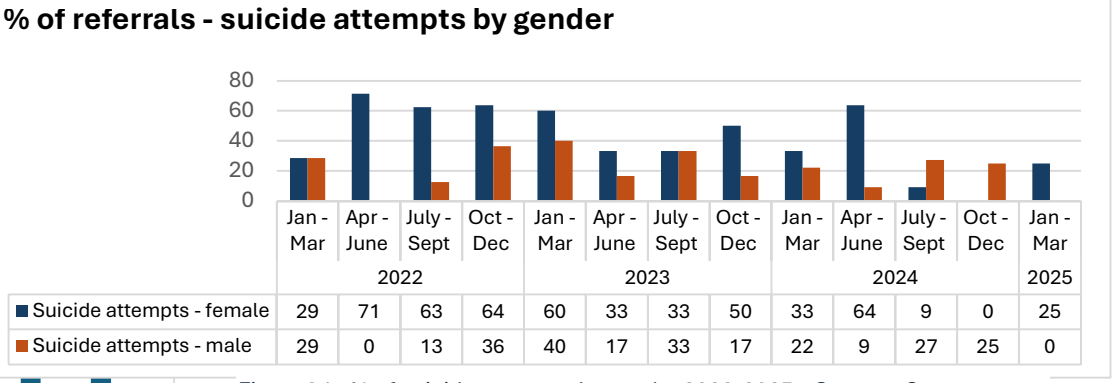


Figure 24 - % of suicide attempts by gender 2022-2025 – Source - Secure Welfare Coordination Unit (SWCU)

Other behaviours included overdoses, running in front of traffic/railway tracks, threatening to jump from buildings/bridges and self-asphyxiation by drowning. **The data indicates a notably higher number of females that attempt suicide than males over the period** (SWCU, 2025).

Figure 25 - % referrals Substance Misuse & Suicide Attempts 2022-2025 – Source - Secure Welfare Coordination Unit (SWCU)

Level of self-harm and inability to manage this need was the highest reason Secure Welfare settings gave for declining referrals from Wales between 2022 and March 2025; 64 referrals, peaking at 45 in 2024 a 34% difference compared to the closest reason of aggression and violence. (SWCU, 2025).

> We couldn't sleep worrying what we'd find in the morning, it was exhausting, we couldn't cope. Support from the Hwb saved us.
>
> Source: Foster Carer, 2022.

Self-harm and the fear of accidental suicide as a result of self-harm is a theme across foster care unplanned endings and, in sample referrals, this features in same day notice or refusal to have a child return home after an urgent admission to A&E as a result of self-harm.

Providers of foster care, residential care and supported accommodation should allocate specific resource to training carers on the nuances of why children may self-harm and have strong Safe Care, safeguarding and risk management policies, to enable carers to stick by children through periods of self-harm with robust safety planning. Links with local support groups and local health services are crucial to resilience.

> Cutting gives me control when everything else feels out of control. It's hard to describe how it makes me feel safer when (carers) see it as so dangerous. CAMHS have helped us talk about it and now we have some rules. I would like to stop, not now.'
> Source: Young Commissioner Event, 2022.

Alex is a 14-year-old girl, who has had multiple mental health assessments, she has not been diagnosed with having a mental health difficulty. Alex has taken several overdoses; she has always told someone when she has done this and has attended hospital as a result. CAMHS suspect that Alex could have ADHD.

Alex presents a significant risk to herself; examples of her behaviour include holding knife/scissors to herself and wrapping leads around her throat. There is concern that although Alex may not intend to harm herself, there is a significant risk of accidental harm. Alex has been known to walk on the motorway and attend the local railway making threats to harm herself. Alex has made threats to harm her family and those who care for her. She has thrown items at her younger siblings and taken them from home without telling parents. She has made threats with lighters and kitchen knives towards adults.

Alex absconds from school and is on a reduced timetable, however she's currently excluded. Her education setting is concerned about their ability to keep her safe due to absconding, threatening to take her life, putting a phone cable around her neck and having a lighter.

Alex will need carers who are trained to support her under a model of care that will adapt to meet her individual needs. She needs to have support in relation to the threats she makes to self-harm and to be protected from accidentally injuring her family or herself. Alex will need to access an education in a safe environment where she is not a risk to herself or to others.

Referral Case Study.

INTEGRATED MENTAL HEALTH AND CLINICAL LED SERVICES, WITH EVIDENCE BASED MODELS OF CARE

The most common additional services requested by Local Authorities for children and young people with a mental health needs profile requiring an integrated approach are: **cognitive behaviour therapy, therapeutic life story work, counselling and onsite education**. Increasingly commissioners look for providers who deliver an evidence-based model of care through a stable trained workforce and a dedicated clinical support to both workforce and the children and young people.

Between 2019 and 2021, provision in this area grew significantly, responding to demand and needs analysis work completed with the market in 2018/19. Reputable providers who grew during this period have embedded the quality of the care they offer, meeting the needs of more children and young people in safe, registered care. However, investment by independent providers in growing these services largely paused in 2021 with the announcement of the eliminate policy by Welsh Government. **Local Authorities are starting to increase public sector provision in this area, due to the lack of sufficiency at this high end of the continuum of need, but there is still a need for more provision able to meet needs**.

Mental health is a broad spectrum but over the period 2021 to 2024, concerns have grown as the impact of Covid-19 on children's mental health has started to unfold. The importance of effective mental health crisis support for children and young people has been outlined in both the Together for Mental Health and the Suicide and Self Harm Prevention Strategy for Wales. **Regional Partnership Boards** have received Welsh Government funding to develop safe accommodation options locally in response to the Children's Commissioner for Wales report calling for improved services for children and young people with mental health issues (No Wrong Door Approach (2020).

Research evidence **increased risk of mental health crisis for young people where there is; substance misuse, in females, aged 16 plus, living in areas of urban deprivation** (PHW, 2022). Young Minds offer worrying statistics on mental health issues (2023/24) making workforce upskilling a focus. Research is mirrored in the qualitative referral trend for children looked after in Wales.

WORKING EFFECTIVELY WITH INPATIENT MENTAL HEALTH SERVICES, DIVERSION & STEP DOWN

A key **gap in sufficiency is for providers able to safely manage young people in crisis, displaying highest risk behaviours, emotionally dysregulated and in distress.** This is a barrier to effective diversion from inpatient care and can create unnecessary delays to discharge.

As part of CAMHS services in Wales the North Wales Adolescent Services (NWAS) based in Abergele and Ty Llidiard based in Bridgend provide inpatient and intensive community services to children and young people aged 12-18 years. Onward out of country referrals have been at concerning levels in the recent past, making it hard for social care and providers to support diversion and step-down effectively, but the NWJCC report a positive change in referrals pattern in 2024/25.

NWAS has had low occupancy with higher referrals for out of country services. This has been due to a combination of the complexities of the presenting needs profiles and the setting environment. There have been several referrals to Psychiatric Intensive Care Units (PICUs) and one long standing patient is looking to transfer to the community. NWAS manage young people with **EATING DISORDERS** well, helped by the co-location of the eating disorder team onsite. NWAS is currently undergoing work to rectify some of the environmental issues, with an extra care area being added. This is hoped to reduce the need to send people out of area and improve local links for carers supporting children or young people receiving services.

Ty Llidiard is referring fewer young people out of country for inpatient care, which is positive. The young people referred out have been to Eating Disorder (ED) units but on transition to adult services there have been queried diagnosis and suitability of placement. Ty Llidiard is undertaking a task and finish group regarding young people with Restrictive Intake Self Harm (RISH)), in a recent case, a young person who was going to be referred out of country to an ED unit has, after several professionals' meetings, been cared for with community support. There are reduced and few referrals for PICU with Ty Llidiard working with the community teams offering weekly 'huddle' meetings, so, they are aware of young people's emerging needs, thereby reducing emergency admissions. **This increased focus on community services works well to support children and young people being cared for locally and Local Authorities want providers to continue to build relationships with community mental teams to minimise unnecessary admissions to hospital.**

From a health perspective, inpatient discharges have been improved with the South Wales teams but discharges with North Wales children and young people have been prolonged due to lack of providers able to offer safe local placements able to meet their needs.

Local Authorities and Health Boards want to work with providers to better co-ordinate the way health and social care support is organised for children and young people in care, shifting away from inpatient care as the option for specialised assessment and treatment for multi-faceted needs, not being met in the community. Improved multi-agency partnership approaches, within community-based systems, are needed to offer relationally informed care for children and young people struggling with complex trauma and emotional and psychological distress who may present in crisis and be referred to Tier 4 or present at A&E with carers.

We welcome discussions with providers who will diversify services in this area, commit to multi-disciplinary partnership working and shared risk ownership. We **welcome new market entrants who may have previous experience working in community mental health services with adults or young people and can invest in services in the locations where there is most need**.

Rachel is currently detained under the Mental Health Act and is on a Psychiatric Intensive Care Unit where she is settled and engaging with therapies, she is prescribed several medications and will need to be supported with this going forward. Rachel is open to the CAMHS and is diagnosed with Autism. She does misinterpret information during conversations and can be literal in her thinking, having said that, she participates in difficult conversations and listens to peoples differing points of view and can be articulate in expressing her opinions.

Rachel is medically ready for discharge and a long-term therapeutic placement is required to support her emotionally, to help her to remain safe, and to help develop her self-care skills as she approaches 16. Rachel struggles with her sleep, mood and mental wellbeing and has verbalised she was suicidal, more recently she has stated she does not have suicidal ideation.

Rachel has presented with some significant challenging behaviours and risks, which include violence towards staff and damage within the home. Rachel has self-harmed on several occasions and will use sharp items to cut herself: predominantly superficial cuts to the arms and could also pick at scabs, she has also run into moving traffic. Rachel could use rope items, shower chords or other chords as a ligature and has swallowed small batteries and drank cleaning fluids or toiletry fluids: this could be anything from washing up liquid, to shampoo or nail varnish remover. There is a risk of accidental suicide.

