



# **A Review Of Systemic Failings In UK Adoption**

## **Harm Seen**

### **Executive Summary**

This system review identifies extensive structural, operational, and cultural failings across the United Kingdom’s adoption landscape. Evidence drawn from trauma science, neuroscience, lived experience, and the PATCH community demonstrates that current practice does not reflect the realities of the children it is intended to safeguard. As the document states, children within adoption “carrying the cumulative effects of harm, abuse, rupture, memory, prenatal exposure, sensory and neurological injury,” yet the system continues to operate on the assumption that permanence alone is sufficient to secure stability and recovery.

The review highlights a pattern of predictable failings across all stages of the adoption journey. These include the persistent misinterpretation of trauma symptoms, the absence of comprehensive multidisciplinary assessment, and the failure to recognise internal injury as a lifelong factor shaping development, regulation, and relational functioning. Critical elements of a trauma-responsive, recovery-focused approach—such as early identification, whole-child assessment, and long-term planning—are largely absent.

A theme emerging from the evidence is the prevalence of parental blame. Families consistently report that trauma symptoms—often communicated through complex, dysregulated, and difficult-to-manage behaviours—are attributed to parenting rather than to the child’s history of adversity. This culture of blame is not an isolated issue; it is embedded across social care, education, health, and safeguarding. Parents who request support are frequently met with suspicion, punitive responses, or system-generated trauma. As the review notes, families experience “delayed intervention, inaccurate assessments, insufficient transparency, and a pervasive culture of blame,” conditions that undermine trust and destabilise placements. The extent of these experiences is wholly unethical, and in many cases so severe that they are difficult to comprehend within a system tasked with protecting children and supporting families.

However, parental blame is only one dimension of a wider systemic pattern. The review identifies significant failings in sibling assessment, educational provision, neuro-developmental pathways, safeguarding practice, allegation handling, matching processes, and post-adoption support. These failings are interconnected and cumulative. They reflect a system that does not adequately recognise trauma, does not consistently respond to complexity, and does not provide the recovery-focused support required to meet children’s needs over time.

The absence of national clinical structures, the lack of mandatory multidisciplinary assessment prior to final orders, and the failure to capture national data on disruptions and outcomes further compound these issues. Without a coherent trauma-responsive framework, families are left to manage internal injuries without treatment, resulting in avoidable crises, placement instability, and re-entry into care.

This review sets out the evidence with clarity and precision. The current adoption system is not trauma-responsive, not recovery-focused, and not aligned with contemporary bio-psycho-social science and research on childhood adversity, neurodevelopment, and relational trauma. A credible system review requires honesty: the sector must first acknowledge the harm already caused. Only then can adoption be re-designed around science, humanity, and the lived realities of children and families.

## **Purpose and Audience**

This paper sets out a clear, evidence-informed analysis of systemic failings across the United Kingdom's adoption landscape, alongside a framework for change grounded in trauma science, neuroscience, and lived experience.

Its purpose is twofold. First, to provide an accurate and unambiguous account of how current systems are not meeting the needs of children who have experienced early adversity. Second, to establish a foundation for reform that aligns policy, practice, and provision with contemporary understanding of trauma, brain injury, neurodevelopment, and recovery.

This document is intended for policymakers, legislators, senior leaders across children's services, health and education professionals, the judiciary, and adoption and safeguarding agencies. It is also relevant to practitioners working directly with children and families, as well as organisations responsible for commissioning, inspection, and regulation.

The paper assumes a shared responsibility across systems. The issues outlined are not confined to a single service or profession; they reflect interconnected structural, cultural, and operational failings that require coordinated, system-wide response.

## **Introduction**

*\*Please note — Throughout this review, the term “trauma” is used in its broad, contemporary sense to describe the full spectrum of developmental injury experienced by children entering adoption. This includes early adversity, prenatal exposure, neuro-developmental and sensory injury, relational harm, epigenetic and transgenerational effects, chemical teratogenicity, and the cumulative impact of what children have lived through, witnessed, or adapted to survive. Chemical teratogenicity refers to the impact of harmful substances—including alcohol, drugs, and other toxic exposures—on the developing foetus, resulting in permanent alterations to brain structure, function, and development. Critically, this definition explicitly includes Foetal Alcohol Spectrum Disorder (FASD), which is recognised here as a form of traumatic brain injury — a permanent, organically acquired neurological condition resulting from prenatal alcohol exposure that fundamentally alters brain structure, function, and development. FASD is not a behavioural choice or a parenting failure; it is a brain injury, and it demands the same recognition, accommodation, and specialist understanding as any other form of acquired neurological trauma. Each of these elements is distinct, significant, and interdependent. None can be minimised or treated in isolation. The HARM → SEEN*

*framework therefore reflects the whole child, the world around the child, and the child's journey – recognising that every aspect of their experience, including the neurological landscape they were born into, shapes development, regulation, and recovery\*.*

Adoption is widely presented as a route to stability, belonging, and permanence. However, for children who have experienced adversity, permanence marks the beginning of their recovery, not the conclusion of their journey. Current adoption practice across the United Kingdom does not reflect this reality. Instead, it is shaped by outdated assumptions, fragmented assessment, and a limited understanding of trauma, neurodevelopment, and the lifelong impact of early adversity.

Trauma is not an event but an internal injury—held in the body, brain, nervous system, emotions, sensory systems, and relational patterns. Children removed from harm carry an “invisible backpack” of experiences that shape development, behaviour, regulation, and perception. As the wider review notes, children enter permanence “carrying the cumulative effects of harm, abuse, rupture, memory, prenatal exposure, sensory and neurological injury,” yet the system continues to operate as though permanence alone is sufficient to secure stability and recovery.

Lived experience accounts consistently describe a system that misinterprets trauma symptoms, overlooks neuro-developmental complexity, and fails to recognise internal injury as a lifelong factor. Families report requesting support that is not provided, agreeing to plans that are never implemented, and encountering professional responses that minimise trauma or misinterpret need. In many cases, escalating distress is treated as evidence of parental inadequacy rather than as an indication of unmet need. This contributes to a pervasive culture of blame that is both unethical and destabilising, and in some cases so severe that it is difficult to reconcile with a system tasked with safeguarding children.

