

follow the money



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Background and Context

The lifelong cost of care is borne by the person and not the 'care system'. The care experienced children, young people and adults who shared their story with the Care Review gave many examples of the impact the 'care system' had throughout their lives and on all of their experiences, including trauma and enduring stigmatisation.

This work was undertaken to understand how Scotland can better allocate its resources to ensure the 'care system' does not harm those within its care, and the cost of care is no longer felt most by the person whom it is supposed to nurture. It was designed to provide the financial back up for the moral argument – financially Scotland can afford to transform the approach, and morally it cannot afford not to.

The Care Review appointed a steering group with members who had expertise across relevant sectors to oversee the collation and analysis of the data used in this work. Further information on the membership of the steering group can be found in **The Thank You**.

This work required the human impact and financial costs to be assembled from across the complex, fragmented, multi-purpose and multifaceted entity that is the 'care system'. The enormously wide variety of supports and services provided by the vast array of organisations, service providers, professionals and volunteers within the 'care system' made it challenging to understand where money was spent. The inclusion of human costs, quantified impacts of the 'care system' on the experiences and outcomes of those who have lived within it, facilitated a move beyond spend being seen simply as a budget line.

There were two key objectives:

- **To quantify the human costs and impacts of the current 'care system'**
- **To determine the financial costs of the current 'care system'.**

Background and Context

This work was challenging from the outset.

The human costs of the current 'care system' are significant. Children and adults who have lived in the 'care system' have reduced opportunities which follow them right through their lives. Health, education and employment outcomes are all poorer than non-care experienced people. Incomes are lower and lives are generally harder with more obstacles.

It is not because Scotland is not spending money. Delivering the current 'care system' in Scotland costs around £942million per annum. The universal services which can be associated with care experienced people cost a further £198million per annum. But the economic impact is high. This work estimates the cost of services required by care experienced people as a result of the current 'care system' failures to be £875million per annum. A further £732million per annum is lost as a result of the lower incomes care experienced people have on average.

These costs are based only on the data it has been possible to find and analyse. There are gaps. Sometimes this has meant a proxy has had to be used to make the best guess possible (for example severe and multiple disadvantage scores indicate likely complex needs), other times it has left a complete gap in the work.

Despite the extensive data collation and analysis undertaken across both sample surveys and administrative data, it has proven impossible to overcome the data challenges in many places. The resulting data has many gaps and there is a lack of precision within the analysis as a result.

While surveys can ask a wide range of questions and relate experiences at the individual level, they do not reflect the seismic events in people's lives, nor are they capable of showing the journeys into and out of those experiences. In addition, some of the most disadvantaged people are either missing completely from typical surveys (because they are not 'usually resident' in private households) or under-represented as their inclusion is reliant on their response and self-identification.

For example, whilst living in temporary accommodation, **Lauren** would have been unlikely to have been included in national survey data. Had she had the opportunity to respond to questions about her life, it would have required her to self-identify as care experienced which may have stigmatised her further and offered no immediate benefits or support.

Lauren

Lauren is 27 and grew up in care. She's kept in touch with a handful of people from her childhood and was closest to her foster parents.

She moved into temporary accommodation when she first left their home and has only recently been given a flat of her own after years of moving around. She has struggled with alcohol and drugs, particularly when she is feeling down.

Everything seemed OK when she first moved out and she felt like she had support. However, as the years have passed, the support seems to have gone away. Lauren wants what everyone else seems to have and doesn't know why it feels so hard for her. She has turned increasingly to her foster carers. They've been a great support when they've been able but they're not able to help Lauren as much as they would like.

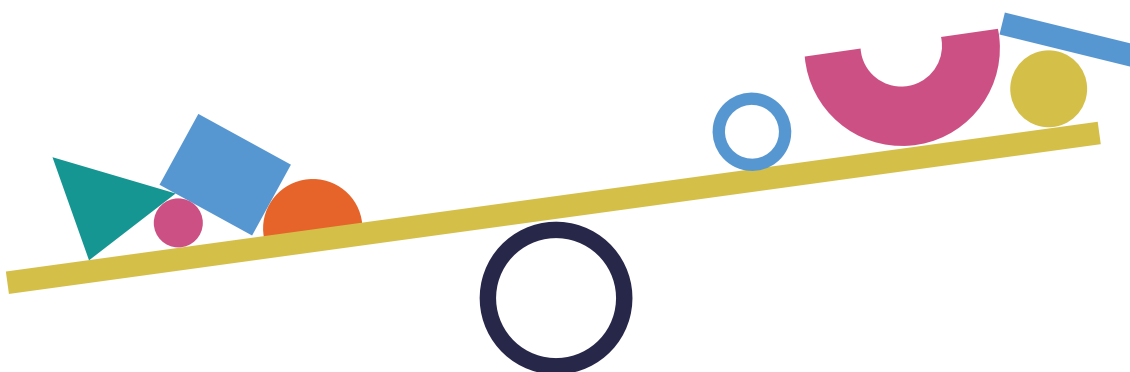
Lauren doesn't go out very much now and doesn't have many friends. She knows the situation is affecting her mental health but that feels like yet another thing she has no support to manage. She is still in touch with a former college lecturer who was great a few years ago. Lauren finds that even just chatting things through over a cuppa makes her feel better.

Background and Context

Within administrative data, there is a general issue of 'attribution' which arises when considering or attempting to quantify the effects of particular childhood experiences on outcomes later in adult life. It has not generally been possible to disaggregate national data collections by those who live within the 'care system' and it has proven impossible to identify those who are care experienced within routinely collected data. This presents a significant issue in pin pointing the extent to which care experience is a determinant of outcomes as documented within the wider evidence base. As a result, attempts to model or estimate with any precision the part of the differential cost which is attributable (in a causal sense) to care experience, as opposed to the background and associated factors, or indeed any other unmeasured factors, has been impossible.

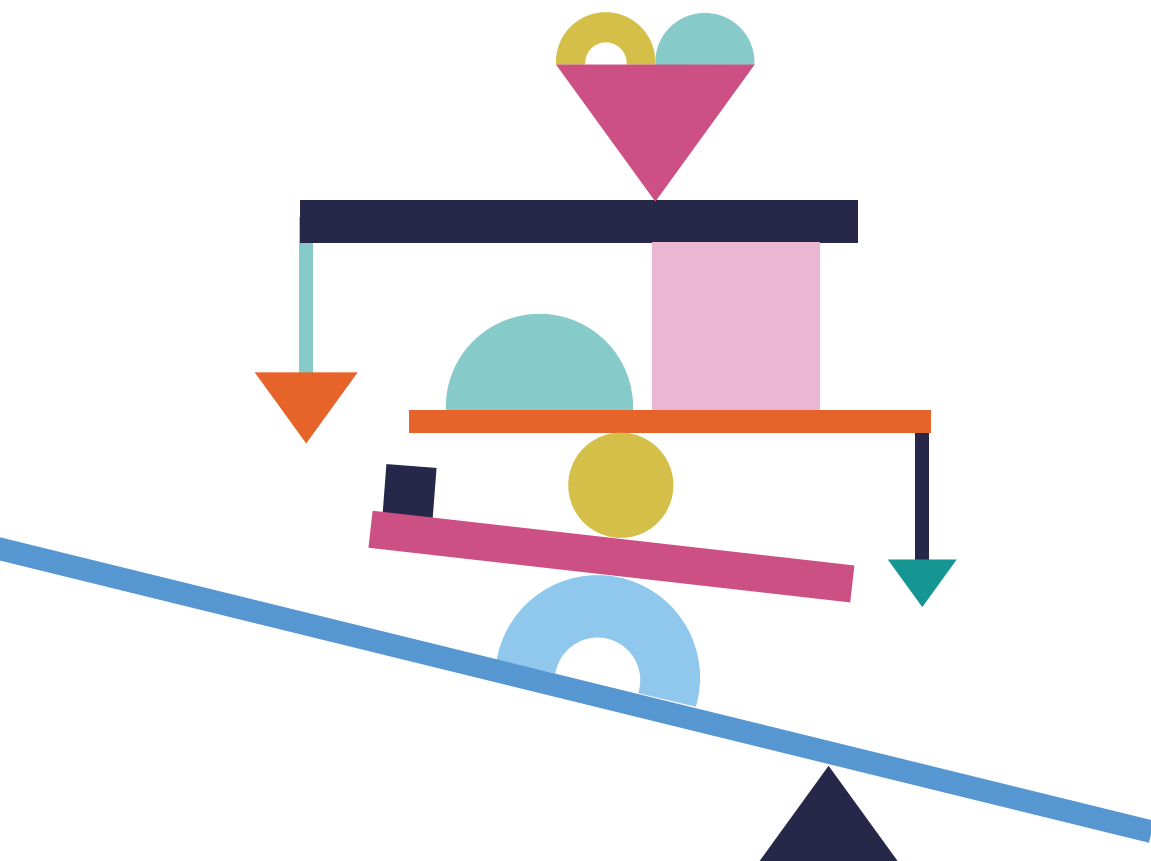
These are all key points in and of themselves. It should not have been necessary for the Care Review to undertake such intensive work to simply understand how much Scotland's 'care system' costs. The sheer volume of under-reporting and lack of precision should not have been the hurdles. However pushing this work forward not only brought the costs into view, it has generated conversations about the quality and availability of Scotland's data.