It is important to recognise that there have been periods where Rachel has received appropriate, consistent support in placements where her behaviour has been settled. She is currently managing community time with 1:1 staff ratio, indicating how her risks of challenging behaviour and self-harm related to distress are significantly reduced when the environment is equipped to meet her care needs.

A significant contributory factor to any setting providing effective support is the ability for staff to listen to, validate, and work through Rachel's distress when she expresses it, rather than simply trying to distract her from any difficult thoughts and feelings. Young people with Autism respond well to routine and structure, this is the case with Rachel. It is vitally important the carers respond to her in a consistent manner. Rachel has said she likes routine, during school holidays she struggles to cope and often displays self-harming behaviours, placing herself and others at risk.

Rachel's carers will have to ensure her day-to-day health and care needs are met. This includes support to complete daily routines such oral hygiene, showering/bathing and changing clothes.

Referral Case Study.

RISK OF ONLINE HARM IMPACTING NEEDS

Increasingly in referrals there is reference to risk of online harm or experience of online harm for children looked after. This can present commonly alongside; lack of routine, tiredness, anxiety, low self-esteem and anger, to less frequent but higher support needs with; self-harm, suicidal thoughts, eating disorders, aggression and violence towards peers and adults.

Care plans range from carer management of screen time to high levels of supervision, or restriction of access to the internet, social media, gaming and smart phones. Risk management requires an informed approach in a highly dynamic and constantly evolving environment.

Children tell us that overly restrictive or risk averse approaches can further compound their feelings of stigma at being looked after, loneliness and anxiety plus damage their peer relationships. They tell us they agree and understand carer's need to help them stay safe but also tell us they think it's an area where few carers are getting the balance right. (Young Commissioners group events).

We need providers to stay as informed as possible in terms of potential online harms and how to manage the risk in a safe but proportionate way for children and young people. Frequent, bite-size training sessions and refreshers are needed for carers to help them manage the dynamic and evolving technology from a risk perspective.

Research into social media use highlights behaviours linked to positive and negative use. Some of the most common positives are; creating communities, self-expression, healthy parasocial relationships (understanding celebrity is not your friend), ability to differentiate social media from reality and use not disrupting daily life. Behaviours associated with negative use are; engaging in online arguments, spreading hateful comments or content, unhealthy parasocial relationships (stalker-like behaviour or idolising celebrities), inability to differentiate from reality and social media use disrupting daily life (Charmaramam et al, 2022; Hoffner and Bond, 2022; Marengo, Poletti and Settani, 2020).

Research by PHW (2025) evidence **self-reported problematic social media use is 18% for girls and 10% for boys**. Secondary school girls in Wales--problematic social media use There was also a reported gap between families in differing economic situations, with girls from low and middle affluence households reported scores for problematic social media use at 21% and 19% respectively, significantly higher than boys in the same groups at 12% and 10%.

70% of young people who completed an Online Harms Consultation (2020) had seen content online that was either violent or explicit during lockdown. Only 40% report online harm to the platforms they were using. Video-sharing platforms, image-sharing platforms, online gaming and social network sites are the most risky online spaces. Young children who are device sharing, can be exposed to harmful content and "pushed content" without the knowledge of adults, but this is not evident in referrals for commissioned services.

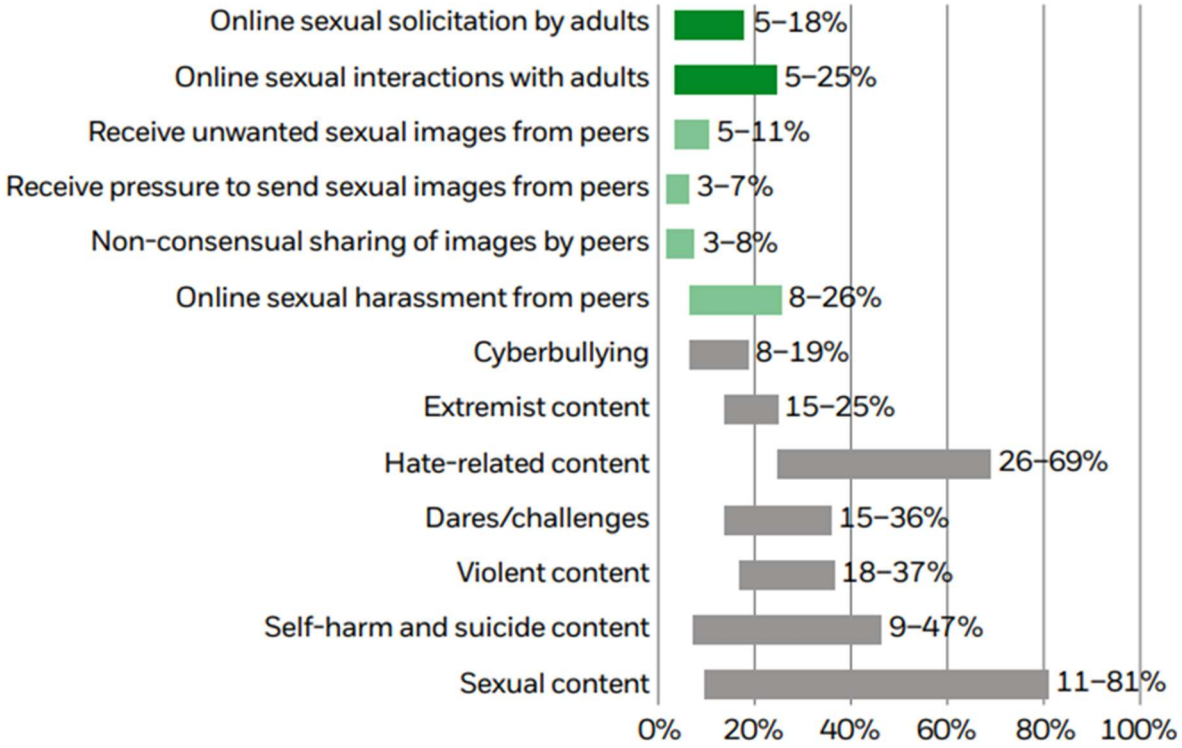


Figure 26 - Prevalence of Online Risk - Source - NSPCC Review Nov 2023

Girls are more at risk of online sexual encounters than males – sexual harassment, intimate image abuse, child sexual abuse material, and victimisation.

Intimate image abuse can have more severe psychological and social impacts for girls.

Older adolescents are more likely than younger children to report experience of online abuse.

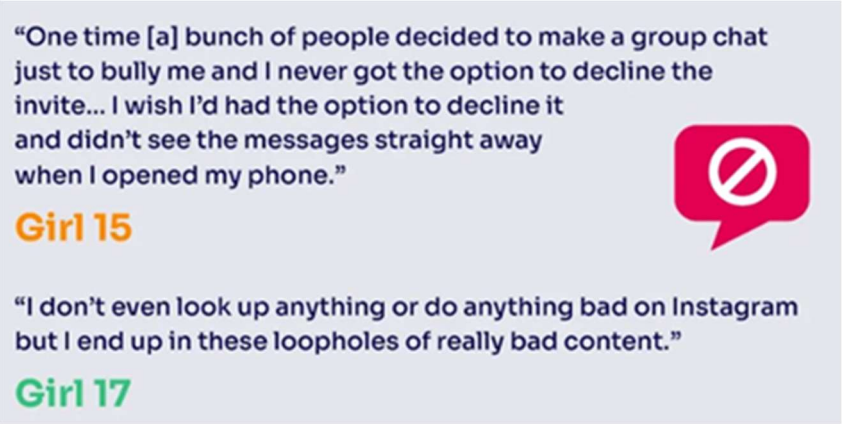
> "I thought it [excessive exercise and disordered eating] was normal behaviour and so it kind of manifested into my own behaviour because I thought all these women are doing it, and I wasn't seeing any healthy behaviours because I was so isolated [because of Covid-19 lockdown]."
>
> Girl, aged 17 (Gill et al, 2022)

[Social media & Mental Health | Guide For Parents | YoungMinds]

The implementation of the Online Safety Act 2023 is intended to mitigate some of the key risks of harm. The Act has also created new offences such as: cyber-flashing – sending unsolicited sexual imagery online and sharing "deepfake" pornography, where AI is used to inset someone's likeness into pornographic content.

There are multiple guides and supports for carers of children and young people known to be at risk or who have experienced harm. **Providers and carers are expected to engage in regular training in this evolving area of risk and need.** Signs of online abuse are similar to other abuse types: cyberbullying, grooming, sexual abuse and child sexual exploitation. Young people aged 15 to 17 are especially at risk of 'sextortion' online.

Further advice is available at Online child abuse - Police advice. CEOP Education. UK Safer Internet Centre and Internet Matters



Children & Young People's Views (Ofcom, 2025: Consulting children on Protection of Children Online Safety Proposals)

Within our home, part of our young people's outcomes is to work towards having a mobile phone they can safely use. When they have a mobile phone, there will be some restrictions and care staff will continue to monitor their use. We are proactive with learning about technology, to ensure they can safeguard the young people and their use of online platforms.

Care staff monitor the use of internet access and online gaming. We hold regular technology meetings across the organisation for information sharing purposes, to understand and keep up to date with advances in technology.

The young people's bedrooms are personalised and have a range of toys/games in their room. Each young person has a gaming console that is not connected to the internet, with staff monitoring their use. There is a separate games room, where there are online games consoles and board games stored, and young people can access the room with supervision of a staff member.

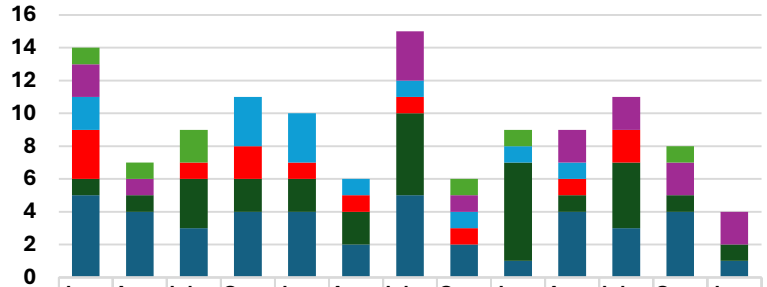
Source: 4Cs QPA, Residential Care Provider, 2024.