These experiences do not occur in isolation. They reflect wider structural and cultural failings across social care, education, health, safeguarding, and post-adoption support. The absence of comprehensive multidisciplinary assessment, the lack of national clinical structures, and the failure to embed trauma-responsive, recovery-focused practice leave families managing internal injuries without treatment. This results in avoidable crises, placement instability, and, in some cases, re-entry into care.

This review brings together evidence from trauma science, neuroscience, bio-psycho-social research, and the lived realities of families to provide a clear, precise analysis of systemic failings. It sets out the structural issues that must be acknowledged to ensure that adoption practice is grounded in science, humanity, and the genuine needs of children and families.

## **The HARM → SEEN Framework**

This paper is underpinned by the HARM → SEEN framework, which provides a conceptual model for understanding both the internal impact of early adversity and the necessary conditions for effective, trauma-responsive practice.

### **HARM: Internalised Impact of Early Adversity**

HARM represents the cumulative and interacting effects of early life experiences:

- **Hurt** – disruption to development beginning in the prenatal period and continuing through early life.
- **Abuse** – experiences of fear, overwhelm, and threat that shape emotional and neurological responses.
- **Rupture** – breakdowns in attachment, trust, safety, and belonging.
- **Memory** – the encoding of trauma within the body, brain, nervous system, and relational patterns.

These are not discrete events but interconnected processes that shape how a child develops, perceives the world, and relates to others over time.

### **SEEN: A Trauma-Responsive Framework for Practice**

SEEN represents the shift required across systems to respond effectively to children's needs:

- **See the Child** – recognising the full context of the child, including in-utero experience, bio-signalling, transgenerational harm, genetics, and adversity.
- **Explore Environment** – understanding the child within their relational, social, and historical context.
- **Examine Impact** – recognising how trauma affects the body, brain, nervous system, emotions, and relationships.
- **Notice Needs** – identifying and responding to need through timely, appropriate, and sustained support.

This framework moves practice away from behaviour-based interpretation and towards a holistic, biopsychosocial understanding of the child. It emphasises that without seeing the full picture, responses will remain partial, and harm will continue to be misunderstood.

The **HARM** → **SEEN** model provides a foundation for the analysis that follows and for the structural changes required across the system.

## **2. Systemic Failings in Adoption**

The following section outlines the full set of structural, operational, and cultural failings identified across the adoption landscape. Each point includes a clear narrative explanation to ensure the issues are explicit, unambiguous, and grounded in trauma science, lived experience, and professional evidence.

### **2.1 Child-Focused Failings**

#### **a. Need for a Transgenerational Perspective in Permanence Planning**

It is essential that permanence planning adopts a transgenerational perspective, recognising the full context in which children enter care: removal from birth families, exposure to

adversity, and the cumulative biological, psychological and social impacts across generations. Without this lens, assessments and interventions risk addressing surface-level behaviours rather than underlying developmental and neurological need.

**b. Failure to Recognise Trauma, Harm and Internal Injury**

Behaviours linked to early adversity are frequently interpreted as defiance, attachment difficulty or parenting challenge, rather than as indicators of underlying neurological and emotional impact. This can lead to misunderstanding and inappropriate responses at critical points. Where internal injury is not recognised, care planning remains limited, contributing to ongoing distress and instability.

**c. Insufficient Recognition of Prenatal and Early Neurological Factors**

Prenatal exposure (including alcohol and substances), early stress, prematurity and medical complications are not consistently integrated into assessment. This can result in unrealistic expectations of development and regulation, leaving families without appropriate guidance. Lack of early identification increases the risk of misinterpretation and delayed support.

**d. Limited Consideration of Intergenerational and Biological Impact**

Assessments do not routinely reflect evidence on the biological effects of adversity across generations, including impacts on stress regulation and development. Without this, understanding of need remains partial, and planning does not fully address the depth or persistence of difficulties.

**e. Behaviour Interpreted Through a Neurotypical Lens**

Adaptive responses such as hypervigilance, shutdown or emotional overwhelm are often viewed as behavioural problems rather than context-driven adaptations. This can lead to responses that do not align with underlying need and may increase distress.

**f. Misunderstanding of Masking and Contextual Presentation**

Reliance on presentation in structured settings can lead to underestimation of need, particularly where children mask difficulties. Differences between home and external environments are not always fully explored, resulting in incomplete assessment and reduced confidence in parental reporting.

**g. Absence of Whole-Child Assessment Frameworks**

There is no consistent requirement for comprehensive assessment across developmental history, neurodevelopment, sensory processing, relational context and the impact of early adversity. As a result, understanding is often fragmented, limiting the effectiveness of planning and intervention.

**h. Limited Focus on Recovery-Oriented Care Planning**

Care planning does not consistently include structured, long-term approaches to recovery. Permanence is often treated as an endpoint rather than the beginning of ongoing support, leaving needs insufficiently addressed over time.

**i. Insufficient Attention to Identity, Culture and Belonging**

Consideration of identity, culture and belonging is not consistently embedded within planning and support. This can affect longer-term wellbeing and sense of self, particularly as children develop.

## 2.2 Parent-Focused Failings

### a. Prevalence of a blame-oriented culture

Parents are frequently held responsible for trauma-driven behaviours arising from harm, neurological injury, or prenatal exposure. This undermines trust and prevents effective partnership working. Blame replaces curiosity, leading to inaccurate assessments and harmful interventions. Families become isolated and fearful of seeking help.

### b. Lack of empathy, compassion, and relational practice

Families report interactions characterised by judgement, dismissal, and a lack of understanding of trauma's impact on family functioning. This erodes trust and discourages engagement with services. Compassion is essential for effective intervention, yet it is often absent. Without relational practice, families feel scrutinised rather than supported.

### c. Systems-generated trauma

Professional responses often exacerbate parental distress, creating fear, shame, and re-traumatisation. This includes punitive safeguarding responses when families request help. Systems-generated trauma compounds the original trauma experienced by the child. It also undermines the stability and well-being of the entire family.

### d. Insufficient practical support

Respite, crisis intervention, and hands-on assistance are rarely provided, leaving families to manage complex needs without adequate support. This results in exhaustion, burnout, and escalating crises. Practical support is essential for maintaining placement stability. Its absence is a significant systemic failing.