A positive impact of the engagement which took place across data, policy and practice has been a willingness to consider the inclusion of care experienced markers and flags within existing administrative data collections. Doing so would facilitate a better understanding of the experiences and outcomes of this population and allow progress and its impact to be measured more effectively.



Crucially though, the under-reporting of costs and lack of precision does not mean the evidence presented is not robust. Nor does it mean the associated implications do not hold weight. In **Kyle's** story, it is not possible to attribute offending and experiences within the criminal justice system as a direct impact of his experiences within the 'care system'. The wider evidence base demonstrates the likelihood of a link between experiences in one area and outcomes in another meaning the need to take action should reside in the domain of the 'precautionary principle'.

Acting on the precautionary principle recognises the plausible risks and bestows a responsibility to reduce exposure to harm. The data demonstrates that there is an over-representation of care experienced adults within the prison populations. Delivery of **The Plan** would make it more likely children would get the support they need, when they need it to ensure more positive experiences and outcomes. For **Kyle**, it is likely that residential care contributed to his engagement with the criminal justice system and, unless something changes, he could find himself in the adult justice system. **The Promise** makes it clear that criminalisation and putting children in prison settings is deeply inappropriate. Scotland must uphold its commitment to the Kilbrandon principles and ensure that offending behaviour is met with care and protection and not a punitive response.



Kyle

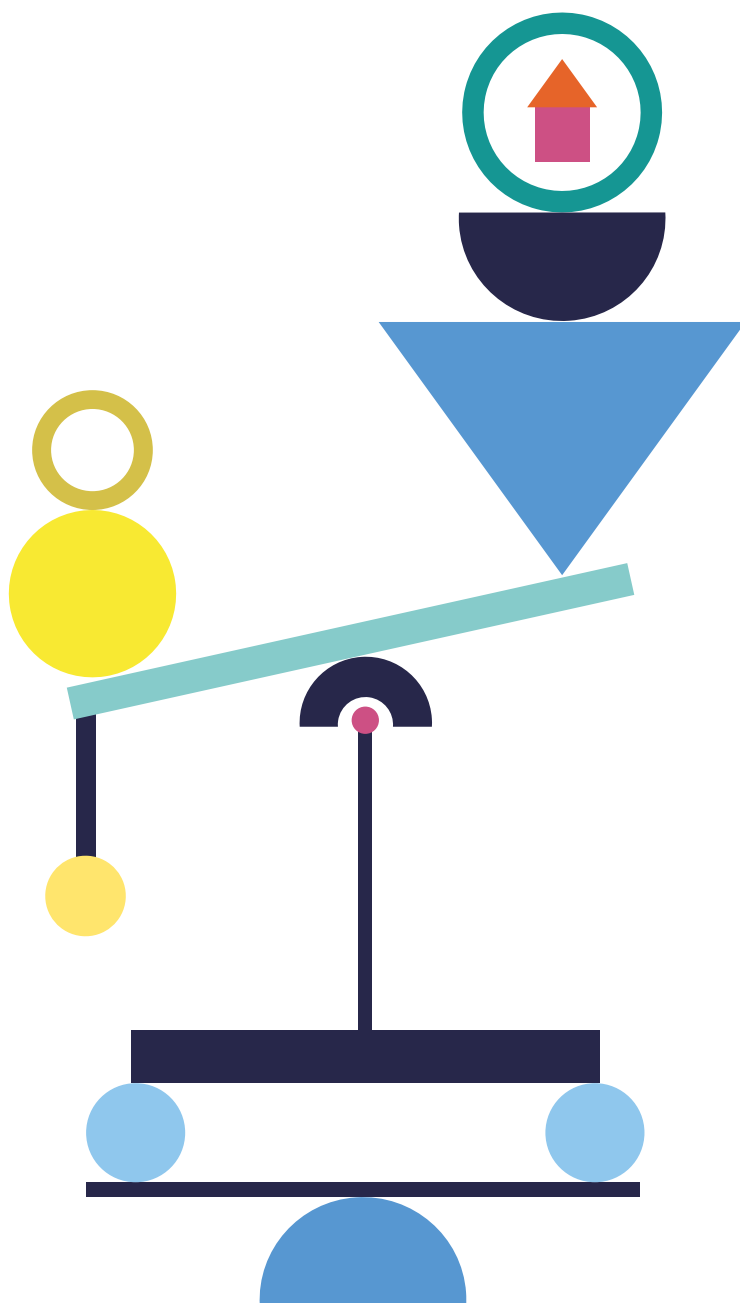
Kyle is 16 and until recently lived in a residential children's home. He has been in care since he was 6. There are things that have happened to him that he finds hard to talk about.

Four months ago he was at the Sheriff Court. He was sent to Polmont Young Offenders Institute and has been there ever since. It wasn't Kyle's first time in Court but it is the first time he's been locked up and it isn't like he expected.

Kyle's mum visits when she can but it's very far from her home. He had some foster carers from a few years ago who were really kind and they visit more regularly. Kyle has made some friends in Polmont, many of them have been there before. He hopes that doesn't happen to him.

Kyle has been thinking about what he will do when he gets out. He finds studying difficult. He knows it won't be long before he leaves Polmont but it doesn't feel like anyone is able to help him. He hopes he can go to the foster carers who have been visiting him, but he isn't sure.

Similarly, transforming the 'care system' in Scotland should not wait for precise attribution: the weight of evidence makes it clear that the costs of inadequate provision are substantial and often avoidable and the human costs significant. The human costs calculated as part of this work do more than humanise the costs of care, they signify the necessary shift from a system lens to a human one. For the first time, Scotland can understand not only what it spends to deliver the current 'care system', but also the outcomes it generates for those it aims to support.



Identifying the operational costs of the current 'care system'

Following consultation between the Care Review, Convention of Scottish Local Authorities (COSLA) and The Improvement Service, it was determined that the most appropriate source of information to identify the financial cost of care was the annual submission of Local Financial Returns (LFRs)¹.

The LFRs are subject to an external validation exercise and therefore represent locally and nationally recognised costs of services provided by the Scottish Local Authorities so can be perceived to provide a certain level of integrity in the underlying cost data. Importantly, their use also provides a replicable calculation. At the time of analysis, the most complete LFRs were those relating to financial year 17/18 and so these were used.



1 See <https://www.gov.scot/publications/scottish-local-government-financial-statistics-2017-18/>

Data on the costs of care was sought for all of Scotland. A subset was also extracted on 5 local authority areas chosen for their geographic and demographic spread. These were: Glasgow City, Perth and Kinross, Scottish Borders, Dundee City and Shetland Islands.

A mapping exercise was undertaken to identify the relevant cost bases from the following 2017/18 LFR submissions:

- **LFR 01:** Education
- **LFR 03:** Social Work
- **LFR 20:** General Fund Housing

Once mapped, the proposed cost framework was circulated to local authorities for comment. Once agreed the cost areas proposed were considered to be representative of the costs associated with the 'care system' in Scotland, the LFRs were analysed and data extracted. The populated cost of cost frameworks for each local authority were then checked with local authority Directors of Finance for completeness, relevance and gaps.