When I came back (after a missing episode) the police took my phone for evidence and the worst thing was thinking of them reading everything, private stuff, messages to friends, not just the bullying. I felt I was judged, everyone would know my personal things. I couldn't speak to friends without it. I was being punished again, it made it all worse. Source: Young Commissioner event, 2021.

SECURE WELFARE REFERRALS, DIVERSION AND STEP-DOWN NEEDS

All Secure Welfare care referrals for Wales and England are processed by the Secure Welfare Coordination Unit (SWCU) in Hampshire. Referrals fluctuate across the period, at a peak post-Covid in 2022, but **there is a declining trend in total referrals**. North Wales region have the most Secure Welfare care referrals each quarter, apart from 2 occasions during 2024 where Gwent had the majority and Jan - Mar 2025 where Cardiff and Vale had the majority. On average North Wales authorities made 3 referrals each quarter during this reporting period. **On average there are 4 re-referrals per quarter as demand exceeds supply across both Wales and England.**

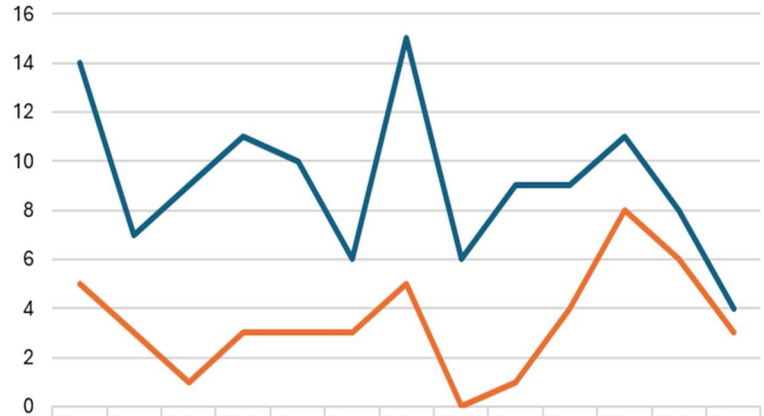
Regional referrals



	Jan - Mar 2022	Apr - June 2022	July - Sept 2022	Oct - Dec 2022	Jan - Mar 2023	Apr - June 2023	July - Sept 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - June 2024	July - Sept 2024	Oct - Dec 2024	Jan - Mar 2025
West Glam	1	1	2	0	0	0	0	1	1	0	0	1	0
Cardiff and Vale	2	1	0	0	0	0	3	1	0	2	2	2	2
Cwm Taf Morgannwg	2	0	0	3	3	1	1	1	1	1	0	0	0
West Wales and Powys	3	0	1	2	1	1	1	1	0	1	2	0	0
Gwent	1	1	3	2	2	2	5	0	6	1	4	1	1
North Wales	5	4	3	4	4	2	5	2	1	4	3	4	1

Figure 27 - Data Analyis of referrals from Welsh regions 2022 – 2025 - Source - Secure Welfare Coordination Unit (SWCU)

Number of referrals and placements



	Jan - Mar 2022	Apr - June 2022	July - Sept 2022	Oct - Dec 2022	Jan - Mar 2023	Apr - June 2023	July - Sept 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - June 2024	July - Sept 2024	Oct - Dec 2024	Jan - Mar 2025
Number of referrals	14	7	9	11	10	6	15	6	9	9	11	8	4
Number of placements made	5	3	1	3	3	3	5	0	1	4	8	6	3

Figure 28 - Data Analyis of Welsh referrals and placements 2022 – 2025 - Source - Secure Welfare Coordination Unit (SWCU)

Over the corresponding 2022 to 2024 period North Wales has seen the de-registration of a number of specialist solo or dual bed residential care homes, where planned closure followed their acquisition by a larger cross border provider. This may be impacting the levels of referrals in this region.

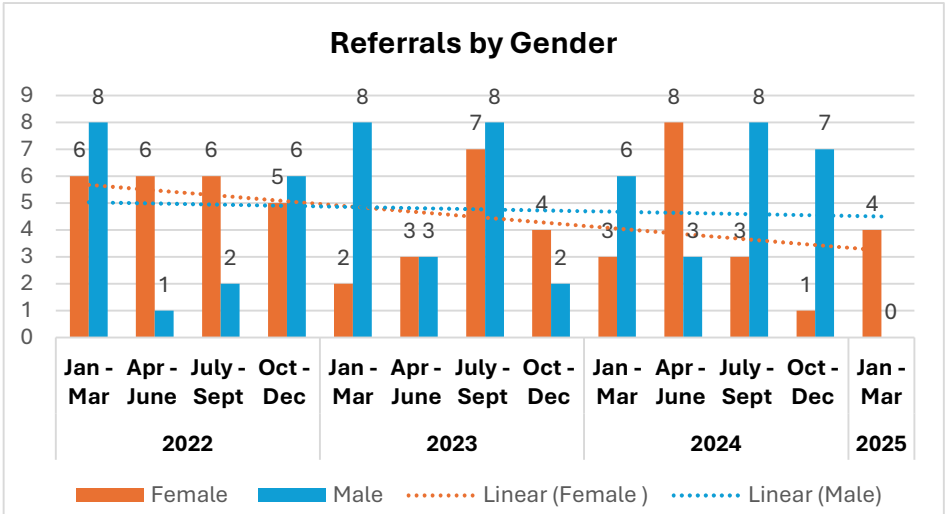
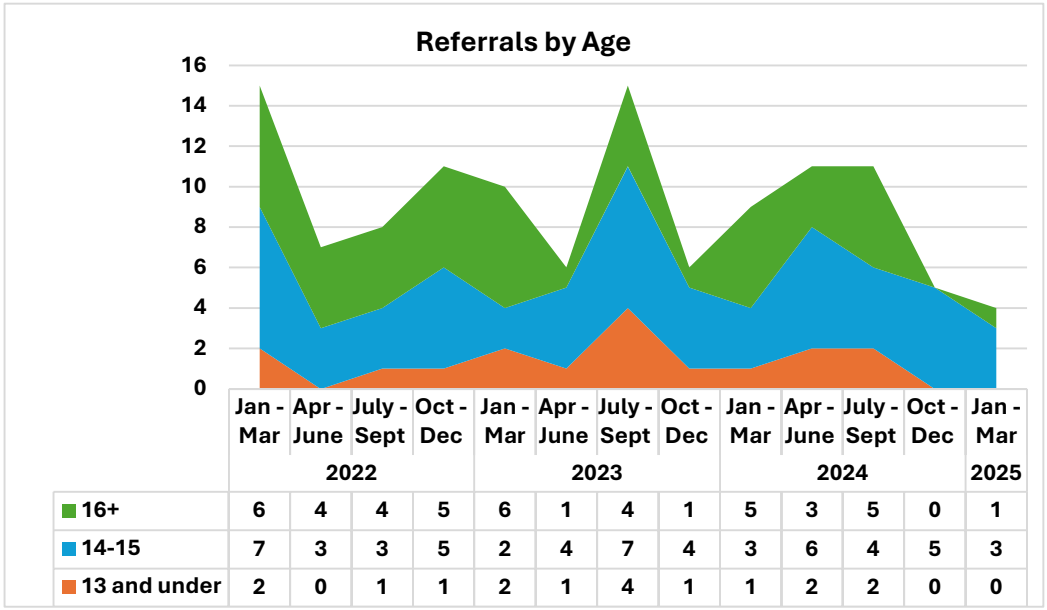
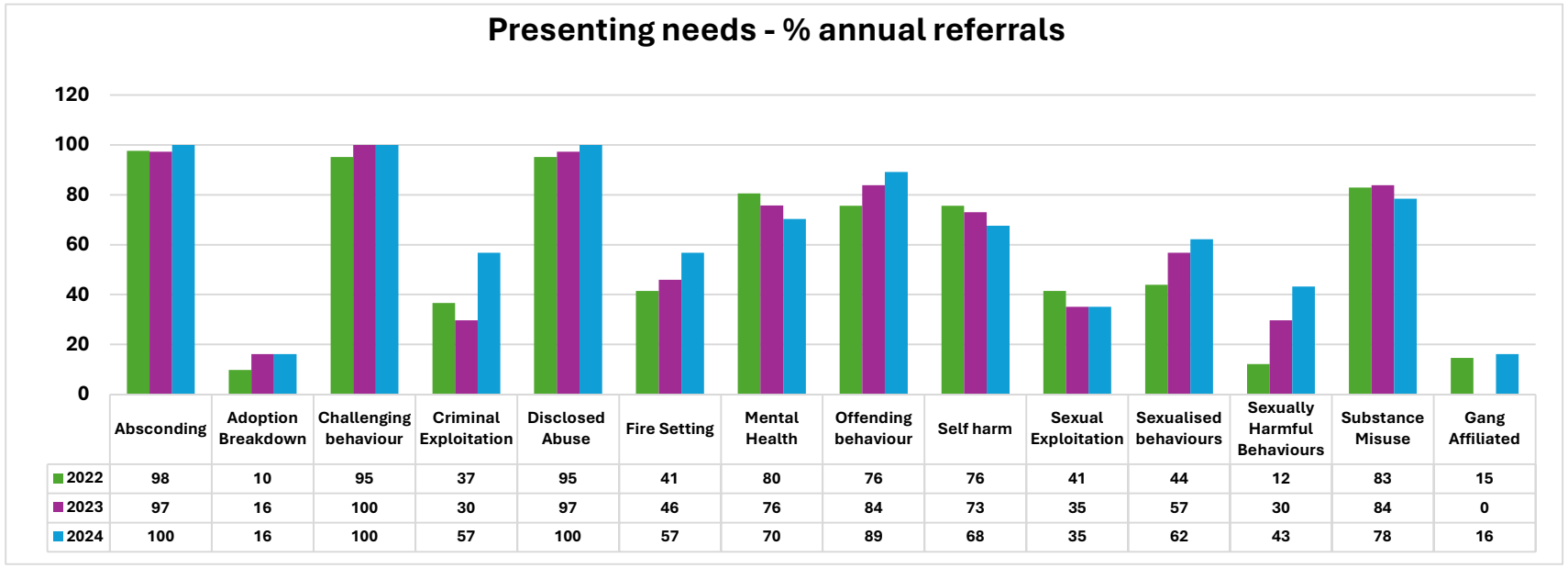