### e. Neglect of parental mental health

Secondary trauma, burnout, and emotional exhaustion are not recognised or supported, despite being predictable outcomes of caring for traumatised children. Parents often experience isolation and despair without access to therapeutic support. This undermines their ability to provide stable care.

### f. Detrimental impact on family stability

Families experience significant disruption to employment, health, relationships, and financial security due to a lack of support and escalating crises. This creates long-term instability that affects all family members. Without intervention, families may reach breaking point. The system fails to recognise the cumulative impact of unsupported trauma.

### g. Adopters functioning as an unrecognised therapeutic workforce

Parents are expected to provide specialist therapeutic care without training, support, or acknowledgement. This constitutes a hidden, unsupported workforce. The emotional and practical demands placed on adopters far exceed those of typical parenting. Without recognition, families are left vulnerable and overwhelmed.

## **h. Physical health consequences arising from chronic stress**

The sustained pressure of caring for traumatised children without adequate support can lead to significant physical health consequences, including stress-related illness, chronic pain, and deterioration in overall wellbeing. These impacts are rarely acknowledged in assessment or planning, despite being predictable outcomes of prolonged, unsupported caregiving. Failure to recognise the physical toll on parents undermines stability and increases the risk of crisis.

### **2.3 Sibling-Related Failings**

#### **a. Presumption that siblings must remain together**

Sibling placements are often prioritised without adequate assessment of trauma bonds, individual needs, or safety. This can result in unsafe or destabilising placements. Trauma bonds are frequently mistaken for healthy attachment. Decisions must be based on individual needs, not assumptions.

#### **b. Minimisation of sibling-on-sibling harm**

Harm between siblings is frequently dismissed as “normal sibling rivalry,” resulting in unsafe situations and unaddressed trauma. This minimisation places children at risk of further harm. Sibling violence must be recognised as a safeguarding issue. Failure to act perpetuates trauma.

#### **c. Lack of individualised assessment**

Sibling groups are treated as a single unit, leading to inappropriate placements and unmet needs. Each child requires a distinct assessment of trauma, development, and relational needs. Without individualised assessment, because each child is an individual with individual needs, placements are based on convenience rather than best interest. This undermines long-term stability.

### **2.4 Education Failings**

#### **a. Insufficient trauma-responsive practice in schools**

Schools often use punitive behaviour management strategies that escalate distress rather than support regulation. Trauma-responsive approaches are not consistently implemented. This results in exclusion, shame, and emotional harm. Education settings must recognise trauma as a core factor in behaviour.

#### **b. Disproportionate exclusions and inadequate SEN provision**

Adopted children are over-represented in exclusion statistics and frequently lack appropriate educational support. SEN systems are often slow, inconsistent, or inaccessible. Looked-after and previously Looked After children with extra SEN and emotional needs are often put in small working groups with children with “behavioural” needs. This leads to

academic underachievement and emotional distress. Early identification and appropriate support are essential.

**c. Misinterpretation of masking**

Schools frequently dismiss parental concerns because the child appears regulated in the classroom. Masking is a common trauma response, yet it is rarely understood. This leads to inaccurate assessments and inadequate support. Children suffer in silence while parents are disbelieved.

**d. Lack of personalised learning plans and educational review mechanisms for adopted children**

Educational needs are not consistently assessed, monitored, or reviewed. Generic provision fails to address trauma-related barriers to learning. There is no automatic entitlement to a Personal Education Plan (PEP) for adopted children, and Virtual Schools are not consistently trained in the specific needs of adopted children. Adopted children consequently fall between systems, with no specialist educational oversight after leaving care. Without personalised planning, children experience avoidable distress and academic difficulties. This contributes to school breakdowns and escalating behaviours.

## **2.5 Health Failings**

**a. Limited access to trauma-competent mental health pathways**

Children often wait months or years for mental health support, despite presenting with complex trauma symptoms. CAMHS services frequently lack trauma expertise. This results in misdiagnosis, inappropriate interventions and often early dismissal. Early access to trauma-competent care is essential for recovery.

**b. Absence of FASD-competent assessment**

FASD remains widely misunderstood and underdiagnosed. Children with prenatal exposure are often mislabelled as defiant or oppositional. Without an accurate diagnosis, families cannot access appropriate support. This omission leads to long-term harm and avoidable crises.

**c. Misdiagnosis or Dismissal of Neuro-developmental Needs, Attachment Disorders, or Complex Trauma**

Children with histories of trauma frequently exhibit neuro-developmental symptoms that may overlap. These presentations are often incorrectly attributed to behavioural concerns or attachment challenges. Such misdiagnoses can delay appropriate interventions and increase psychological distress. Implementing a multidisciplinary assessment is crucial for accurate identification and effective support.

**d. Lack of multidisciplinary assessment at placement**

Children are placed without a comprehensive assessment of trauma, neurodevelopment, sensory needs, or health concerns. This results in incomplete understanding and inadequate

planning. Multidisciplinary assessment should be standard practice. Its absence is a significant systemic failing. Every child in permanence should receive an Impact Pathway before any final orders are made, to be completed by trauma trained professionals considering the whole of the child, the world of the child and the journey of the child, rather than needs identified reactively often in crisis rather than at the point where early intervention would be most effective.

**e. Neuro-developmental Presentation in Adopted Children and Gaps in Support**

A significant proportion of adopted children present with traits associated with neuro-developmental conditions, including autism. However, these presentations frequently overlap with the effects of early adversity, disrupted attachment and complex trauma, resulting in layered and sometimes ambiguous profiles.

There is a risk that diagnoses such as autism or ADHD are applied without sufficient consideration of co-occurring or alternative explanations, including trauma-related responses. While such diagnoses can enable access to support, they may also oversimplify need if relied upon in isolation.

Current funding arrangements, including the Adoption Support Fund, do not consistently support comprehensive, multi-disciplinary assessment. As a result, provision may only partially reflect a child's needs or focus on behavioural change rather than underlying developmental differences.

A more effective approach would prioritise holistic, whole-child assessment to ensure support is appropriately matched. Without this, unmet need may persist, contributing to distress and placement instability.