Identifying the operational costs of the current 'care system'

Whilst the LFRs provide a good indication of local government spend on the 'care system', they did not extend to the budgets of the various national bodies involved in its delivery. To fill some of these gaps, the cost frameworks were then supplemented by data provided directly by Children's Hearings Scotland (CHS) and the Scottish Children's Reporters' Administration (SCRA). Both the CHS and the SCRA data is collated at the all Scotland level. For the purposes of this work, the national costs were weighted by organisational workload in each of the local authority areas to estimate the proportion of costs relevant to the areas of focus. This meant the figures were calculated on the number of Hearings that took place in each area, rather than on the number of children living in each area.

There are some cost areas which are directly linked to the delivery of the 'care system' and wholly attributable to the care experienced population. This list is not exhaustive. There are various costs which have not been possible to assemble. Those which have been possible to obtain are summarised below.

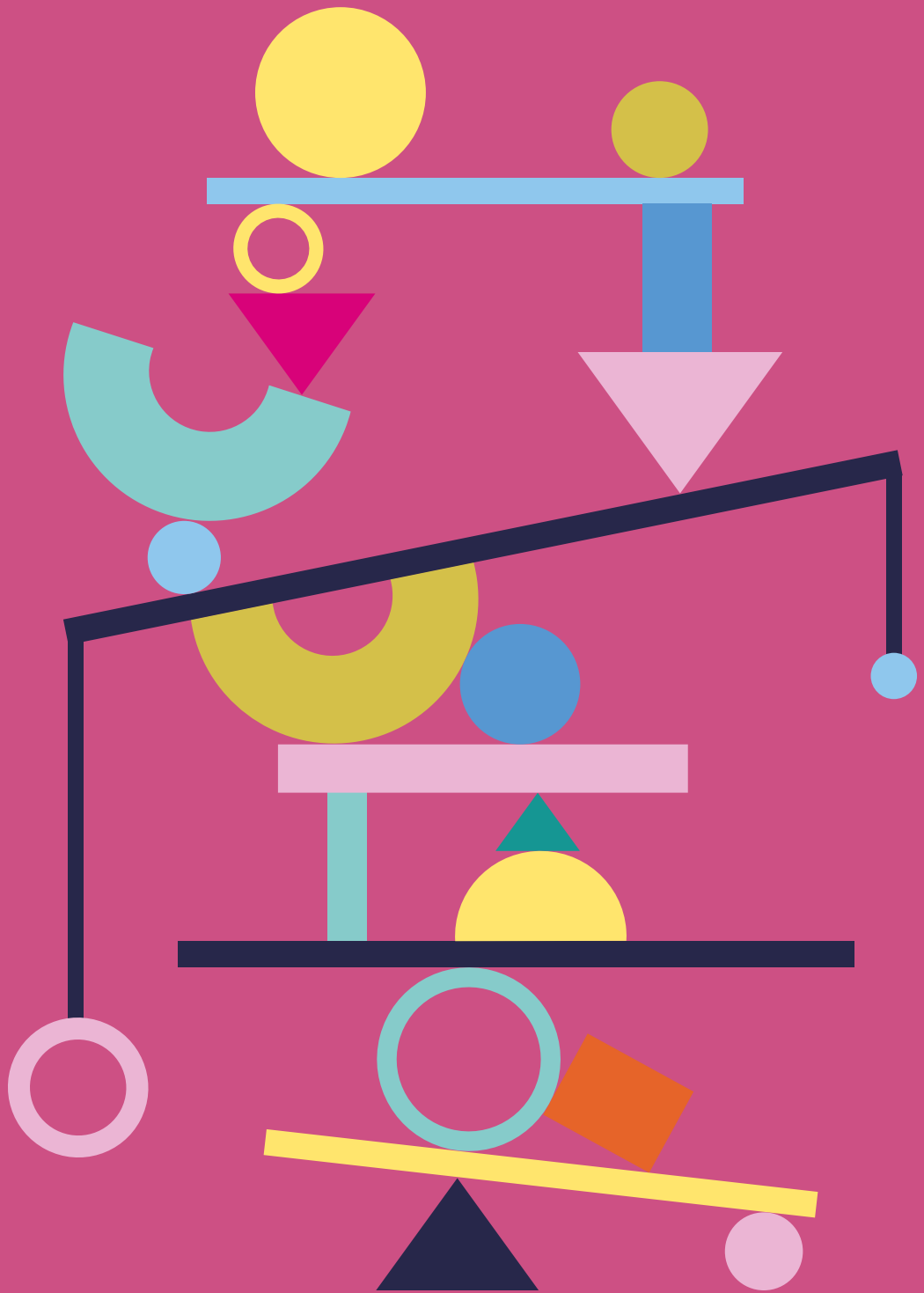
Further detail on the analysis undertaken can be found in Table 1 on page 23.

Annual operational costs of the current 'care system'²

- **Children's Panel** – Total costs across the five Local Authorities is £0.1million; for Scotland the figure is £1million.
- **Children's Hearings Scotland** – Total costs across the five Local Authorities is £1million; for Scotland the figure is £5million.
- **Children and Families** (including support services, placements and other community based services) – Total costs across the five Local Authorities is £246million; for Scotland the figure is £897million.
- **Scottish Children's Reporters Administration** – Total costs across the five Local Authorities is £5million; for Scotland the figure is £27million.
- **Education** – Looked After Children Pupil Equity Fund for Scotland the figure is £12million.

This provides a total estimated operational cost of £252million for the five identified local authorities and £942million across Scotland as a whole.

2 These figures have been rounded



Identifying other costs associated with the current 'care system'

Throughout this work, the issue of attribution has been a constant presence. There are universal services which are funded for the general population in which the care experienced population is likely to be significantly over-represented according to the wider literature.

The costs associated with these services are therefore relevant when seeking to understand the cost of the 'care system' but without better data they cannot be wholly attributed to the care experienced population. The circumstances and experiences associated with care experience can lend themselves to an increased likelihood of additional support needs and greater need for service inputs. Determining the extent of over-representation however has proven difficult.

To fill some of the gaps which exist, data has been taken from elsewhere to estimate the proportion of spend attributable to the care experienced population. To do this, national longitudinal studies have been analysed to gain an understanding of the extent to which there is an increased likelihood of the relevant outcome. The resulting figure has then been multiplied by estimates of the proportion of those with care experience in the relevant population. This results in a percentage which has then been applied to the total cost units. It is important to note this estimates the total amount spent on the care experienced population, rather than identify the value which is considered to be spent as a direct result of care experience. There will be some areas in which spend would be the same regardless of care experience. In others, there may be increased costs as a result of poverty, deprivation, disadvantage or other circumstances adjacent to the care system. It has proven impossible to separate these out to determine the root causes and the extent to which they impact.

The data which has been possible to obtain has been summarised on the right. This list is not exhaustive. There are various costs which have not been possible to assemble. **Further detail on the analysis undertaken can be found in Table 2 on page 25.**



Other annual costs associated with the current 'care system'³

- **Education** (care experienced bursary) – Total costs for Scotland is £6million.
- **Pre-primary education** (including school meals and Additional Support for Learning) – Total costs relevant to this population across the five Local Authorities is estimated to be £1 million; for Scotland it's £2million.
- **Primary education** (school meals and Additional Support for Learning) – Total costs relevant to this population across the five Local Authorities is estimated to be £9million; for Scotland it's £40million.
- **Secondary education** (school meals and Additional Support for Learning) – Total costs relevant to this population across the five Local Authorities is estimated to be £5million; for Scotland it's £22million.
- **Special education** (School meals and Additional support for Learning) – Total costs relevant to this population across the five Local Authorities is estimated to be £19million; for Scotland it's £91million.
- **Child and Adolescent Mental Health Services** (including community mental health teams, child psychiatry and child health) – Total costs relevant to this population for Scotland is estimated to be £9million.
- **Pupil Equity Fund** – Total costs relevant to this population for Scotland is estimated to be £28million.

The calculation of costs in these areas produces an estimated additional cost of £34million across the five local authorities and £198million for Scotland as a whole.