Figure 29 - Referrals by gender - 2022 -2025 - Source - Secure Welfare Coordination Unit (SWCU)



	Jan - Mar 2022	Apr - June 2022	July - Sept 2022	Oct - Dec 2022	Jan - Mar 2023	Apr - June 2023	July - Sept 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - June 2024	July - Sept 2024	Oct - Dec 2024	Jan - Mar 2025
16+	6	4	4	5	6	1	4	1	5	3	5	0	1
14-15	7	3	3	5	2	4	7	4	3	6	4	5	3
13 and under	2	0	1	1	2	1	4	1	1	2	2	0	0

Figure 30 - Referrals by age 2022 -2025 - Source - Secure Welfare Coordination Unit (SWCU)

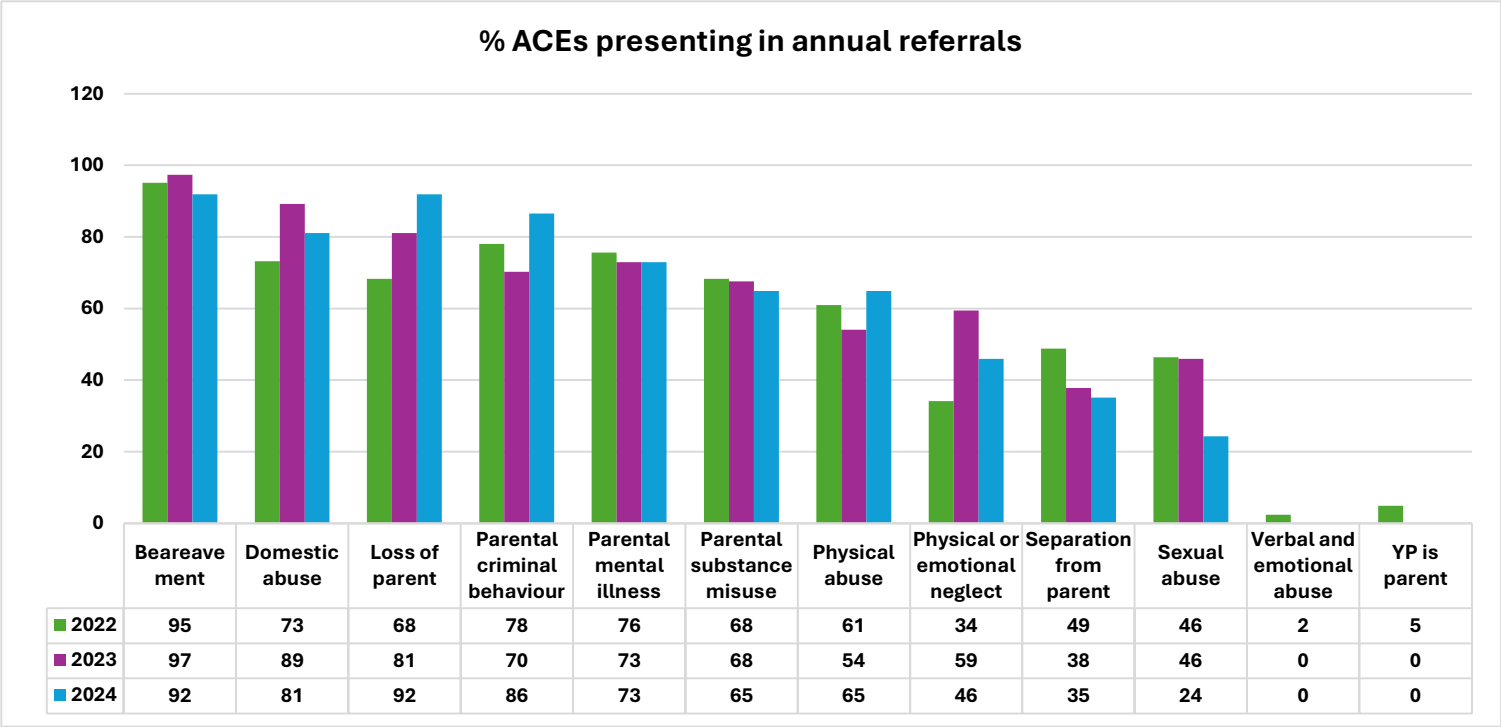


	Absconding	Adoption Breakdown	Challenging behaviour	Criminal Exploitation	Disclosed Abuse	Fire Setting	Mental Health	Offending behaviour	Self harm	Sexual Exploitation	Sexualised behaviours	Sexually Harmful Behaviours	Substance Misuse	Gang Affiliated
2022	98	10	95	37	95	41	80	76	76	41	44	12	83	15
2023	97	16	100	30	97	46	76	84	73	35	57	30	84	0
2024	100	16	100	57	100	57	70	89	68	35	62	43	78	16

Figure 31 - Presenting Needs - 2022 -2024 - Source - Secure Welfare Coordination Unit (SWCU)

The majority of referrals received identify mental health service involvement; **75% open to CAMHS**.

Number of placements moves experienced is collated; **the highest being 27 moves and the lowest being 8** (in care 5+ years).



	Beareavement	Domestic abuse	Loss of parent	Parental criminal behaviour	Parental mental illness	Parental substance misuse	Physical abuse	Physical or emotional neglect	Separation from parent	Sexual abuse	Verbal and emotional abuse	YP is parent
2022	95	73	68	78	76	68	61	34	49	46	2	5
2023	97	89	81	70	73	68	54	59	38	46	0	0
2024	92	81	92	86	73	65	65	46	35	24	0	0

Figure 32 - ACE - 2022 -2024 - Source - Secure Welfare Coordination Unit (SWCU)

Children and young people who are referred for Secure care present with high levels on ACEs and trauma as is seen in this analysis by SWCU.

The most notable ACE, which has minimal presence in referrals and is similarly lacking evidence in care and support packages, is **BEREAVEMENT AND LOSS OF A PARENT**. This is potentially **an under-representation of the needs profile**.

Providers and carers should assist children to access formal bereavement support where necessary and understand its impact.

The lack of Secure sufficiency has driven a **change in placement finding practice by Local Authorities, through necessity, not choice**. While Secure referrals are declining overall, the multi-faceted needs profile at this highest end is not reducing. Needs largely mirror residential referrals but with children in distress and crisis adding to the acuity. **Secure care is insufficient both in terms of capacity and capability to meet demand fully.**

In practice, referring for residential placements who will accept **deprivation of liberty arrangements has grown over the 5-year period**. Use of deprivation of liberty arrangements in non-secure care has seen a growth in excess of the declining referrals to Secure. There has also been growth in temporary placements operating without registration (OWR) which Local Authorities seek to minimise but, if necessary as a last resort, are taken through a registration process with CIW with a child in situ.

Monitoring and analysis of DoL information sourced from the Nuffield Family Justice Observatory, reports in 2024, 1,280 children were subject to applications in England and Wales, an estimated ten-fold increase in 7 years. In 2024, there were 261 applications for Secure Orders to place children in a Secure children's home, but over five times the number (1280) DoL applications to Court. This reflects **a growing trend and Wales is in the top 5 regions** over the reporting period. ADSS Cymru continues to engage in discussion with Welsh Government regarding the capacity, location, size and model of care of Secure care available to Welsh children in Wales. The context of the HSCW Act adds a further layer of complexity to this pre-2030.

CRIMINALITY; VULNERABILITY, EXPLOITATION, AND CRIMINALISATION

Referral analysis shows that after a recent gradual decline, the number of children and young people with needs profile related to criminality is increasing for commissioned care. The **3 categories of need that correlate most strongly are challenging behaviour, including absconding (84%) aggressive and violent behaviour (71%) and substance misuse (65%).**

Figure 33 - Trend data for referrals including criminal behaviour – Source – CCSR referral data 2020 - 24

Less frequent but notable correlating profiles are, risk of sexual exploitation, neurodiversity and communication needs, self-harm and mental health.

Analysis of snapshot data of the total number of children and young people looked after open to Youth Justice Teams in Wales by Police Force footprint between 2020 and 2024 offers insights to needs. This data includes those looked after in a family arrangement, foster care, residential care, or Secure accommodation. Children looked after in these arrangements represent 15% of the total caseload, notably disproportionate to the 1.1% of children looked after as a proportion of children under 18 in Wales.

Across all regions, **males are more likely to be criminalised** for committing offences. Most children and young people looked after involved in criminality are **aged 13 – 17 years old**. The average age of first offence across Wales is 13.9 years and the average age of children involved with the Youth Justice Team is 14.9 years old. In North Wales this is older at 15.4 years. **Young people aged 17 account for 29% of all cases**. When we analyse the age of children criminalised living in residential and foster care the pattern is different. Data indicates offending begins at an earlier age in both and peaks at an earlier age.

Analysis of snapshot data indicates regional differences and more offences committed by younger teenagers in residential and foster care in the urban regions of South Wales and Gwent. South Wales and Gwent data also indicates for those living in foster and residential, a higher proportion of children are becoming criminalised whilst in care. The trend in North Wales and Dyfed Powys suggests the opposite, with more children in care having offending behaviour before becoming looked after. The geographical characteristics of South Wales and Gwent regions having Wales's 3 largest cities; Cardiff, Swansea and Newport; gives the context of greater likelihood of exposure to crime in densely populated urban areas, especially those areas of high deprivation. This data indicates that children looked after who are vulnerable to targeting by criminals may be at increased risk of criminalisation in these areas and some providers of care are not able to mitigate these risks or build sufficient protective factors.

Of the children looked after open to Youth Justice Teams 60% are living in residential care and foster care, a further 25% living with family.