**f. Limitations of Standard Frameworks for Complex Needs**

In the UK, service provision is largely shaped by frameworks developed by the National Institute for Health and Care Excellence. While these provide important consistency, they are designed for the general population and do not always reflect the complexity of adopted children's needs.

Adopted children may present with overlapping neuro-developmental and trauma-related profiles that do not fit neatly within established diagnostic categories. Where such profiles are not formally recognised, access to appropriate support can be limited.

This gap extends across systems. Eligibility for Education, Health and Care Plans (EHCPs), and access to provision more broadly, often depends on recognised diagnoses. Children whose needs fall outside these frameworks may therefore be excluded.

Routine, comprehensive assessment that considers developmental history, relational context, sensory needs and the impact of early adversity would support more accurate identification of need and more appropriate provision.

## **2.6 Social Care Practice Failings**

**a. Threshold treated as objective fact rather than professional interpretation**

Threshold is frequently presented as a definitive judicial finding, despite being a narrative constructed from professional opinion. Its use as authoritative evidence in later assessments constitutes a misuse of professional power. This leads to biased decision-making and unfair scrutiny of families. Threshold must be understood as an interpretation, not a fact.

**b. Professional opinion treated as evidence**

Social worker judgement is often afforded disproportionate weight, even when influenced by bias, limited observation, or incomplete information. This undermines fairness and accuracy in assessments. Opinion must be distinguished from evidence. Failure to do so results in harmful interventions.

**c. Toxic professionalism**

Authority, procedure, and organisational defensiveness are prioritised over evidence, science, and humanity. This creates a culture where families feel scrutinised rather than supported. Toxic professionalism undermines trust and collaboration. It also contributes to systems-generated trauma.

**d. Defensive, compliance-driven practice**

Professionals often prioritise procedural compliance over meaningful engagement. This results in superficial assessments and missed opportunities for early intervention. Defensive practice is driven by fear of criticism rather than the child's best interests. It undermines effective support.

**e. Lack of curiosity and reflective practice**

Professionals frequently fail to explore the underlying causes of behaviour or family distress. This leads to inaccurate conclusions and ineffective interventions. Curiosity is essential for trauma-responsive practice. Its absence perpetuates harm.

**f. Proceduralism overriding relational engagement**

Rigid adherence to process replaces relational, human-centred practice. Families experience interactions as cold, transactional, or dismissive. This erodes trust and discourages engagement. Relational practice is essential for effective support.

## **2.7 Safeguarding Failings**

**a. Safeguarding processes overriding post-adoption expertise**

Safeguarding teams often override the insights of post-adoption professionals who understand the child's trauma history and family context. This results in decisions being made without full information. The hierarchy between services undermines effective intervention. Collaboration is essential but frequently absent.

**b. Families seeking help treated as risk indicators**

Parents who request support are often viewed with suspicion rather than compassion. This discourages families from seeking help early. Fear of punitive responses leads to crisis escalation. Safeguarding must distinguish between need and risk.

**c. Punitive responses escalating crisis**

Families report intrusive investigations, removal of children and siblings, or police involvement following requests for help. These responses cause significant harm and re-traumatisation. Punitive safeguarding undermines trust and destabilises placements. Proportionate, trauma-informed responses are essential.

**d. Absence of a trauma-responsive safeguarding framework**

Safeguarding processes do not incorporate trauma science, neuro-developmental understanding, or contextual analysis. This leads to misinterpretation of behaviour and inappropriate interventions. A trauma-responsive framework is essential for accurate assessment. Its absence is a major systemic failing.

## **2.8 Allegation-Handling Failings**

**a. Criminalisation of parents based on uncorroborated or misunderstood allegations**

Parents are increasingly subjected to police involvement, arrest, or intrusive safeguarding procedures following allegations made by children whose trauma histories affect perception, memory, and interpretation. These responses often occur without trauma-competent assessment. When police become involved, allegations made by adopted children may be treated in line with standard practice, without sufficient consideration of the child's trauma history, neuro-developmental profile, or the ways in which early adversity can shape perception, memory and communication. Given the complexity of these presentations—including evidence from research on trauma, memory and phenomena such as confabulation—there is a need for a more explicitly evidence-informed approach to the assessment of allegations.

The absence of a trauma- and neuro-developmentally informed lens can place significant strain on families and carers and may contribute to escalation in already fragile situations. A more nuanced, research-led approach would support more accurate understanding while maintaining appropriate safeguarding and help to reduce the risk of further placement instability.

This results in unnecessary criminalisation and significant family harm. Allegations must be evaluated within a trauma-informed framework.

**b. Absence of a trauma-informed, evidence-based approach to disclosures**

Children with trauma histories frequently present with fragmented memory, sensory recall, confabulation, and trauma-coloured perception. These phenomena are rarely considered in safeguarding decisions. As a result, disclosures are interpreted literally rather than contextually. This leads to disproportionate and harmful interventions.

**c. Failure to apply scientific understanding of memory and perception**

Trauma research shows that children may misattribute intent, conflate past and present experiences, or express emotional states as factual events. Without specialist interpretation, these expressions can be misread as evidence of harm, leading to inaccurate conclusions and unnecessary investigations. Early bonding experiences with biological parents also shape how children perceive the world: traumatised infants, for example, may misread facial expressions, interpreting a frightened face as threatening. Scientific understanding of these mechanisms must guide assessment and intervention.

**d. Disproportionate and harmful safeguarding responses**

Investigations often escalate rapidly to police involvement, removal of children, or emergency procedures. These responses cause significant distress and destabilise family life. The investigative process itself can retraumatise children. Proportionate, least-harm approaches are essential for both parents, carers and their children.

**e. Lack of specialist assessment prior to escalation**

There is no requirement for trauma-informed evaluation, neuropsychological assessment, or contextual safeguarding review before initiating statutory or criminal processes. Any police involvement in cases concerning children in permanence should be underpinned by a robust, evidence-based understanding of the impact of early adversity, neglect, and neurodevelopmental complexity. This should include access to specialist input and review prior to significant action being taken, particularly where there are known histories of complex need. Without such safeguards, intervention risks misinterpretation of behaviour, perception, and disclosure, including where research highlights factors such as memory distortion or confabulation. This may inadvertently compound harm for both the child and the family and contribute to further instability in already vulnerable placements. This leads to premature escalation and avoidable harm. Specialist assessment must be mandatory before intrusive action is taken.