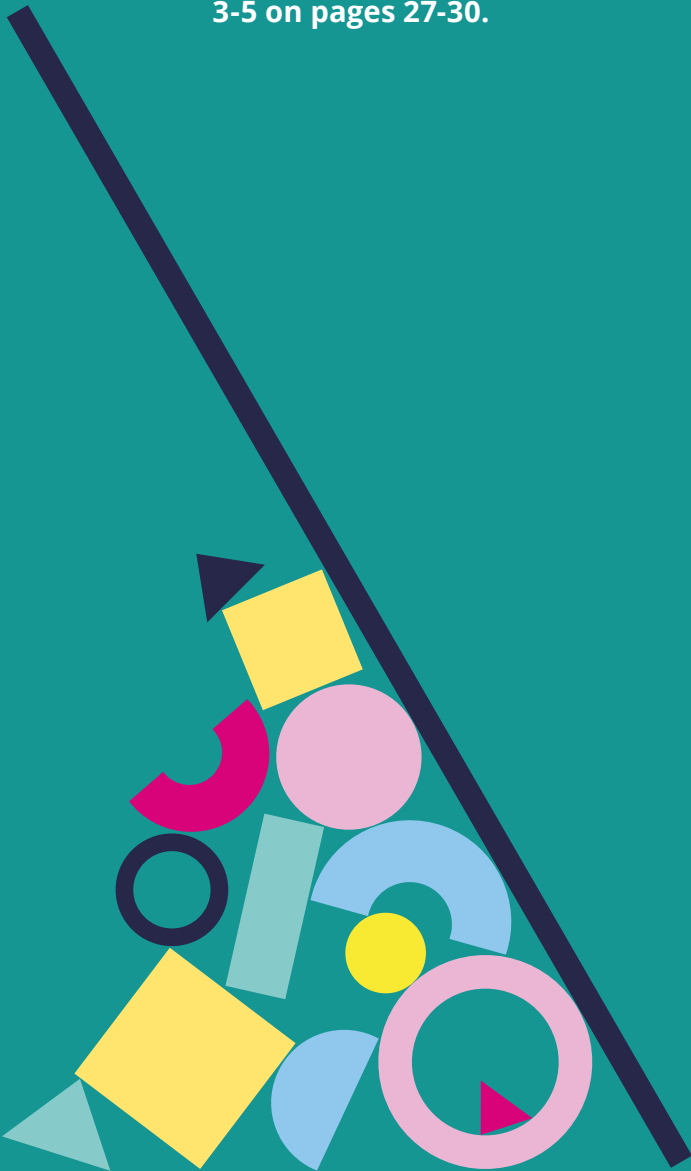
3 These figures have been rounded

Understanding the human costs of the current 'care system'

Building on an analysis of the British Cohort Study initially developed to look at experiences of homelessness up to age 30⁴, it was possible to explore a wide range of outcomes for care experienced people up to age 42 including experiences of severe and multiple disadvantage.

This analysis shows the likelihood care experienced people have of experiencing a series of outcomes. It does not show the care journeys or lives which have led up to these outcomes. Composite stories have been included to illustrate the lives in which these outcomes are lived.

Further detail on the analysis undertaken can be found in Tables 3-5 on pages 27-30.



4 Bramley, G. and Fitzpatrick, S. (2017) Homelessness in the UK: who is most at risk?, *Housing Studies*, 33(1), 96-116

Annually Scotland...



Understanding the human costs of the current 'care system'

Zahara

When Zahara was 5, her dad became unwell and she went to live with a new family. She's now 8 and lives with different family.

Zahara likes to joke this means she has 3 dads but she hasn't been able to see the first 2 since she left their homes. Zahara isn't sure why this is, or why she's different to her friends. She remembers the teddy she left when she first moved and wishes she had it now. She keeps the teddy she has now with her as much as she can in case she needs to move again.

Zahara is in Primary 4 and has lots of friends at school. She finds school work really difficult though and struggles to ask for help. The easiest days are Tuesdays and Thursdays when a teacher sits with her and helps her with her work. The rest of the time, Zahara is very quiet in class.

Zahara feels different at home. She gets upset easily and sometimes wonders why she feels so angry. Everyone tries to help her but no one seems to know how.

Care experienced children bear the lifelong cost of care and are:

almost
one and a half
times more likely
to have anxiety at 16

almost
two and a half
times more likely
to be excluded from
school up to age 16

almost
twice
as likely to moderately
use drugs at 16

almost
one and a half
times more likely to have
unauthorised absences
at school at 16



Children living in the 10% most deprived areas of Scotland are 20 times more likely to become care experienced than those in the 10% least deprived areas.

Understanding the human costs of the current 'care system'

Jack

Jack was brought up in care. He's 18 now and has recently moved into a flat that other people have called 'temporary accommodation'. He remembers the months leading up to his 18th birthday. The idea of getting his own place seemed so exciting but now it feels really hard.

Jack moved a lot throughout his childhood and went to lots of different schools. He was in Secure Care for a while. He found education difficult. It felt like he found school harder than his friends and he didn't leave with many qualifications. He's applied for a few jobs since moving but hasn't had any interviews. He has been leaving the 'references' section on his application form blank and wonders whether that's not helping. He's tried to ask for help but no one seems to be able to give it.

All of the jobs he would like to do seem to ask for more qualifications than he has. He knows the local college offer courses he could take but he's already worried about paying his bills so he needs to spend his time earning, not learning.

Care experienced adults bear the lifelong cost of care and are:

almost
twice
as likely to have
poor health

over
twice
as likely to have no
educational qualifications
and less than half the
chance of having a degree

more than
twice
as likely to
have experienced
homelessness

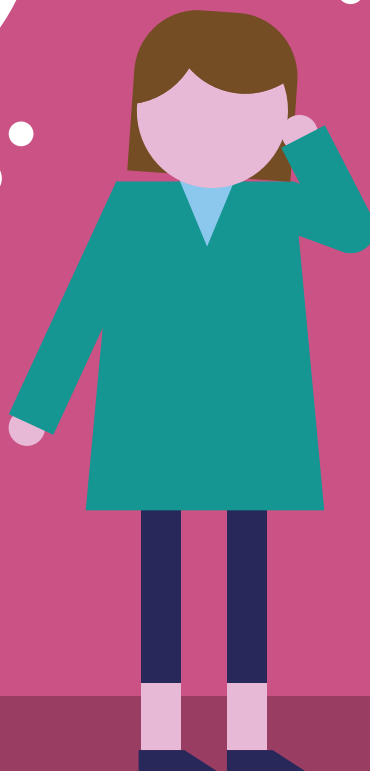
over
**one and a
half times**
more likely to have
financial difficulties

over
**one and a
half times**
more likely to
experience severe
multiple disadvantage*

almost
twice
as likely to have no
internet at home

over
**three
times**
as likely to have not
had a full time job
by age 26

on average, earn
**three
quarters**
of the salaries
of their peers



*homelessness, substance use, mental health, offending

Estimating the costs of 'system failure'

The costs of 'system failure' tend to arise from the evidenced tendency for care-experienced adults to be substantially more likely to experience a range of disadvantages and challenges, quite often in combination, which tend to require more support from services and therefore incur excess public sector expenditure.

These problems include unemployment, domestic abuse, mental and physical ill-health, offending, substance use, and homelessness, and the impacts may be seen within social security/welfare benefits, criminal justice, social work, housing and the NHS.

A series of methodologies were employed to identify the annual public spending associated with these disadvantages and challenges using the data it was possible to obtain. This included substance treatment, physical health, criminal justice, mental health hospital care, prison, rough sleeping, hostels, benefits and support services. The extent to which these costs could be attributed to the care experienced population was then estimated.

Further information on the methodology used and the analysis undertaken can be found on pages 31-38.





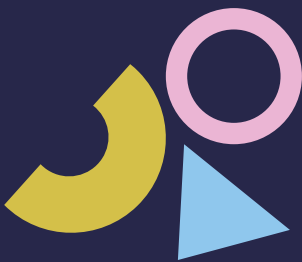
Multiple Exclusion Homelessness data (2017, repriced to 2019 public spending values to allow for inflation) analysed by spend on adults who were ever in care compared to non-care experienced peers.



The human costs of the current 'care system' applied to the costs extracted from Multiple Exclusion Homelessness 2017 data.



Application of the Economic and Social Costs of Crime data⁵ to Scotland to estimate the private costs of crime, physical and emotional harm, lost output and public service costs.



Economic cost of the failure of the care system = **£875million**

Income tax and national insurance foregone as a result of lower incomes = **£732million**

The tables on the following pages provide greater detail relating to the operational and associated cost spend by local authorities and Scotland as a whole.