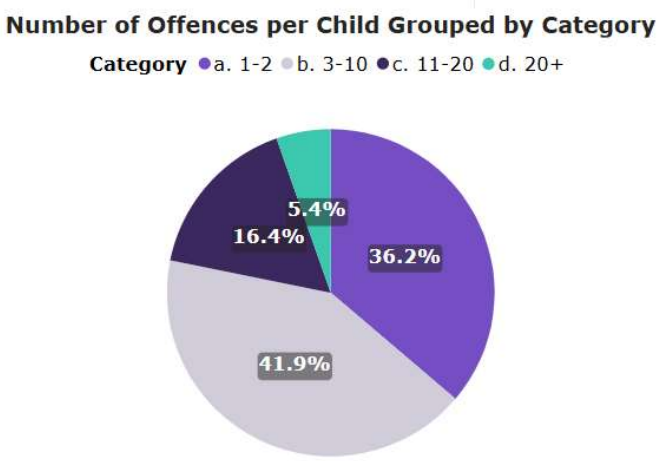


Figure 34 – Numbers of offences by CLA - Source - Welsh Youth Justice Team data

When we consider number of offences and repeat offending, the national average is 6 offences per child, North Wales is the highest at an average of 8 offences. South Wales has the most children and young people committing offences, but lowest average number at 5.

The main types of offences can be grouped as violence, criminal damage/public order, theft, drugs (including alcohol) and sexual assault. **Violence is over 40% of the total type of offences and the highest across all regions of Wales.**

Those with violent offending have commonly experienced emotional and physical abuse, neglect, school exclusions and multiple placement breakdowns, with strong correlations to drug or alcohol abuse and missing periods. Child criminal exploitation, where the child becomes involved with youth justice is most prevalent across the South Wales police force area, 45-50% higher than the nearest force area of Gwent. Child sexual exploitation is most frequently recorded in Gwent.

Jay is a 9-year-old boy, previously living with his mother and younger siblings. Jay's presenting needs are emotional dysregulation and frequent outbursts of aggression; disrupted education having not attended school consistently for several months and awaiting a 1:1 tutor. He has lack of routine: minimal structure at home, particularly sleep, meals, and hygiene. Jay has attachment difficulties; he struggles to form and maintain healthy peer relationships and exhibits obsessive behaviours when he does connect with others.

Jay's behaviours have become increasingly high-risk. Fire-setting: multiple incidents of lighting fires in the community and inside a property. Physical aggression: towards family, including his mother and gran. Anti-social behaviour: theft, vandalism, and threatening behaviour in public spaces. Absconding: regularly leaves home unsupervised for extended periods, often returning only after police intervention. His mother says she is unable to manage his safety. Jay's father, recently released from prison, has chosen not to engage in contact, citing his own instability.

Jay's risk profile: Jay engages in dangerous activities such as climbing scaffolding, riding his bike in unsafe areas, and associating with older youths. He has made threats, including to kill his mother in the future, and has physically harmed family members. In the community: Jay's behaviour has caused distress to residents and businesses, including theft and property damage. Jay is vulnerable to exploitation due to his unsupervised presence in the community and lack of fear of authority. Jay needs therapeutic support to address trauma, emotional regulation and social skills.

Despite the challenges, Jay has shown affection towards his family in calmer moments. He can be polite and engage with select professionals. He has an interest in bikes and outdoor activities, including positive experiences at a youth-led bike project. Referral Case Study.

Providers should be familiar with the All Wales Protocol on reducing criminalisation and use the Missing People Toolkit as part of their core training with workforce Reducing the Criminalisation of care experienced children and young adults in Wales: A Practical Toolkit for Professionals - Missing People. Local Authorities expect providers to support the use a preventative approach to restrictive practice techniques meeting principles of the Welsh Government Reducing Restrictive Practices Framework.

Frank is a male aged 16, who entered care age 10, due to parental domestic abuse, their substance misuse, criminal behaviour, and neglect. Frank lived in a foster home for 5 years, which ended due to his challenging behaviour both at home and in the community, which included frequent involvement with the police for anti-social behaviour.

Searches for alternative homes were unsuccessful. Frank and a sibling were placed with a family member, as the only available option. The placement with family ended within 6 months and Frank went missing for several days.

Since then, he has lived in an unregistered placement, he goes missing on average twice a week and is the subject of criminal exploitation. He is misusing illegal substances, and his overall behaviour is volatile and hostile towards adults.

Frank was referred to YJS when he was 10 years old for diversion work, he has shown some commitment to change his behaviour. His school previously said he has great potential but has struggled to maintain his education by being excluded several times for anti-social behaviour.

Frank has previous criminal offences including violence, theft, and criminal damage to property.

Referral Case study.

POTENTIAL IMPACT OF COVID-19 ON NEEDS

Throughout the analysis there is a thread relating to spikes in presenting behaviours, reported children's experiences and their needs post-Covid. **A high proportion (65%) of identified attributes within the profiles, show a sharp increase in 2021, peaking in 2022, reducing or stabilising in 2023 to 2024 but at a higher rate than pre Covid.**

While we can't be certain these are a direct result of Covid-19 and children's experiences of life during lockdown. These patterns do appear to correlate to wider research into the impact of Covid on children in the general population and on children looked after.

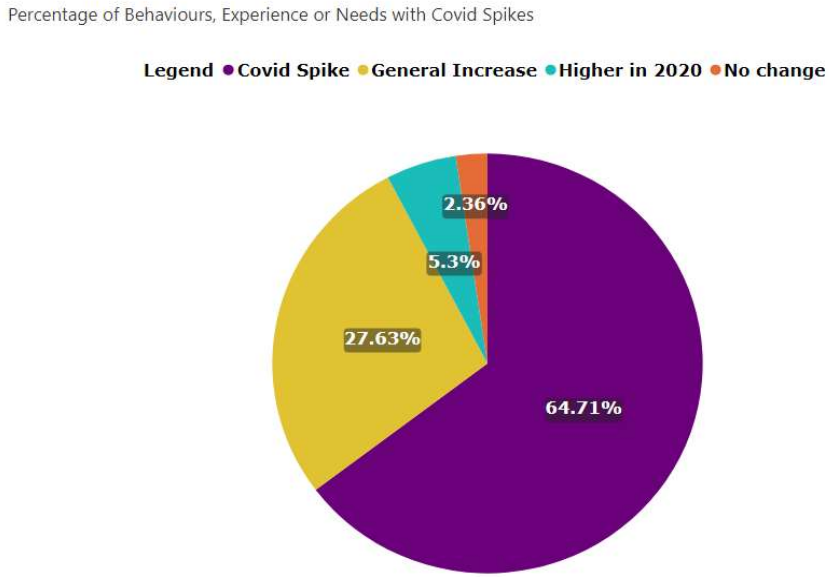


Figure 35 – % of Behaviours, Experiences & Needs included in referrals which were affected by Covid spike in numbers – Source – 4Cs CCSR referral data – 2020-2024

PARENT AND CHILD

Baby and child, care and support needs, across each placement type are primarily related to safeguarding. A small number have presenting health needs related to poor maternal health during pregnancy or ante-natal care.

Parental needs and behaviours are highest for abusive and violent relationships, and drug and alcohol abuse. These are also the needs least likely to receive placement offers or matches; the main gap in sufficiency. The next most common needs profile are young girls, often care experienced themselves, who need parenting support, or parental social use of soft drugs, self-harm, ADHD and additional learning needs.

> I was worried I'd be watched all the time, with someone just taking notes not helping. When I met (carers) I felt relaxed straight away, they didn't judge me and helped me learn how to be a good mum and trust myself. I'll always be grateful for that time. Source: Care experienced mother, 2020.

Parent and child placements are a relatively small cohort of short-term assessment placements, a proportion of which are Court directed. Court directed placements occasionally lack referrals which hinders analysis of need. Placement searches from 2020 to 24 totalled 991 for 520 individual family groups.

87% of searches are for parent and child foster care, but the number of resulting foster placements is gradually decreasing, in the main due to lack of sufficiency, which is influencing a slightly reducing trend of total parent and child placements, but also a reported **increase in parental needs leading foster carers to consider risk cannot be safely managed in their homes.**

Figure 36 - Parent & Child referrals – Source 4Cs CCSR referrals data 2020-2024

Searches for parent and child placements were most common in Swansea and RCT, but with every authority searching at least once. Placements were most commonly made in RCT with a 53% successful match rate between 2020 to 2024, however, mirroring the trend for reduced parent and child foster placements with a sharp decrease across 2023 and 2024. 90% of initial searches for a parent and child foster carers are recorded as receiving no suitable response in 2024.