**f. Failure to distinguish between harm and distress**

Children with trauma histories may express fear, overwhelm, or sensory overload in ways that resemble allegations. Without specialist interpretation, these expressions are misread as factual accounts. This leads to inappropriate safeguarding responses. Distinguishing between harm and distress is essential.

**g. Absence of Evidence-Based Prosecution Review within the Crown Prosecution Service**

The Crown Prosecution Service has no dedicated mechanism for reviewing cases involving children in permanence where allegations may be shaped by early adversity and neurodevelopmental complexity. As a result, decisions may be made without full consideration of research on memory, perception and communication, including factors such as confabulation.

This gap risks misinterpretation of evidence, unjust outcomes for families, and further instability in vulnerable placements. A specialist, evidence-based review pathway is needed to ensure prosecutorial decisions reflect the complexity of these cases.

## 2.9 Matching Failings

### a. **Lack of transparency in information sharing**

Critical information about the child's history, trauma, and needs is often withheld or minimised. This undermines informed decision-making and places families at risk. Transparency is essential for safe matching. Its absence is unethical and harmful.

### b. **Children presented as “more adoptable”**

Information is sometimes softened or omitted to increase the likelihood of placement. This creates unrealistic expectations and undermines trust. Families are left unprepared for the child's needs.

### c. **Absence of trauma-responsive matching criteria**

Matching processes do not consistently consider trauma, neurodevelopment, sensory needs, or recovery requirements. This leads to placements that cannot meet the child's needs. Trauma-responsive criteria are essential for long-term stability. Their absence contributes to breakdowns.

### d. **Agency oversight of adopters' susceptibility**

Given that more than 50% of parents come to the adoption process after experiencing fertility issues there is very little in place to support disenfranchised loss and its alignment with child placement. There may be some space for this to be addressed at the adoption application stage, but LA's all too often take advantage of the idealised perceptions and 'blinded' love of prospective adoptive parents. This may overshadow any rational understanding of the adoptee's antenatal backdrop, trauma, etc.

Adopters want to believe they can 'fix' or 'mould' any obvious behavioural aspects. They can be left unaware of underlying mental health issues that may emerge further down the line. LA's tend therefore to overlook susceptibility or take advantage of the desperation of adoptive parents who have experienced infertility.

## 2.10 Post-Adoption Support Failings

### a. **Geographic Inconsistency in Support Provision**

Support for children in permanence varies significantly by location. The Adoption and Special Guardianship Support Fund (ASGSF) is limited to England and not available in Northern Ireland, Wales, or Scotland, creating national disparity. Within England, access and application of the fund remain inconsistent across Regional Adoption Agencies, resulting in a postcode lottery. In practice, this variability can leave families in crisis without timely or effective support. Greater national consistency is required.

### b. **Limitations of the Adoption and Special Guardianship Support Fund**

The ASGSF is often insufficient to meet complex needs and can become the primary focus of professional involvement rather than a means to deliver timely support. Recent funding changes have reduced flexibility, requiring assessment and intervention to be delivered

within a single, limited allocation. This can delay access to appropriate provision and restrict the scope of support.

In practice, families may wait extended periods for intervention, and support may not align with the child's evolving needs. The current model does not reliably prevent escalation or stabilise families in crisis. A more flexible, needs-led approach is required to ensure timely and effective support.

**c. Lack of early intervention pathways**

Support is often reactive rather than proactive. Early intervention could prevent crises, but it is rarely offered. This leads to escalating distress and avoidable breakdowns. Early support must be standard practice.

**d. Absence of crisis response mechanisms**

Families in crisis frequently receive no immediate support. This results in emergency interventions that could have been avoided. Crisis pathways must be clearly defined and accessible. Their absence is a major systemic failing.

**e. No support for parental trauma or burnout**

Parents experience significant emotional strain without access to therapeutic support. This undermines their ability to care for their child. Supporting parents is essential for supporting children. Its absence contributes to placement instability.

**f. Regulatory barriers restricting access to therapeutic support**

Under the Adoption and Children Act 2002 and associated regulations, adoption support services are typically delivered through organisations registered with Ofsted or commissioned by local authorities. While recent changes have clarified that individual therapists do not always need to register where they are working under contract, access to publicly funded support remains largely restricted to these commissioned pathways.

In practice, this continues to limit the pool of available clinicians, as many independent psychologists and therapists are unable to deliver funded support directly. The result is a constrained workforce and delays in accessing appropriate intervention.

This framework creates a system in which families rely on state-mediated provision, yet access to support is often shaped by funding and commissioning structures rather than clinical need, with implications for timely support and placement stability.

## **2.11 Data and Accountability Failings**

**a. Pre-Order Disruptions Not Captured**

Disruptions before the adoption order are not consistently recorded. This results in incomplete data and an inaccurate understanding of system performance. Without accurate data, meaningful change is impossible. Transparency is essential.

**b. No National Data On Pre- Or Post-Order Breakdowns**

There is no national system for tracking adoption breakdowns. This creates a significant blind spot in understanding outcomes. Without data, patterns of failure remain hidden. National tracking is essential.

#### **c. No Tracking Of Children Re-Entering Care**

Children who return to care after adoption are not consistently monitored or documented. This results in lost learning and repeated harm. Tracking is essential for accountability and improvement. Its absence is unacceptable.

#### **d. No National Data On Adopted Children Entering Secure Accommodation**

There is no consistent recording of how many adopted children enter secure accommodation, either pre- or post-order. This omission conceals the severity of placement instability and the escalation of unmet need. Without this data, the system cannot recognise patterns or intervene early. Its absence represents a significant failure of accountability.

#### **e. No Evaluation Of Support Outcomes**

Support services are not routinely evaluated for effectiveness. This leads to inconsistent practice and wasted resources. Evaluation is essential for improvement. Its absence perpetuates ineffective interventions.