5 See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732110/the-economic-and-social-costs-of-crime-horr99.pdf

Some more detail on the methodology

Table 1: Operational costs of the current 'care system'

Cost area	Budget line	Total cost (£k)	
		LAs	Scotland
Children's Panel	Support Services	31	99
	Other Expenditure	34	227
	Employee Costs	2	364
	Third Party Payments	65	243
	TOTAL	132	933
Children and Families	Support Services	11,124	40,636
	Assessment, Casework, Care Management, Occupational Therapy and Criminal Justice Field Work	57,681	252,964
	Care Homes - Other	39,925	99,033
	Secure Accommodation	1,454	10,967
	Residential Schools	30,193	118,992
	Other Accommodation-Based Services	9,003	46,290
	Adoption Services	2,820	18,036
	Fostering/Family Placement	69,468	225,417
	Other Community-Based Services	24,584	84,697
TOTAL	246,252	897,032	
Children's Hearings Scotland	Total budget (weighted by workload for local authorities)	1,037	5,036
	TOTAL	1,037	5,036
Scottish Children's Reporters Administration	Total budget (weighted by workload for local authorities)	5,333	26,950
	TOTAL	5,333	26,950
Education	Looked After Children Pupil Equity Fund	-	12,000
	TOTAL	-	12,000

Local Authorities attributable cost (£k) to the 'care system'		All Scotland attributable cost (£k) to the 'care system'		Data source	Devolved/ reserved spend	Single year/ cumulative data	Attributable cost
Min	Max	Min	Max				
31	31	99	99	Local Government Finance Returns 17/18	Devolved	Single	100%
34	34	227	227				
2	2	364	364				
65	65	243	243				
132	132	933	933				
11,124	11,124	40,636	40,636	Local Government Finance Returns 17/18	Devolved	Single	100%
57,681	57,681	252,964	252,964				
39,925	39,925	99,033	99,033				
1,454	1,454	10,967	10,967				
30,193	30,193	118,992	118,992				
9,003	9,003	46,290	46,290				
2,820	2,820	18,036	18,036				
69,468	69,468	225,417	225,417				
24,584	24,584	84,697	84,697				
246,252	246,252	897,032	897,032				
1,037	1,037	5,036	5,036	Children Hearings Scotland 19/20	Devolved	Single	100%
1,037	1,037	5,036	5,036				
5,333	5,333	26,950	26,950	Scottish Children's Reporter's Administration 18/19	Devolved	Single	100%
5,333	5,333	26,950	26,950				
-	-	12,000	12,000	Pupil Equity Funding School Allocations 19/20	Devolved	Single	100%
-	-	12,000	12,000				

Some more detail on the methodology

Table 2: Costs associated with the current 'care system'

Cost area	Budget line	Total cost (£k)		Data source
		LAs	Scotland	
Education	Care Experienced Bursary	-	6,400	Students Awards Agency Scotland Statistics 18/19
	TOTAL	-	6,400	
Pre-primary education	School Meals	1,314	2,953	Local Government Finance Returns 17/18
	Additional Support for Learning	3,520	6,504	
	TOTAL	4,834	9,457	
Primary education	School Meals	23,206	118,939	Local Government Finance Returns 17/18
	Additional Support for Learning	19,443	70,094	
	TOTAL	42,649	189,033	
Secondary education	School Meals	10,102	59,042	Local Government Finance Returns 17/18
	Additional Support for Learning	14,071	48,867	
	TOTAL	24,173	107,909	
Special education	School Meals	654	2,577	Local Government Finance Returns 17/18
	Additional Support for Learning	106,300	502,475	
	TOTAL	106,954	505,052	
Child and Adolescent Mental Health Services	Community Mental Health Teams: Children & Adolescents	-	46,513	Information Services Division data 2018/19
	Child Psychiatry	-	8,081	
	Child Health	-	1,909	
	TOTAL	-	56,503	
Pupil equity fund	Pupil Equity Fund	-	120,000	Pupil Equity Funding School Allocations 2019-2020
	TOTAL	-	120,000	

Devolved/ reserved spend	Single year/ cumulative data	Min attributable cost	Max attributable cost	Evidence in support of cost attribution	Local Authorities attributable cost (£k) to care experience		All Scotland attributable cost (£k) to care experience	
					Min	Max	Min	Max
Devolved	Single	100%	100%	N/A	-	-	6,400	6,400
					-	-	6,400	6,400
Devolved	Single	23%	23%	Combined analysis of Children in Need administrative dataset and National Pupil Database England 14/15	302	302	679	679
		18%	18%		634	634	1,171	1,171
					936	936	1,850	1,850
Devolved	Single	23%	23%	Combined analysis of Children in Need administrative dataset and National Pupil Database England 14/15	5,337	5,337	27,356	27,356
		18%	18%		3,500	3,500	12,617	12,617
					8,837	8,837	39,973	39,973
Devolved	Single	23%	23%	Combined analysis of Children in Need administrative dataset and National Pupil Database England 14/15	2,323	2,323	13,580	13,580
		18%	18%		2,533	2,533	8,796	8,796
					4,856	4,856	22,376	22,376
Devolved	Single	23%	23%	Combined analysis of Children in Need administrative dataset and National Pupil Database England 14/15	150	150	593	593
		18%	18%		19,134	19,134	90,446	90,446
					19,284	19,284	91,038	91,038
Devolved	Single	16%	16%	Adult Psychiatric Morbidity Survey England 2014	-	-	7,442	7,442
					-	-	1,293	1,293
					-	-	305	305
					-	-	9,040	9,040
Devolved	Single	23%	23%	Combined analysis of Children in Need administrative dataset and National Pupil Database England 14/15	-	-	27,600	27,600
					-	-	27,600	27,600

Some more detail on the methodology

Analysis of the British Cohort Study (1970 cohort) to understand the human costs of care

The British Cohort Study (BCS) dataset was used to contrast the 4.1% of the cohort who reported ever having any experience of the 'care system' with others in the cohort across a range of indicators of outcomes through childhood, particularly the teenage years and into adulthood, including severe and multiple disadvantage (SMD). The differences are summarized by the 'risk ratios' shown below. The variables in the first block are scores for various composite indicators, while in the second and third block individual experiences on a 1=Yes 0=No basis are flagged.

Table 3: Prevalence of childhood and teenage experiences and selected adult outcomes up to age 30 by whether ever 'in care' – 1970 Birth Cohort, Great Britain (mean scores)

Ever in Care	SMD Count v.1 age 30	SMD Count v.2 age 30	Partial ACE count (0-5)	Teenage educational difficulties	Employment/ financial difficulties in '20s	Left education @ 16
No	0.206	0.270	0.646	0.897	0.699	0.654
Yes	0.328	0.384	1.133	1.154	0.701	0.743
Total	0.211	0.274	0.666	0.907	0.699	0.657
Risk ratios	1.59	1.42	1.75	1.29	1.00	1.14

Ever in Care	Moderate drug use @ 16	'Malaise' (anxiety) score @16	Unauthorised absence before 16	Behavioural problems @ 16	Excluded from school	Moderate drug use @ 16
No	0.035	0.071	0.121	0.042	0.010	0.044
Yes	0.056	0.106	0.168	0.085	0.025	0.081
Total	0.035	0.073	0.123	0.044	0.011	0.045
Risk ratios	1.62	1.48	1.39	2.03	2.39	1.85

Ever in Care	No Educational Qualifications @ 26	Any unemployment before 26	Never had fulltime job before 26	Long term illness before 26
No	0.026	0.261	0.013	0.097
Yes	0.052	0.228	0.039	0.087
Total	0.027	0.260	0.014	0.097
Risk ratios	2.03	0.87	3.01	0.90

Regression models were also run for some composite outcomes, the SMD composite scores at age 30 are referred to here. These suggest that 'Ever in Care' does have a significant positive predictive effect but the size of this effect is not that strong, and there are other factors that also impact on someone's likelihood to experience SMD such as mixed ethnic background, having been excluded from school, no qualifications at 26, behavioural problems at 16. Below are a selection of key outcome indicators up to age 42, on the same basis.