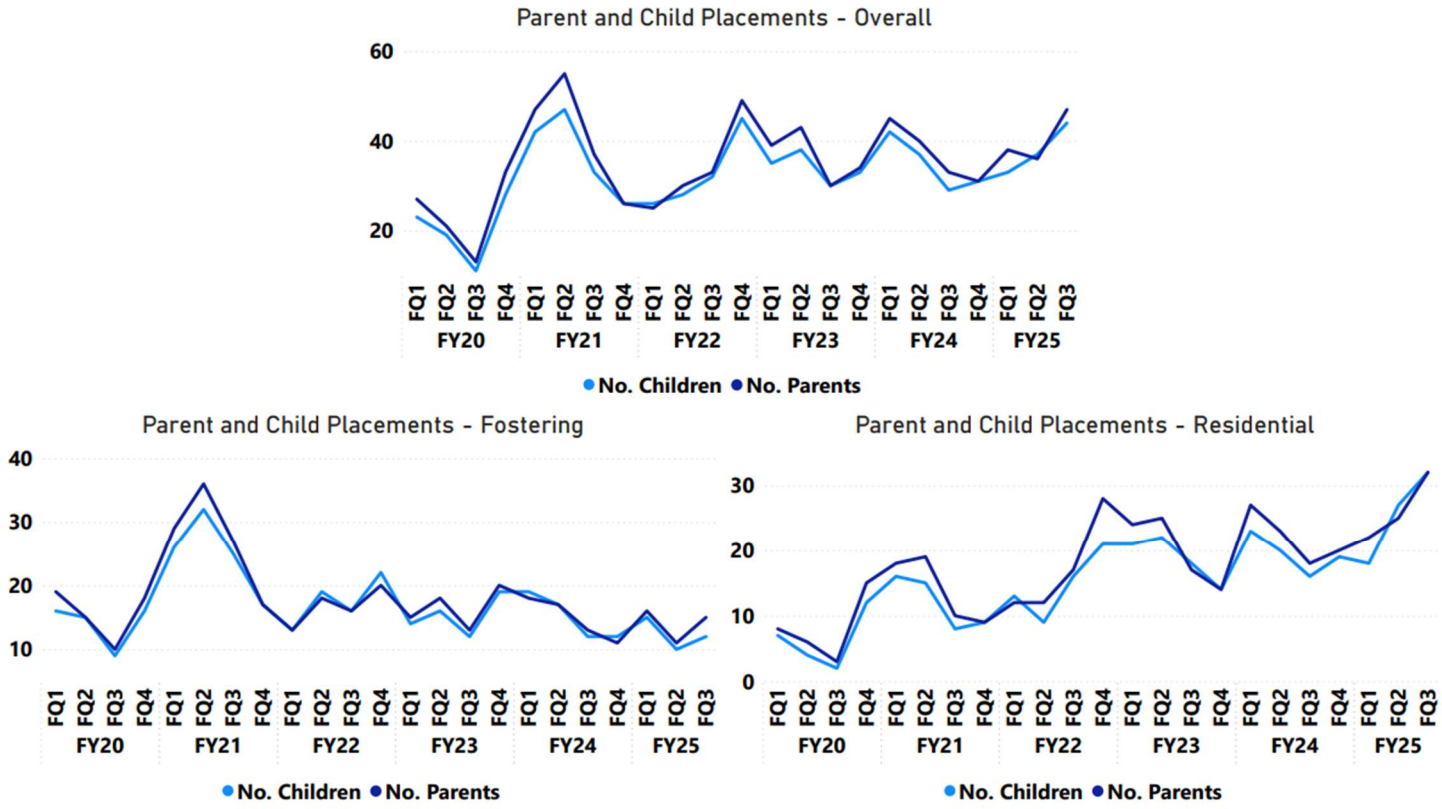


Figure 37 – Parent & Child Placements Overall & split by Foster & Residential – Source 4Cs CCSR placement data 2020 - 2025

The proportion of parent and child residential placements is increasing and a significant growth in residential capacity in Wales continues, with 4 settings offering 79 placements as of March 2025.

Residential Family Centre Places by LA

LA	Max Places
Bridgend	33
Denbighshire	22
Merthyr Tydfil	24

Figure 38 – Residential Family Centre places by LA – Source – 4Cs CCSR

This increased capacity is not mirroring demand for residential parent and child placements in Wales and over-supply is resulting in increased families placed in Wales from England.

Further parent and child residential placements (classified under RISCA as family assessment centres) are not required in Wales in terms of capacity. However, the placements in Wales are significantly higher in price compared to in England, with a lack of transparency of cost versus price evident with some providers. **4Cs would welcome discussion with providers who can offer better value for money for Local Authorities.**

Local Authorities are working with Foster Wales to attract new foster carers into parent and child, and new regional services will share lessons learnt as they develop. **Independent foster care agencies are encouraged to maintain current capacity, focusing on building carer resilience and risk management, to complement planned public sector growth**.

A referral originally requested a foster parent and child placement with no suitable responses. While foster providers had parent and child availability, they did not have carers who could be appropriately matched. A suitable placement was found with a Family Assessment Centre within the local authority region.

This is mum's 6th pregnancy, with her 5 older children currently living with grandparents due to domestic violence and poor home conditions leading to issues of neglect. Family is an important factor in mum's live and contact will need to be maintained. Dad's whereabouts are currently unknown, but he is deemed to be a risk to mum and baby.

Mum needs people to communicate with her in simple language so she could understand what was going on. She may have a learning disability, but this has not been diagnosed due to the amount of education she missed. Mum has been physically and emotionally abused by her previous partners and is extremely vulnerable. Mum can also become angry when challenged but is learning coping mechanisms.

Due to her pregnancy, mum has stopped taking medication for anxiety and depression. It is likely this will need to be reinstated once she has given birth to support her mental health difficulties. While mum does have a history of drug and alcohol misuse there are no concerns during her pregnancy, providing negative toxicology results.

Once placed in the residential home, an assessment was undertaken to understand the needs of the whole family and what outcomes would be measured to ensure the right decisions were made at the end of the placement. Plans for exit and transition from the service were discussed at the start of the placement to identify potential outreach support and community-based assessments that may be required.

The provider used an inclusive assessment tool which was designed to support parents with learning disabilities. It allowed mum to successfully evidence how she could safely parent her child(ren) and a traffic light system supported her understanding of the assessment.

Referral Case Study

SIBLINGS

In the main**, searches for siblings to live together are for foster care (98%)** not residential care. A growing number of sibling placements are commissioned externally, as occupancy levels of Local Authority carers increased from 2020/21, the number of tenders for commissioned sibling placements rose sharply before settling into a more stable trend. The referral trend over the last 5 years is captured opposite alongside the size of sibling group being referred.

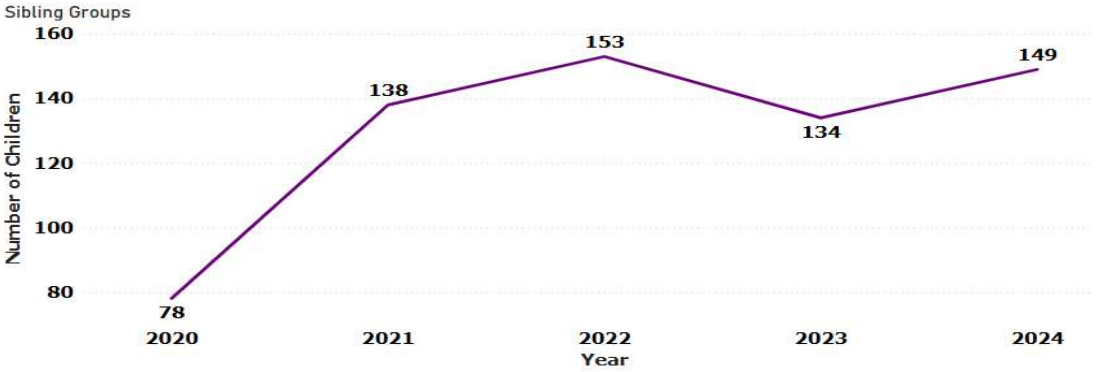


Figure 39 – Number of referrals for sibling group trend – Source 4Cs CCSR referral data 2020-2024

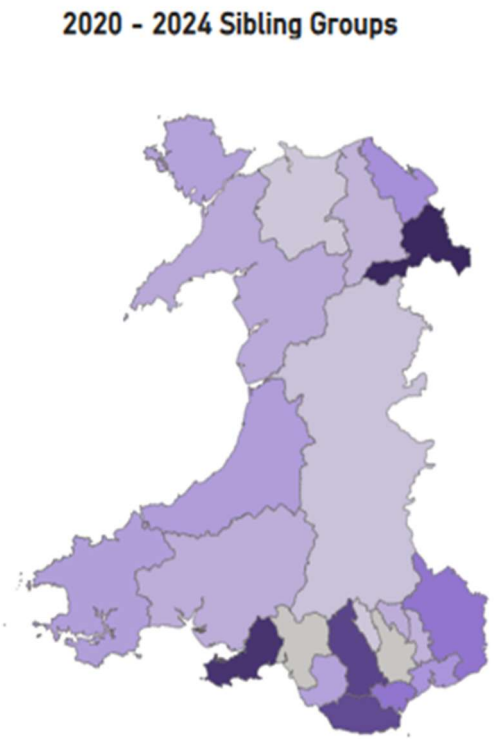


Figure 41 – Sibling Groups – 4Cs CCSR referral data 2020-2024

Geographical demand for placements for sibling groups is most notable in RCT, the Vale of Glamorgan, Swansea and Wrexham.

37% of referrals for sibling placements are reported by Local Authorities as receiving no suitable response, and in the majority of these cases siblings go on to be referred individually for carers.

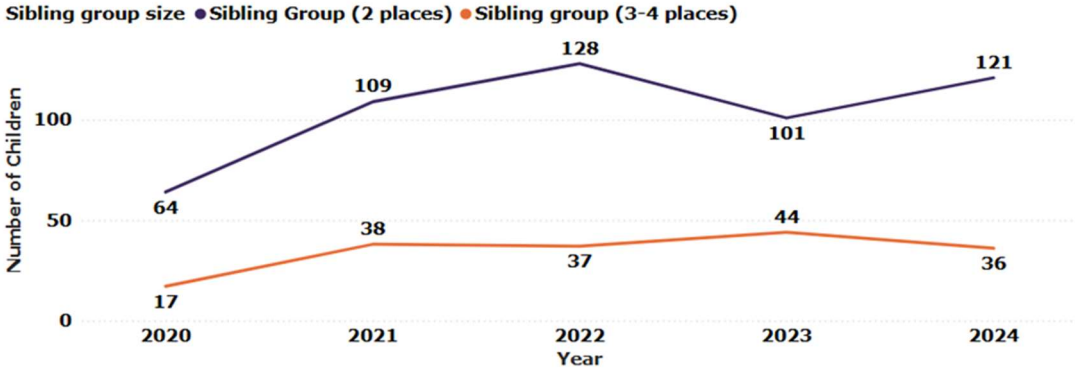


Figure 40 - Number of referrals for small and larger sibling group trend – Source 4Cs CCSR referral data 2020-2024

Anecdotally placement finders have reported increasingly large sibling groups of 5 or more children requiring care in early 2025, especially across Southeast Wales. This will be monitored through the data moving forward.