#### **f. Lack Of Accountability For Professional Failings**

Professional errors, bias, and poor practice often go unchallenged, creating a culture where inaccurate assessments and harmful decisions are allowed to stand without scrutiny. This undermines trust in the system and leaves families without recourse when they are treated unfairly or subjected to poor-quality intervention. The absence of robust oversight mechanisms enables patterns of poor practice to persist across teams and Local Authorities. Without clear accountability structures, systemic failings are repeated, and children and families continue to experience preventable harm.

### **2.12 Economic Failings**

#### **a. Crisis responses are significantly more costly than early support**

The system routinely invests in high-cost crisis interventions rather than low-cost preventative support. Emergency placements, residential care, and safeguarding investigations consume substantial resources that could have been avoided with timely, trauma-responsive intervention. This reactive model is financially unsustainable and harmful to children and families. Investing in early support would reduce long-term expenditure and improve outcomes.

#### **b. No cost-benefit analysis underpinning current practice**

There is no systematic evaluation of the financial impact of failing to support families early. As a result, decision-making is driven by short-term budget pressures rather than long-term economic logic. The absence of cost-benefit analysis leads to repeated investment in

ineffective, high-cost interventions. A strategic financial framework is essential to guide sustainable practice.

**c. Families pushed into financial instability due to lack of support**

Parents often reduce working hours or leave employment entirely to manage their child's complex needs. Without financial assistance, families experience significant hardship, which further destabilises the home environment. This economic strain contributes to stress, burnout, and crisis escalation. Supporting families financially is essential for maintaining placement stability.

## **2.13 Societal Failings**

**a. Harm to children**

When the impact of harm is unrecognised and untreated, children experience long-term emotional, psychological, and developmental harm. This affects their ability to form relationships, regulate emotions, and succeed in education and employment. The consequences extend into adulthood, shaping life trajectories, such as the "Care to Prison Pipeline". Society bears the cost of this preventable harm.

**b. Harm to families**

Families caring for traumatised children often experience isolation, exhaustion, and breakdown of relationships. Without support, the emotional toll becomes overwhelming. This leads to family instability and, in some cases, the loss of placements. The system's failure to support families has profound and lasting consequences.

**c. Harm to communities**

Unaddressed trauma/ harm contributes to increased demand on schools, health services, social care, and the criminal justice system. Communities experience the ripple effects of instability, exclusion, and unmet need. When families are unsupported, the burden shifts to wider society. This represents a collective failure to protect vulnerable children.

**d. Intergenerational transmission of trauma**

Children who do not receive responsive support are at increased risk of carrying unresolved trauma into adulthood. This affects their future relationships, parenting capacity, and mental health. Without intervention, trauma becomes cyclical, passing from one generation to the next. Breaking this cycle requires early, sustained support.

**e. Increased burden on public services**

The cumulative impact of unaddressed trauma/ harm places significant pressure on education, health, social care, and justice systems. These services are forced to respond to crises that could have been prevented. This reactive model is inefficient and costly. A coordinated, preventative approach would reduce demand and improve outcomes.

## **2.14 Structural Blind Spots**

**a. The misconception that permanence is an endpoint**

The system operates on the assumption that achieving permanence resolves the impact of trauma. This misconception leads to the withdrawal of support at the moment families need it most. Permanence is the beginning of recovery, not the end. Failing to recognise this results in long-term harm.

**b. Absence of a national clinical framework for adoption**

There is no unified clinical model guiding trauma assessment, intervention, or recovery planning for adopted children. This results in inconsistent practice and significant regional variation. A national framework is essential to ensure equitable, evidence-based support. Its absence leaves families navigating a fragmented system.

**c. The adoption preparation gap**

Prospective adopters often receive limited or overly optimistic preparation that does not reflect the realities of caring for traumatised children. This leaves families unprepared for the complexity of trauma, neuro-developmental needs, and behavioural challenges. Inadequate preparation contributes to crisis and breakdown. Comprehensive, realistic training is essential.

**d. No post-order review mechanisms**

Once an adoption order is granted, there is no statutory requirement for ongoing review of the child's needs or the family's well-being. This creates a significant blind spot in monitoring outcomes and identifying emerging difficulties. Without review mechanisms, early signs of distress are missed. Regular post-order reviews are essential for safeguarding stability.

**e. Lack of trauma-responsive language in policy**

Policy documents often use generic or outdated terminology that fails to reflect trauma science or neuro-developmental understanding. This leads to misinterpretation and inconsistent practice. Trauma-responsive language is essential for clarity and accuracy. Its absence contributes to systemic misunderstanding.

**f. No national adoption outcomes framework**

There is no consistent method for measuring long-term outcomes for adopted children or their families. This prevents meaningful evaluation of practice and policy. Without outcome data, systemic failings remain hidden and unaddressed. A national outcomes framework is essential for accountability and improvement.

**g. No national strategy grounded in science**

Current adoption policy is not consistently aligned with trauma science, neuroscience, or evidence-based practice. This results in outdated assumptions and ineffective interventions. A national strategy must be rooted in scientific understanding of trauma and recovery. Its absence perpetuates systemic harm.

## **h. Cascading Structural Failures Arising from Limitations in Clinical Frameworks**

Current clinical frameworks, including those developed by the National Institute for Health and Care Excellence, do not consistently account for the complexity and overlap of needs seen in children in permanence. Presentations often reflect layered profiles, including neuro-developmental differences, the impact of early adversity, and other less clearly defined or emerging conditions.

In practice, there can be an over-reliance on established diagnostic categories such as autism or ADHD, which, while useful, may not fully capture the breadth of a child's needs when considered in isolation. At the same time, profiles that fall outside recognised frameworks may be overlooked or insufficiently understood. This creates a systemic issue: access to support across health, education and social care is typically tied to recognised diagnoses. Where a child's needs are only partially captured—or not formally recognised at all—support may be limited, delayed or inappropriate. A more effective approach would embed routine, whole-child assessment that reflects developmental history, neuro-developmental variation and the impact of early adversity. Without this, gaps in clinical recognition continue to translate into gaps in provision, with the most complex needs least likely to be met.