Table 4: Prevalence of selected adult outcomes up to age 42 by whether ever 'in care' – 1970 Birth Cohort, Great Britain (mean scores)

Ever in Care	Income net annual £k @42	Financial difficulties @ 42	Degree level qualification @ 42	No home internet @ 42	Any homeless to 30	Any homeless to 42
No	50,491	0.054	0.151	0.015	0.042	0.048
Yes	36,724	0.085	0.073	0.027	0.085	0.100
Total	50,076	0.055	0.148	0.016	0.043	0.050
Risk ratio	0.73	1.57	0.48	1.77	2.04	2.06

Ever in Care	Poor Health @ 42	BMI of 30+ @ 42	Moderate depression WEMWBS @ 42	'Malaise' (anxiety) @ 42	Drinks >35 units alcohol / week @ 42	Alcohol 'Audit' score @ 42
No	0.025	0.128	0.150	0.163	0.049	0.045
Yes	0.048	0.112	0.151	0.164	0.041	0.044
Total	0.026	0.128	0.150	0.163	0.048	0.045
Risk ratio	1.88	0.87	1.01	1.01	0.85	0.97

	Income net annual £k @ 42	Financial difficulties @ 42	Degree level qualification @ 42	No home internet @ 42	Poor health @ 42	Mental ill health @ 42
Neither Care nor SMD	51,039	0.04	0.15	0.01	0.02	0.29
Not Care, in SMD	48,334	0.11	0.17	0.03	0.06	0.83
In Care, Not SMD	38,492	0.07	0.07	0.01	0.03	0.26
In Care and SMD	31,553	0.16	0.09	0.08	0.12	0.85
Total	50,076	0.06	0.15	0.02	0.03	0.38
Total care	-0.25	0.55	-0.54	0.14	0.55	-0.10
Total SMD	-0.05	1.63	0.12	1.93	2.11	1.86
Combined totals	-0.35	0.42	-0.46	1.35	1.05	0.02

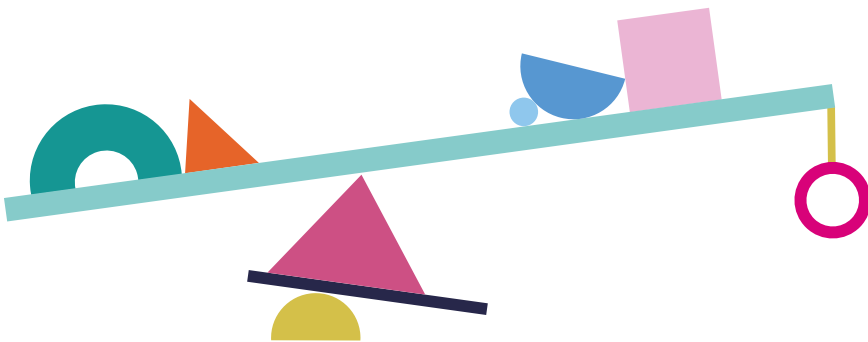
Some more detail on the methodology

This analysis shows care experienced people earn incomes which are 27% lower on average than their non-care experienced peers, have over one and a half times greater chance of experiencing financial difficulties, less than half the chance of having a degree, are nearly twice as likely to have no internet at home and have more than double the chance of experiencing homelessness, mainly before age 30.

Poor general health is markedly more apparent by age 42, although this does not manifest as above average prevalence of BMI>30, (lack of exercise, not shown), depression /anxiety, or problematic drinking at age 42.

Although it may appear somewhat dated, the BCS is in fact one of the most useful datasets for this exercise, because it enables people with an identified care background to be followed through the first half of their adult life, when the risks of adverse outcomes are likely to manifest themselves. Of particular interest was vulnerability to SMD, a proxy for complex needs which are likely to be particularly costly, for people personally and for the public services. It is also of value that the flagging of care experience appears to be at a realistic level of prevalence.

The definition of SMD it is possible to achieve using the BCS is reasonable as there is quite good coverage of homelessness, substance misuse (particularly alcohol), and mental health. Offending is limited to one indicator from the teenage years plus an indirect indicator from the 20s, which is less than ideal, and there is no useful explicit indicator of domestic violence and abuse. For this exercise a slightly modified measure was used which takes account of indicators from different waves up to the age of 42, using six indicators with relatively moderate thresholds to err on the side of inclusivity⁶.



⁶ Moderate drug use to age 30, heavy alcohol use to age 42, homelessness to 42, convicted or cautioned to 16, accident or assault to 26, and mental health to 42 (common mental health conditions indicated, based on WEMWbS and Malaise scores); two or more of these counted as SMD.

Of the 4.1% of cohort members with care experience, 0.9% are SMD on this indicator, leaving 3.3% who are care-experienced but not SMD; while 16.4% are SMD (on this fairly inclusive basis, closer to the 'Ever 5D version used in Hard Edges Scotland) but without care experience, and 79.5% with neither flag.

Table 5: Analysis of outcomes in BCS to age 42 by four-way Care-SMD classification

	SMD Score	Partial ACE count	Teenage educational difficulties	Employment/ financial difficulties in 20s
Neither Care nor SMD	0.46	0.60	0.87	0.62
Not Care, in SMD	2.28	0.77	1.02	1.06
In Care, Not SMD	0.43	1.06	1.11	0.58
In Care and SMD	2.34	1.26	1.31	1.16
Total	0.77	0.65	0.91	0.70
Total care		0.77	0.28	-0.07
Total SMD		0.29	0.17	0.70
Combined totals		0.62	0.28	0.09

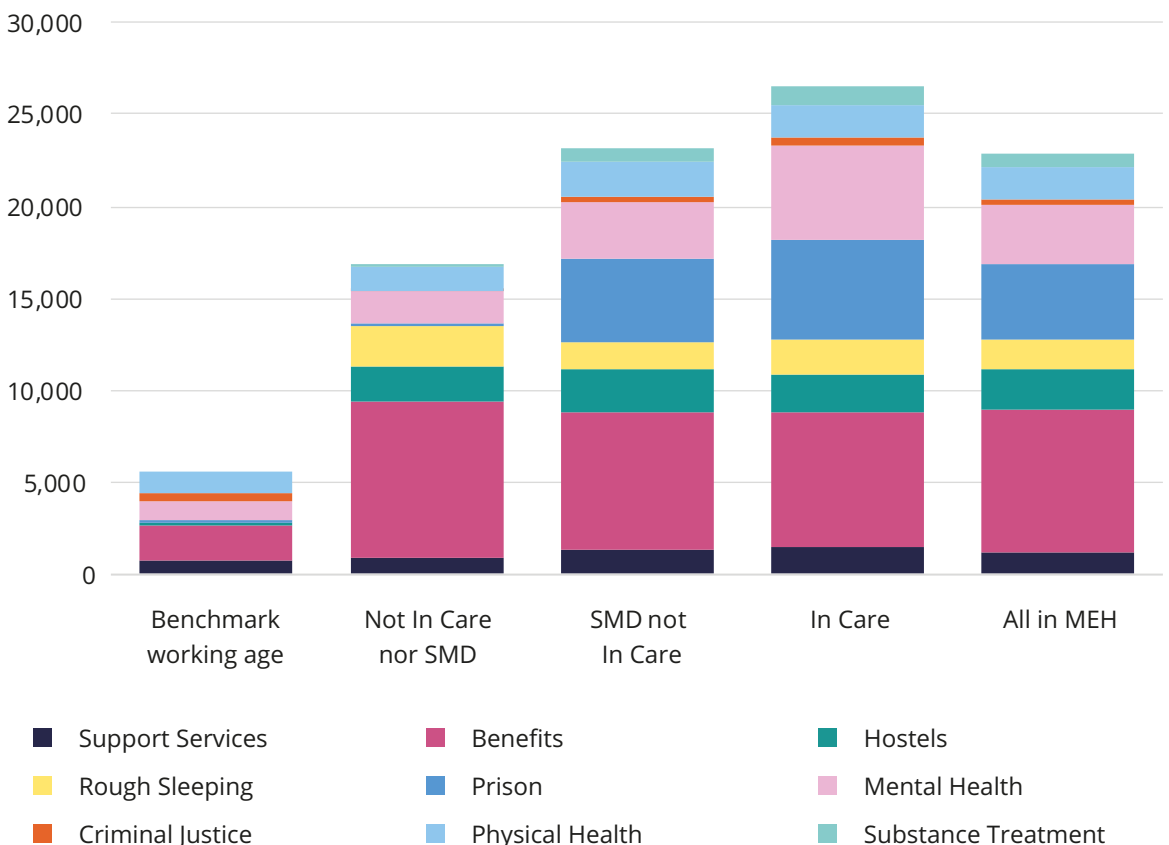
	Left school @ 16	No Educational Qualifications @ 26	Any unemployment before 26	Never had full time job before 26	Long Term Illness before 26
Neither Care nor SMD	0.66	0.02	0.23	0.01	0.08
Not Care, in SMD	0.62	0.04	0.40	0.02	0.16
In Care, Not SMD	0.77	0.05	0.19	0.03	0.07
In Care and SMD	0.65	0.07	0.36	0.06	0.14
Total	0.66	0.03	0.26	0.01	0.10
Total care	0.16	1.12	-0.17	1.69	-0.13
Total SMD	-0.06	0.87	0.70	0.20	0.84
Combined totals	0.05	0.67	-0.10	2.88	-0.11