> We were on our own a lot, we were always together. I'm oldest and I help take care. I miss (them) so much although (carers) let us call and message and meet at the park or beach. We want to be together.
> Source: 360 Degree Survey, 4Cs QPA, 2022.

Jamie and his siblings have been placed in a foster placement together for 10 days. His current carers do not feel that they can manage all three children. The local authority would like the children to remain together (Jamie, aged 9, Cameron, aged 7 and Sally, aged 3).

Jamie is very outgoing and sociable child. Jamie has reached all his developmental milestones and there are no known health concerns or unmet health needs. Jamie a protective older brother to his younger siblings. Jamie is an active boy and loves to be outside, he has a particular interest in rugby and would like to join a local club and loves to talk about rugby and other sports.

This is Jamie's first foster placement and understandably when he came into care, he was upset and overwhelmed, resulting in him running away from his foster home and refusing to return so police were called, this has not happened again, but he is finding things difficult at the moment.

Jamie's brother Cameron is withdrawn and has a shy temperament compared to Jamie. Cameron struggles with his speech and often relies on Jamie to translate for him. Cameron is receiving speech and language support in school. Cameron does not like talking to adults and needs to be provided a lot of emotional warmth as well as structure and boundaries. Cameron prefers to play on electronic devices and is reluctant to go into the community and play outside but can be encouraged to do so by Jamie.

Jamie and Cameron currently attend the local primary school. Jamie will talk about his day and loves history and learning facts. Cameron is more reserved and can be reluctant to engage in conversation. Jamie and Cameron are used to sleeping in the same bedroom together, they are close and depend on each other.

Sally is a busy and active little girl, who is quite advanced for her age. Sally is up to date with all her immunisations and has no identified health needs.

Whilst living with her family, Sally has been restricted to being indoors and doesn't like wearing clothes. Sally can punch, kick and bite due to the lack of boundaries and of exercise. Sally enjoys playing with her dolls and a tea set. Sally will go to a male adult over a female adult and can present as overfamiliar with strangers.

All three children have been exposed to high levels of substance misuse and domestic violence.

Referral Case Study.

SOLO CARE

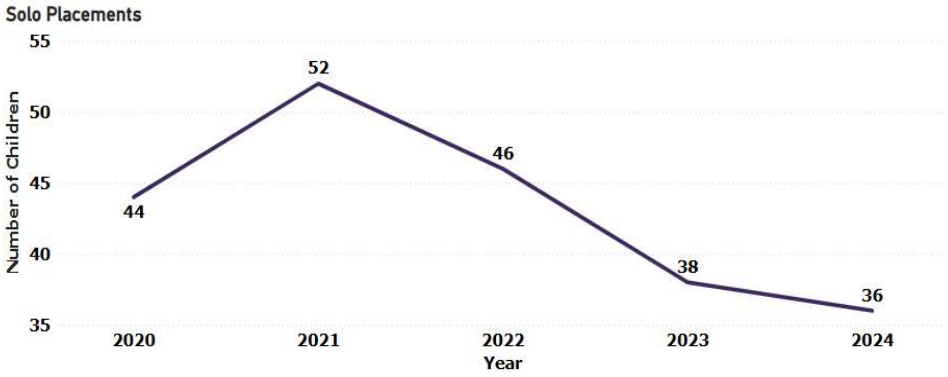


Figure 42 – Number of referrals indicating preference for solo placement – Source 4Cs CCSR referrals data 2020 - 2024

The number of **specific referrals to commission solo placements is declining overall.** There are a number of reasons thought to underpin this trend:

- Placement finders acknowledge increased occupancy and reduced vacancies means few solo placements are available in foster care.
- A concern that while solo placements can contain some risks, they can cause a barrier to effectively managing behaviours or needs and delay step-down to other types of home after the initial period of crisis has receded.
- De-registrations of independent care homes with solo or dual occupancy was a feature between 2021 to 2024, especially in North Wales and on the Northeast border with England.

Referrals and matching training had identified a pattern of risk averse solo referrals against this context. Updated advice is to engage providers in discussion on where it is safe to match alongside, or not, upon receiving a placement offer and consider the feasibility of a proposed safety plan. It is common to see risk management requests where extra staffing ratios are in place to supervise children, however, this should be proportionate to safeguarding. There is a need for providers and carers to work effectively with the Local Authority to timetable reductions in staffing ratios where positive progress is made. In some scenarios high staff ratios have been seen as 'oppressive' and perversely escalating behaviours.

Iolo presented with harmful sexual behaviours with his siblings and has been living in solo residential home with 2:1 staff ratio for 2 years. He has a 1:1 ratio in school and so is always supervised. Iolo is on a waiting list for therapy related to the harmful sexual behaviours and previous self-harming behaviour, but the current provider does not offer these services as part of his care. He is in regular contact with his family but remains supervised when he is with his siblings. Iolo wants to move to a foster family.

The Local Authority believes strongly Iolo is ready for fostering given his positive behaviour in the care home and school, however, is unable to find a placement match due to unknown current risk, essentially because he is unable to be unsupervised and supported to live alongside other young people in his current solo setting. Foster care providers say the risk has just been 'contained' with supervision rather than reduced.

Referral Case Study.

The majority of referrals for solo placements are in the **10 to 15 age range**. The highest **needs profiles linked to searches for solo provision are challenging behaviour, inappropriate or harmful sexual behaviour, and categories of aggression and violence to others or self**.

A majority of fostering solo arrangements relate to concerns about instability in the home should another child be introduced alongside. From a sample these concerns are broadly in two categories: firstly, foster carer resilience and secondly, child's anticipated risk to others increasing should another child be introduced to the family dynamics.

Local Authorities want providers of foster care to pro-actively suggest how they can support these arrangements to mitigate the identified concerns.

> **Smaller homes teach children to share and respect each other, this doesn't happen when they live alone.**
>
> **Children who live alone are lonely.**
>
> Source: 4Cs Young Commissioners, 2024.

A majority of existing residential solo placements over this period are for children and young people with a **DEPRIVATION OF LIBERTY ORDER** in place, and a majority are Local Authority arrangements, often **OPERATING WITHOUT REGISTRATION** (OWR) at the point the child is placed, where no other registered placement able to meet needs can be identified.

Local Authorities want providers of registered residential care to collaborate closely with commissioners to develop their services to be better able to meet the needs of young people with the highest acuity and multiple presentations of risk-taking behaviours, to stabilise their care and meet their needs effectively.

During 2023- 2024 CIW determined 117 services were operating without registration. **In 2024- 2025 there have been an average of 25 OWRs active per week in Wales; over the same period CIW were notified of 65 DoLS arrangements** (CIW data, 2025). Analysis of arrangements indicate that not all of these children require solo provision, particularly those who enter an OWR as a result of a same day emergency scenario, but a majority are assessed as requiring a solo placement during a period of heightened distress and emotional dysregulation. A notable proportion would likely meet the thresholds for Secure care, if there were sufficiency. For further analysis on children and young people deprived of their liberty access Nuffield Family Justice Observatory . Over half of children in England and Wales (57.3%) subject to applications in 2024 were aged between 13-15 years, 32.3% were aged between 16 and 18, and 10.3% were 12 or under. There was an equal gender split (female: 51.5%; male: 48.4%). Data shows that the majority of children are subject to a DoL order for more than six months, suggesting that these are not short-term measures.

STEP DOWN: RESIDENTIAL TO FOSTER

Foster carers able to step down children from residential care are in high demand across Wales. Local Authorities report multiple children in residential care who could be a fit for a family setting with the right carers at any snapshot point in time. Demand is across a broad age range and needs profile. Foster providers are encouraged to refocus capacity here providing clear service models, identifying distinct phases of intensive wrap around support to be pro-actively reviewed as carer and child form relationships and there is a good level of stability, but responsive if concerns arise.

Morgan is 14 and he's been living in a care home for 2 years. He's stated the last few months he would like to return to foster care. Morgan went to live in residential care after several foster placements ending. His last ended after he was aggressive to his foster carers and began absconding from home. Morgan assaulted his carer by kicking her in the stomach.

Morgan has flourished whilst living at his care home. He has regular unsupervised family time every fortnight with his family and siblings, he has lots of warmth and love towards his family, is very well behaved and happy in their company. Morgan's level of aggression and previous assaults on carers has been addressed during his time in his care home. The development of good trusting relationships and a consistent approach to manage periods of heightened behaviour has seen levels of aggression reduce significantly. His carers have followed a trauma informed approach with a low arousal response, and space to calm himself down.

Morgan attends his education setting for 3 afternoons every week and his attendance is very good but there is no plan with school to return to a full timetable yet. Morgan is excellent at maths and sciences; he would like to study Chemistry in college after GCSEs.

Much of the time, Morgan is a polite and well-mannered. However, in the last few weeks he absconded to his girlfriend's house. Whilst there her father threatened him to stay away, causing him to feel upset and resulting in him being angry. On his return home he was verbally aggressive. The next day Morgan apologised for his actions and said he was ashamed of his behaviour.

Morgan can have verbal arguments with other young people out in the community. Morgan told carers these incidents have been when another young person made derogatory comments about his family. There have also been 2 incidents when Morgan has returned home under the influence of alcohol.

Morgan's move from his current care home to his new foster home would be phased and supported with a clear transition plan. This will include multiagency input and advice. Current carers will help ensure transition is timely and successful for Morgan and his foster carers.

Referral Case Study.

We are caring for much younger children than before; social workers can't find foster carers. In (care home) we have 3 under age 10 so we've changed the environment and routines to make it as nurturing as possible, particularly bedtime routines where reading a story and staying until they're settled, creates strong bonds with carers. We're keen to offer support to foster families to make planned step-down work well for everyone.

Source: Residential Care Provider, 2022.

Carys age 9, was adopted when she was a year old. Concerns about adopters' ability to meet her needs and manage her behaviours started to escalate when she was 7 years old, following an incident of aggression to another child, leading to a temporary exclusion from school. Prior to this Carys had struggled to form friendships, experienced some bullying in school and was becoming increasingly reluctant to attend. This presented as tantrums in the morning, refusing to get in the car to school, lashing out at adoptive parents and her attendance rate had dropped worryingly.