### **Key Systemic Insights**

Across all areas of the system, the evidence points to a small number of consistent underlying patterns:

- Behaviour is prioritised over underlying injury, leading to misinterpretation of need.
- Permanence is treated as an endpoint, rather than the beginning of recovery.
- Systems operate in isolation, preventing a full understanding of the child.
- There is no embedded trauma-responsive clinical framework, resulting in inconsistent and often ineffective practice.
- Blame replaces curiosity, undermining trust and partnership with families.
- Intervention is reactive rather than preventative, increasing crisis and cost.

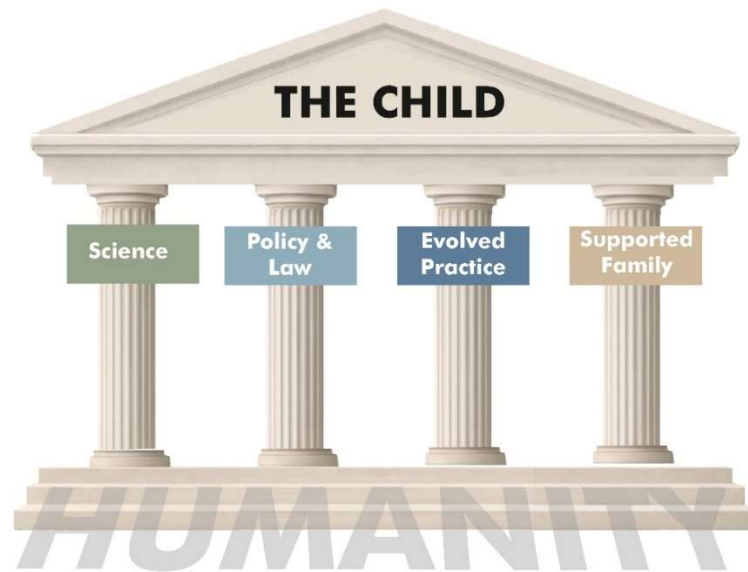
These patterns are systemic rather than incidental. Meaningful change requires structural reform, not isolated improvements.

## **3. Structural Model for Change**

Each child and family should be supported by Science, Policy & Law, Evolved Practice, and Supported Family, resting on Humanity, with Sur'thival above — illustrating the architecture required for a system that protects children and families.

It is not a blueprint for reform. It is a framework for truth, accountability, and future system design.

# SUR'THRIVAL



## Recommendations

The following recommendations set out the structural changes required to align adoption practice with trauma science, neuro-developmental understanding, and the lived realities of children and families.

### 1. Mandatory Multidisciplinary Assessment Prior to Placement

All children should receive a comprehensive assessment before any final order is made. This must include trauma history, transgenerational harm, genetics, neurodevelopment, sensory processing, relational context, and prenatal exposure. Assessment should be conducted by appropriately trained, multidisciplinary professionals.

### 2. Establishment of a National Trauma-Responsive Clinical Framework

A unified clinical model should be implemented across the United Kingdom to guide assessment, intervention, and long-term recovery planning. This framework must be grounded in contemporary neuroscience and biopsychosocial research.

### 3. Early Intervention as Standard Practice

Support should be provided proactively from the point of placement, rather than reactively in response to crisis. Early intervention pathways must be clearly defined, funded, and consistently applied.

### 4. Removal of Blame-Based Practice Models

Professional practice must shift from judgement to curiosity. Training, supervision, and accountability structures should explicitly address bias, blame culture, and misinterpretation of trauma-related behaviour.

### **5. National Data Collection and Outcomes Framework**

A national system should be established to track adoption outcomes, including disruptions, re-entry into care, and long-term wellbeing. This data must inform policy, funding, and practice development.

### **6. Integrated Cross-System Working**

Health, education, social care, and safeguarding must operate within a coordinated framework that enables shared understanding, joint assessment, and consistent response to need.

### **7. Access to Trauma-Competent Support for Families**

Families must have access to timely, flexible, and clinically appropriate support. This includes therapeutic intervention, crisis response, and support for parental wellbeing and secondary trauma.

### **8. Mandatory Training in Trauma and Neurodevelopment**

All professionals working within adoption and safeguarding systems should receive accredited training in trauma, neurodevelopment, and relational practice. This should be a requirement, not an optional enhancement.

These recommendations are not aspirational; they are necessary. Without structural change, the patterns identified in this review will continue, and children and families will remain unsupported.

## **Conclusion**

This review presents clear and consistent evidence that the current adoption system is not aligned with the realities of trauma, neurodevelopment, or recovery. The failings identified are systemic, predictable, and preventable.

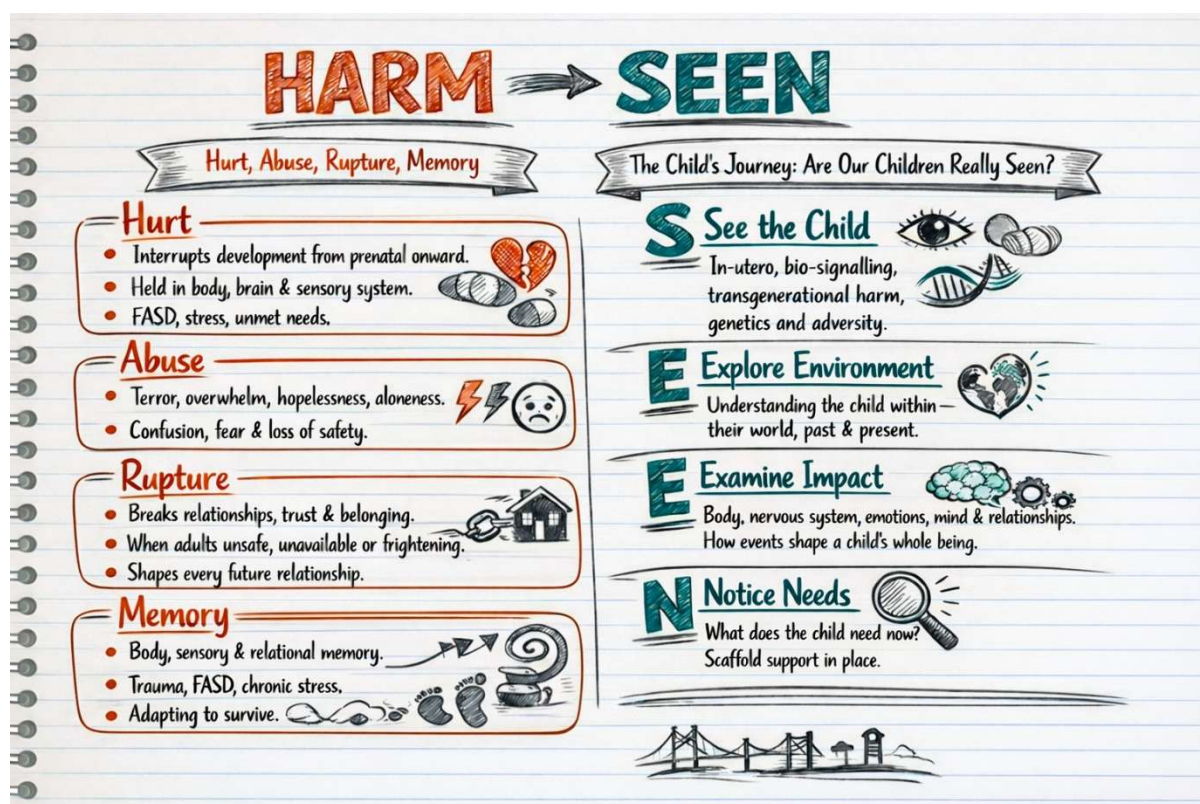
Children entering permanence do not leave their experiences behind. They carry the cumulative impact of harm within their bodies, brains, and relationships. When this is not recognised, needs are misunderstood, support is delayed, and families are left to manage complexity without the structures required to sustain them.