This analysis shows there are systematic relationships in most cases, whereby adverse outcomes are more likely when people have had care experience, or where they are experiencing SMD, or both. In some cases the effect of care is greater than SMD, in other cases the impact of SMD seems to be greater. In most instances there is an additional total effect from having both care experience and SMD. These totals are shown at the bottom – the proportional addition to the risk of that outcome associated with care, SMD or both.

Some more detail on the methodology

The analysis provides another route to estimating the 'cost of failure', insofar as particular outcomes can be taken to be associated with greater demand on particular services. So for example, unemployment (any, or longer term) and long term illness are proxies for high use of welfare benefits; poor health is a reasonable proxy for higher use of general health services, while mental ill-health implies higher use of mental health services; greater financial difficulties (e.g. debt arrears) and lack of home internet may be proxies for more intensive use of local services. Although the BCS is used as the most convenient and robust source of evidence on adult outcomes associated with care experience, evidence was also derived from several other sources, particularly the combination of the British Household Panel Survey (BHPS) with UK Household Longitudinal Study (UKHLS), the main annual longitudinal panel surveys for the UK, and also the Adult Psychiatric Morbidity Survey (APMS, for England only). These sources showed a similar pattern of outcomes associated with care experience and provide supporting evidence for the general approach followed here. Also, the income data in Table 4 can be used to estimate the loss of tax and national insurance contributions from adults whose earning capacity falls well below the average, which is clearly the case for those with a care background (for reasons which have emerged earlier).

Analysis of the Multiple Exclusion Homelessness (MEH) data (2017)



Whereas the average person of working age incurs costs for this range of public services amounting to £5,500, adults using low threshold homelessness services incur costs averaging much more than this. Those using such services and with experience of the 'care system' cost around £27,000, which is nearly five times the costs an average person of working age incurs. As can be seen above, the group with a care background cost noticeably more (£4,300 more) than other adults experiencing SMD (those with two or more disadvantages, on a core '3D' definition), who in turn cost considerably more (£6,000 more) than adults who have experienced only one of the three key disadvantage domain; they in turn cost £11,300 more than the average working adult.

It is important to understand that the population from which the MEH data was sampled was towards the more extreme end of the spectrum, and so these costs are likely to be higher than those associated with the former care population as a whole.

It is also vital to appreciate that the higher costs, while indicative of a relatively more severe situation of adult disadvantage, may or may not be attributable to the effects of the care experience, but may rather reflect other factors which are to some degree correlated with it.

Sources of Information on Unit Costs used in the MEH analysis

The most comprehensive and useful source of information in unit costs was the spreadsheet-based *Unit Cost Database (v1.3)* produced by *New Economy* in Manchester⁷. This cost database was developed with support from Department of Communities and Local Government (DCLG) in conjunction with six local authorities or groups of authorities, and it was made available via the Local Government Association (LGA) website.

The next most useful single source was Curtis, L. (2013) *Unit Costs of Health and Social Care 2012*⁸. This compiled very comprehensive estimates of unit cost for the whole range of health and social care activities. This publication is regularly updated.

Brookes et al (2013)⁹ was a similar if shorter volume dealing with Criminal Justice costs. Most useful was Appendix 5 which provided summary costs per year for prisons by type of prisoner and overall averages, distinguishing costs of prison establishment itself and enhanced cost including all overheads. Rates of prevalence for in-patient hospital episodes and A&E were taken from HESOnline (2013)¹⁰ in conjunction with population by age data for England.

7 See <http://www.neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis>

8 See <https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2018/>

9 See <https://www.pssru.ac.uk/publications/pub-4459/>

10 See <https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics>

Some more detail on the methodology

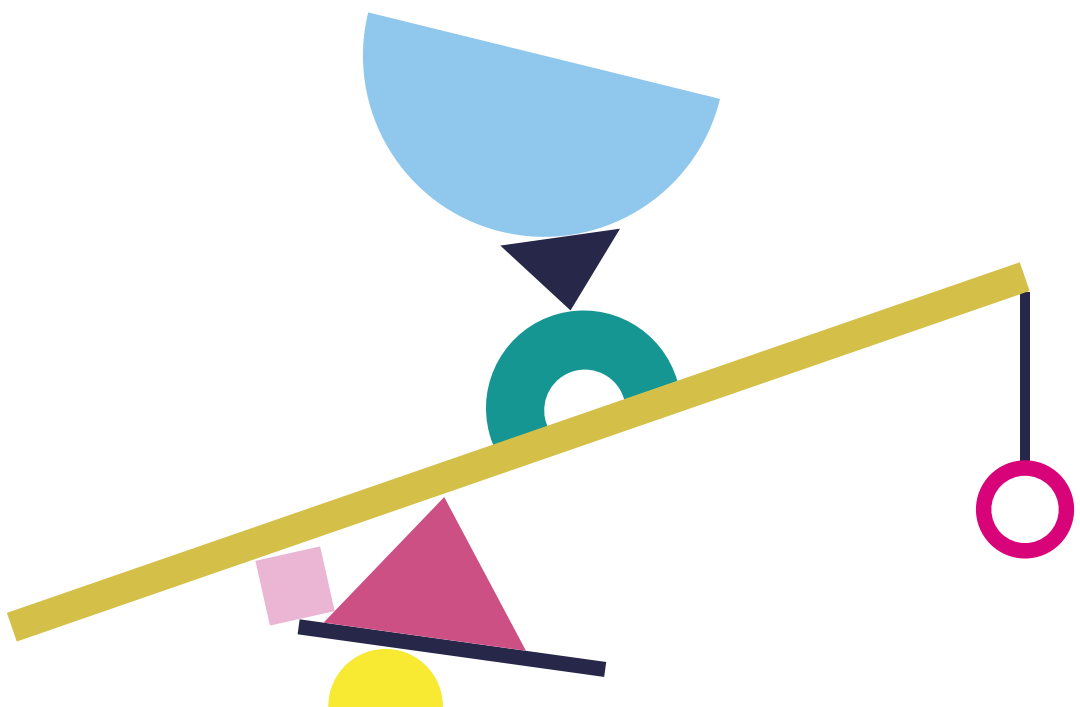
Cost Elements of the MEH analysis

The initial estimates were built up from the following elements.

- Cost of services used, proxied by whether respondents have seen any of the following types of worker in the last month: employment service; housing/floating support; street outreach; social worker; drug worker; alcohol worker; Community Psychiatric Nurse or other psychologist/psychiatric worker; GP; probation; other. It was assumed that these monthly rates apply over the total time period spent sleeping rough or in hostels, plus 20% of their remaining time excluding prison, mental health hospital or armed forces. The unit cost per contact-month are varied somewhat by type of worker in the range £60-220, and a London cost mark-up of 20% is applied.
- Cost of benefits received, comprising composite Employment Support Allowance/Job Seeker's Allowance daily rate times the number of days sleeping rough, in hostels or in mental hospitals, plus 70% of remainder days for those who said they have lived on benefits for most of their adult life. Cost of Housing Benefit is calculated from national average daily amount (with a London mark-up of 45%) times the same totals excluding rough sleeping.
- Cost of hostels, in terms of subsidy over and above the Housing Benefit amounts, based on £16 per day (with 20% London mark-up) times total hostel days.
- Rough sleeping uses an estimate equivalent to £23 /day for local authority costs incurred in respect of rough sleepers.
- Cost of imprisonment, based on national average cost per prisoner (£110 per day) times total days in prison (with London mark-up of 20%).
- Cost of mental health inpatient time, based on national average cost per day for acute mental inpatient treatment (£445) times total days in mental hospital (with London mark-up of 20%).
- Cost of offending to police and criminal justice system, estimated from various sources at around £700 per typical 6-month jail term times equivalent number of such terms from total time in prison (with 20% London mark-up). Additional allowance for probation costs for ongoing supervision of offenders based on £400 per year.