Carys has additional learning needs and has 1:1 support for 8 hours per week in school but she became increasingly aggressive to her TA, including hitting, biting, pinching, throwing items, kicking and hiding under the table when refusing to engage. After a further incident in school, adoptive parents refused to have Carys home and a same day emergency placement was needed.

A foster placement was found for 48 hours but due to carer's commitments to other children could not be maintained. During this time Carys was withdrawn, tearful and injured herself through repeated head banging and hitting. Unfortunately, no other foster carer could be identified at short notice, and Carys was moved to a residential care home.

Carys has been in the home for 6 months and has thrived in a nurturing environment alongside 3 older children. She responds well to clear routines and boundaries. She has formed friendships and positive bonds; she is re-engaged in school and her attendance was 100% last term. She loves to colour, paint, use the trampoline in the garden and be outdoors with carers. Her speech and language has improved significantly with support at the home. This has reduced frustration and outbursts of anger. Occasionally Carys does have nighttime enuresis, but she has clear routines to support managing this, otherwise her health is good.

Carys would like to live with a foster family long-term as she is unable to return to live with her adoptive parents. The care home are keen to support a phased transition to a foster family when one is identified to help maintain Carys' positive routines and progress.

Referral Case Study.

MODELS OF CARE

In the last decade across Wales there has been an investment in researching and understanding the different approaches and models of care in terms of what works well for children looked after in foster care and residential care.

Expectations of providers of commissioned services relate to their intended service remit, caring for children with distinct needs profile, however, at a minimum level we want to see all providers take a trauma informed approach to care delivery. As the main gaps in sufficiency are towards the higher end of the continuum of need, providers who can offer an evidence-based model of care delivering child focused outcomes are in greatest demand. At the top of the continuum a small proportion of children will require highly structured intervention services often short term in nature and dealing with children in crisis.

Model of care definition: "A blueprint or framework to guide the practice of staff, with a particular focus on how to create and sustain change/impact. Ideally, these models deploy proven techniques that are based on either a theory of behaviour or why problems arise and/or evidence of 'what works'. These models help to ensure that people with similar types of need are supported in similar and joined-up ways, i.e. practice is replicable and transferable." Cordis Bright (2018).

> **Everything is structured and consistent, it means you know what to expect and who you are going to get support from.**
> Source: Young Commissioner 2024.

4Cs encourage commissioned providers to stay up to date with published evidence on what works well. No one model is a fit for all, some work well with a narrow needs profile, others are broader in applicability to a range of needs and intended outcomes. The following links will open the topic to new market entrants.

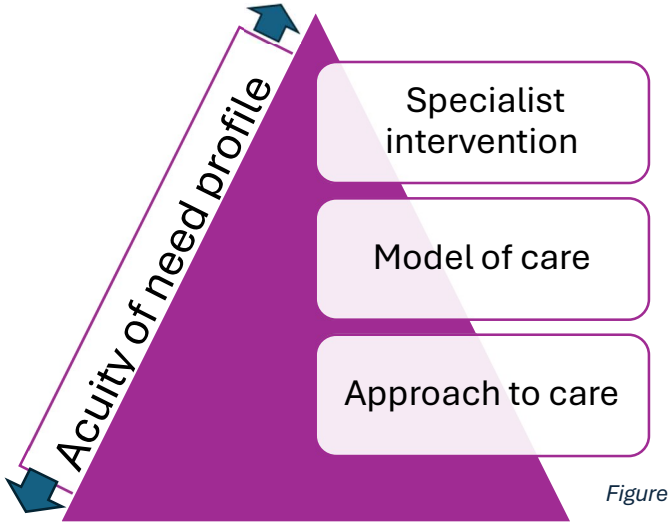


Figure 43 – Acuity of Needs Profile – 4Cs guidance on models of care 2024

Cordis Bright reports:

Models of childrens residential care

Models of foster care

Social Care Wales evidence summary: Supporting positive outcomes in childrens residential care

> **When you have a lot of chaos in your life, having the consistency makes you feel safe and loved.**
> Source: Young Commissioner *2024.*

COMPLEXITY OF MULTIPLE PRESENTING NEEDS AND COMPLEXITY OF SERVICE RESPONSE – NOT A 'COMPLEX CHILD'

Language and specificity are important when we describe children's needs profile. Children and young people often tell us they feel labelled by use of words specifically 'complex'; it reinforces negative feelings of stigma from being looked after and makes them feel like they are 'the problem'.

In 2018, 4Cs worked with the National Commissioning Board and IPC to develop guidance for Regional Partnership Boards on how to commission integrated care packages for children and a self-assessment tool. Within the report there is consideration of how to talk about complexity and the importance of being clear on what or where the complexity is; it is often a system complexity; this report remain relevant and can be found here. A more recent definition of complexity is offered by Nuffield Family Justice Observatory (2023).

We are important, we deserve good care that helps us the right way.
Source: Young Commissioner, 2024.

'They said I was 'complex', and no-one would give me a 'placement'. So basically, no-one cared enough to try to understand or wanted me around.'
Source: Young Commissioner, 2019.

Understanding specific needs, how they co-occur and how best to meet those needs, helps identify and develop essential training for the childrens care workforce. In referrals, we encourage social workers to describe what a day may feel like for a child and their carer to help match carers and children in the best possible way, and to identify where carer's training or support may need to be boosted to manage gaps in the match. This early identification of needs promotes stability of care from the outset.

In 2024, our Young Commissioners presented at a joint conference with Social Care Wales promoting the benefits of models of care in residential care. As part of the preparation for the event we discussed the importance of consistent quality care tailored to meet individual's needs, where integrated service delivery is strongest. Here are a sample of their views:

A therapist will help; they provide a balanced view; they can work with carers and pass on their skills.
Everything is structured and consistent (in a model of care), it means you know what to expect and who you are going to get support from.
You may not need a therapist, support can be given by familiar people, and if you trust them, you can ask for a therapist if you need to. I have a bond with my carers so if I speak to them, it's easier.
It can sometimes be quite intense, especially in the beginning, which can lead us to push the staff away and not follow the rules and boundaries.
If I'm having a hard time, all of the staff communicating well helps me to be supported in all areas of my life.

CONCLUDING REFLECTIONS

Children looked after needs profiles are evolving and changing in Wales. Crucially, there is a mismatch between available service provision and childrens presenting needs. More vulnerable children are falling through these gaps and their opportunities for positive lifelong outcomes impacted.

The analysis highlights the commonalities of presenting needs, experiences and behaviours, which require care and support with a trauma informed approach. Meeting these needs is the essential basis of quality care.

Further exploration identifies increased needs profiles. Some emerging, requiring dynamic risk management as the safeguarding context evolves, such as online safety and harm; many embedded but with increased prevalence, such as self-harm with co-occurring mental health needs.

Trends are identified with forecasts for decreased, stable, or increased likelihood presenting over the next 5 years, such as neurodiversity. Under-reporting of needs is noted where there is a strong likelihood from evidence, such as child sexual exploitation. Covid-19's long term societal impact on needs is not yet fully evident but 65% of identified attributes show an increase in prevalence post-Covid.

The impact of needs profiles and correlating behaviours on instability of care and disrupted child : carer relationships is identified, such as aggression and violence, with links to guidance and legislation for providers and carers to explore.

Quality of care overall is good within commissioned services, as evidenced by the regulator CIW and by commissioning activity. There are substantial gaps, however, when overlaying the range of targeted services to meet the full continuum of needs of children looked after. This is especially evident where needs are multi-faceted and high risk.

We want to work with providers and multi-agency partners to close gaps, with a fuller range of services that deliver evidence-based care shown to meet needs and allow children to thrive into adulthood. In the wider context, the legislative landscape is changing under the Health and Social Care (Wales) Act 2025. We want to work with providers committed to delivering ongoing registered care and support services, to minimise disruption to children looked after during implementation, alongside a targeted re-alignment of service provision to better meet the needs profile.

If you would like to contact 4Cs for a discussion about targeted service development, needs profiles, or wider commissioning activity, get in touch at:

4Cs@rctcbc.gov.uk 01443 570098

An accessible summary Infographic of this document is available. Welsh language versions of both documents are available.

APPENDIX ONE: KEY DATA SOURCES AND DATA INTEGRITY STATEMENT

The following key sources were used for the needs analysis:

Childrens Commissioning Support Resource (CCSR) – e-tender procurement tool used by the 22 Welsh Local Authorities, 2020-2025.

Quarterly Baseline Data Return (QBDR) – snapshot data returned by the 22 Welsh Local Authorities, 2020-2025.

Quality Performance Assessment (QPA) - annual returns and reports, 2021– 2024.

4Cs Bespoke Tenders – specific ad hoc referral support available to Local Authorities where they are unable to identify care and support through the normal tendering process, 2020-2025.

Strategic Commissioners - needs analysis Local Authority engagement sessions (2) plus individual sessions, May 2025.

NHS Wales Joint Commissioning Committee (NWJCC) - commissioning discussion and data sharing, April 2025.

4Cs Peer Support Groups - Placement Finders, Contract Monitoring Officers, Commissioners, 2024 – 2025.

Analysis of 4Cs duty call logs regarding referrals and placements, 2021-2025.

4Cs Young Commissioner Groups / YCV Board - conferences, events and report summaries, 2018 - 2025.

Reducing Criminalisation of Care Experienced Children and Young Adults Steering Group – minutes, discussion and data, 2018 – 2025.

Randomised All Wales Referrals - dip samples, 1st April 2023 – 31st March 2025.

Local Authority Case Studies – sample submissions, 2020 – 2025.

All case studies are anonymised for the purpose of the report.
Data is self-reported by Local Authorities; basic parameter checks are completed by Data Cymru. 4Cs does not complete verification.
Local Authorities aim for within 10% integrity on CCSR/QBDR supported by 4Cs, this can be impacted by workforce turnover and capacity.
Quantified needs within this document are likely to be an under-representation rather than over-representation where derived from CCSR based on 4Cs data integrity monitoring.