The consequences are significant. Children experience ongoing distress, families reach crisis, and systems respond reactively at considerable human and financial cost. These outcomes are not inevitable; they are the result of decisions, assumptions, and structures that can be changed.

A different approach is both possible and necessary. By grounding practice in science, embedding trauma-responsive frameworks, and working in genuine partnership with families, the system can move from crisis management to prevention, from blame to understanding, and from instability to recovery.

The responsibility to act is shared. The evidence is clear. The need for change is urgent.

## HARM SEEN – Changing the Legacy



**Harm unseen harms everyone** – the child, the family, professionals, systems, and society as a whole. Hurt hurts, and what is predictable is preventable. For healing to begin, harm must first be seen. When harm is missed or misunderstood, trauma responses are misinterpreted as behavioural choices, parents and carers are judged instead of supported, and histories of adversity are overlooked. Requests for help lead to assessment rather than intervention, and families are left carrying the weight alone.

Over time, crisis escalates. Parents and carers become isolated, exhausted, financially strained, and unwell – and blame is too often used when understanding is absent. These patterns are not anomalies; they are predictable outcomes of a system that does not yet hold the full picture of a child's world.

Professionals are being asked to hold extraordinary complexity: early adversity that shapes brain development; trauma that affects behaviour, learning, and relationships; neurodivergence including FASD, ADHD, autism, and sensory processing differences; attachment disruption and relational fear; shame, hypervigilance, and survival strategies; siblings absorbing one another's distress; carers living in constant threat mode; and families navigating daily crisis with little or no support. These realities do not sit neatly within existing systems. They require curiosity, empathy, and professional depth.

Families consistently describe the same experiences: support promised but never delivered; blame when help is requested; trauma and neurodiversity misunderstood; long periods of silence followed by crisis-driven intervention; schools judging rather than supporting; professionals holding significant power with limited accountability; and critical information before placement that was inaccurate or withheld. These are not isolated accounts – they reflect systemic patterns.

The system is not failing by accident; it is failing by design. Families encounter systemic gaslighting that invalidates lived experience, confirmation bias embedded within assessments, outdated practice lenses that harm children, rigid systems resistant to learning, and a culture that prioritises procedure over humanity. The belief that adopters and carers are “lucky” rather than families navigating trauma further distorts professional judgement. This is not sustainable, ethical, or aligned with what children need to recover.

Families are not asking for perfection. They are asking for practice that reflects the complexity of the children at the centre of permanence. This requires:

**1. Curiosity**

Looking beyond presentation and asking what came before.

**2. Context**

Holding the child’s history, the family’s journey, and the cumulative impact of trauma and neurodiversity.

**3. Empathy**

Seeing the human story behind the behaviour.

**4. Depth**

Reading the full file, seeking supervision, and challenging assumptions.

**5. Partnership**

Recognising families as experts in their children and working with them, not against them.

**6. Action, not delay**

Support delayed is support denied; families need intervention, not endless assessment cycles.

**7. Accountability**

When decisions cause harm, acknowledging it and learning from it rather than hiding behind procedure.

Language matters. Terms such as “blocked care” are too often misused as evidence of parental inadequacy rather than understood as predictable physiological responses to prolonged exposure to trauma, fear, and dysregulation. Blocked care is not a moral failing; it is vicarious trauma and burnout. Judgemental language silences families, erodes trust, and prevents honest conversations about safety and need. This must change.

In 2026, it is no longer acceptable for professionals across the permanence landscape to practise without accredited, comprehensive training in trauma-informed care. Children and families need practitioners who understand the neurobiology of trauma, recognise vicarious trauma and

blocked care, distinguish trauma responses from behavioural choices, understand FASD and neuro-developmental conditions, work from a developmental lens, and support carers without judgement. This should not be optional; it should be a safeguarding requirement.

Children deserve professionals who see them fully. Families deserve support that reflects the reality of trauma. Professionals deserve systems that allow ethical, compassionate practice. We are asking — clearly, respectfully, and firmly — for practice that goes beyond the surface; decisions grounded in understanding, not assumption; partnership instead of blame; and support that arrives before crisis, not after.

For every child in permanence — adopted, in kinship care, under SGO, or beyond — it is our shared responsibility to see the journey of the child, see the world of the child, see the whole child, and see their hurt so that they can sur\*thrive.

**Harm Seen — Change the Legacy.** When we do this, we move from managing crises to preventing them. What is predictable is preventable. From survival to sur\*thrival — and we change the legacy for children whose lives depend on our decisions.

Written by Fiona Wells

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