- Health service (hospital and A&E/ambulance) costs in respect of physical health problems, based on national average episodes per head by age group, weighted by whether subject reports serious physical health problems or not (based on three general and 12 specific indicators). These costs were assumed to apply over the whole SMD career duration from first serious experience to date. The weightings were half the national average for those not reporting serious physical health problems and three times for those who did report these. The composite unit cost were £360 for A&E attendance including ambulance and £1779 for inpatient episodes (the London mark-up of 20% was applied).
- Cost of substance (drug) treatment course (£2,664), for those who appear to have been active recipients of treatment currently/recently, with full cost of a course of treatment adjusted to allow for some dropout.

It should also be noted that there are a high number of assumptions within these estimates and a number of items were not explicitly and separately measured (prescribing costs, disability-related benefits (Disability Living Allowance/Personal Independence Payment, training/work programmes).



Some more detail on the methodology

Applying the human costs of 'system failure' to the costs extracted from Multiple Exclusion Homelessness 2017 data

The evidence on differential adult outcomes for those with care experience, with or without SMD, was then used to modify and develop slightly further the original analysis based on Hard Edges and the MEH survey. This approach enables a reasonable if conservative estimate of 'the cost of failure'. In this, two groups are focused on: those who are care experienced and are now currently experiencing SMD (taking the '5D' definition), and those who are care experienced and suffer some lesser (single) deprivations and more general socio-economic disadvantages which make for increased costs. None of the costs of the SMD adult population who did not actually experience care are counted. BCS-based estimates of the service use/cost markup are used in certain cases where this seems appropriate, and potentially more appropriate than the MEH estimate (e.g. physical and mental health, use of local services such as advice, assistance, social work), and welfare benefits. Some of these estimates may be relatively high compared with certain other sources.

Table 6: Estimate of 'Cost of Failure' based on MEH Survey, adjusted to reflect evidence from BCS, applied to SMD populations assessed in Hard Edges Scotland.

Service Category	Benchmark per working age (£ p a)	In care not SMD (£m)	In Care and SMD (£m)	SMD not In Care (£m)	Total Excess Cost Care (£m)
Support Services	754	118.0	70.6	128.9	
Benefits	1,855	318.0	149.8	460.5	
Hostels	227	3.9	42.0	139.2	
Rough Sleeping	15	4.9	38.1	96.2	
Prison	95		46.5	115.7	
Mental Health	180		17.6	31.2	
Criminal Justice	436		6.9	17.5	
Physical Health	1,080	199.9	90.2	198.0	
Substance Treatment	22		21.6	49.5	
Cost /year	4,663	644.8	483.4	1236.6	
Excess Cost		264.8	388.4	951.7	
Add - lost tax & NI		537.1	195.3	68.9	1385.7

It can be seen that the big ticket items are benefits and physical health treatment/services. Local support services taken together are moderately important, and there are smaller but still significant amounts for homelessness related services, prisons and mental health (less than there should be, given underprovision in this sector).

The estimates for 'criminal justice' (other than prisons) also seem low. So the 'excess costs' per year for the care experienced group of adults (of working age) amounts to (£265m+£388m=) £653m (column 2 plus column 3 total extra costs). There is a similarly large number for the income tax and national insurance contributions not collected from care experienced adults because of their low earnings/incomes, which reflect their poor employment histories and prospects in terms of both actual employment and skill/pay level, as reflected in evidence on the educational attainment and post-school destinations of care leavers. These amount to (£537m+£195m=) £732m¹¹.



11 Some of income tax and all of NI contributions currently accrue to UK exchequer, not Scotland's devolved tax administration.

Some more detail on the methodology

Application of the Economic and Social Costs of Crime data to Scotland

In the Economic and Social Costs of Crime¹² analysis which covers England and Wales and is heavily based on the Crime Survey for England and Wales, an analysis is conducted broken down by 21 categories of crime (4 of serious violent personal crimes, 10 of less serious personal crimes, and 7 of commercial crimes). For each of these categories a typical average unit cost is determined, comprised of nine distinct elements which may be grouped as follows:

● Private Costs

- Defensive expenditure (e.g. security measures)
- Insurance administration
- Value of property stolen or damaged

● Physical & emotional (psychological) harm

● Lost output

● Public service costs

- Health services (NHS)
- Victim support
- Police costs¹³
- Criminal justice costs (courts, legal, prisons, supervision)

By multiplying the number of crimes in each type by the average unit cost for each element, total costs under each of these headings can be estimated. The four main headings are of most interest. The valuation of physical and emotional harm is based on the well-established framework in health economics which seeks to bring as many different kinds of health disadvantages into the common framework of QALYs (Quality-Adjusted Life Years). These valuations are generally estimated in terms of proportional shortfalls (based on a lot of survey research) from the notion of a good, healthy life, times the length of time they are experienced, times the standard value of 100% QALY (£70,000).

Lost output is generally valued based on estimates of amounts of time lost from work valued at the average gross wage/salary. Health costs reflect the type of injury and associated treatments. Police costs are based on Activity Based Costing models used within the service.

12 Heeks, M., Reed, S., Tafhiri, M. and Prince, S. (2018) The economic and social costs of crime. 2nd edition. Research Report 99. London: Home Office. ISBN: 978-1-78655-694-3

13 It is important to note general police costs extend much more widely than crime which constitutes only a proportion of the spend on this service. Within this analysis, only the police costs which relate to crime are used as per the original analysis in Heeks et al, 2018.

Table 7: Cost of Crime in Scotland by Type of Cost, and implied Cost of Crime associated with adults with a care background in Scotland

	Total Economic Value	Private	Psycho-social	Economy	Public Expenditure
Combined Total Crime England & Wales¹⁴ £M	49,687.3	7,945.7	22,045.7	5,833.5	13,862.4
England & Wales Population 2016	58,405,047				
Scotland Population 2016	5,411,821				
Ratio	0.0927				
Crime Level Difference Stated	0.855				
Grand Total Crimes Scotland	3,936.4	629.5	1,746.6	462.2	1,098.2
Share Attributable For Ex-Care Population @ 25%	984.1	157.4	436.6	115.5	274.6

The above shows how the total economic and social cost of crime is distributed across the four main types of cost, and then how this is used in a broad brush way to estimate equivalent figures for Scotland.

A similar broader cost analysis conducted by Rhys et al (2019) in relation to domestic violence and abuse¹⁵ was also reviewed. Without going into the detailed evidence and issues raised by this study, a key piece of evidence from the APMS was taken, that probability of experiencing violent abuse as an adult is 2.4 times higher for those who are care-experienced. That provides a simple way of estimating a cost for this impact. The annual social and economic cost of violent abuse suffered by adults who were formerly in care in Scotland would be $0.04 \times (2.4-1) \times 0.13 \times 4,563,343 \times £34,015 = £1.12$ bn. [where 0.04 is the estimated share of adult population in Scotland with care experience; (2.4-1) is the extra proportionate cost; 4.556m is the adult population, and £34,015 is the annual unit cost from Rhys et al, 2019].

Only about £61m of this would be public spending costs. It is not quite clear how far this figure overlaps with the cost of crime discussed above (probably some but not necessarily all).

14 Figures for England based on data in Heeks et al, 2018. Population estimates are from author's sub regional housing market model but based on Mid-Year Estimates. The difference in general crime level between Scotland and England & Wales is based on statement in Scottish Government's Main Findings report on Scottish Crime and Justice Survey 2014/15, p.24.

15 Rhys, O., Barnaby, A., Roe, S. & Wlasny, M. (2019) The economic and social costs of domestic abuse. Research Report 107. London: Home Office. ISBN: 978-1-78655-767-4. www.gov.uk/government/publications

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