ENOUGH IS ENOUGH

A report on child protection and mental health services for children and young people

A policy report for the Centre for Social Justice
by Adele Eastman

June 2014




THE CENTRE FOR
SOCIAL
JUSTICE

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About the Centre for Social Justice

The Centre for Social Justice (CSJ) is an independent think-tank, established to put social justice at the heart of British politics.

Moved by shocking levels of disadvantage across the nation, it studies the root causes of Britain's acute social problems in partnership with its Alliance of over 350 grassroots charities and people affected by poverty. This enables the CSJ to find and promote evidence-based, experience-led solutions to change lives and transform communities.

The CSJ believes that the surest way to reverse social breakdown – and the poverty it creates – is to build resilience within individuals, families and the innovative organisations able to help them.

Enough is Enough

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Preface

In 2012 the CEO of Kids Company, Camila Batmanghelidjh, raised a number of serious concerns regarding child protection and statutory mental health provision for vulnerable children and young people with the CSJ. These concerns prompted us to embark on what has become one of the most detailed single reports that the CSJ has ever undertaken.

Two years of research, over 70 interviews, many weeks of legal advice, and, most importantly, the experiences and views of some extremely vulnerable children and young people have gone into its making.

At the centre of this work has been a detailed analysis of the cases of 20 vulnerable children and young people who have been supported by Kids Company. These provide a window on to the horrific challenges they have endured and the multiple barriers to statutory services that they have often faced.

Their stories and the testimony of the experts we have consulted reveal a growing group of children and young people whose family lives have broken down or are in deep crisis, who are in desperate need of help and love but who are struggling to receive the necessary care and support of statutory services. As Camila explained to us, many are our country's 'lone children.'

We have heard of such children and young people cycling in and out of statutory services without receiving the sustained help they need; but for the extraordinary work of voluntary sector organisations (VSOs) like Kids Company, would be entirely without support. It is exceptionally important that, as a society, we find a way of helping these vulnerable children and young people; unless we do, the outlook is extremely bleak. As the CSJ has seen so often, just as the family breakdown, addiction and abuse experienced by vulnerable parents affects their children, so such vulnerable children are the parents of tomorrow. In some cases, they are the parents of today.

The current Government has made huge efforts to improve child protection and social work. The Munro Review of child protection, the Narey Review of social work training, and the overhaul of adoption procedure, to name but a few, have made valuable contributions to the improvement of services and will, over time, help to rebuild lives. But as the Government would acknowledge, there is still much further to go.

Our work has shown that some grave concerns remain. The quality of local authority services is obviously highly variable, but a number of themes have presented themselves both through the case studies and consultation with experts in the field that are clearly being felt in many parts of the country. In particular we have highlighted concerns about the effectiveness of some social work services, about their limited engagement with voluntary sector organisations, about the inaccessibility of some mental health services, and about the way in which the current legal framework is being subverted by some statutory services.

Whilst services are operating in particularly tightened financial circumstances, the solution to the problems outlined here is not merely more money. Simply pouring additional resource into a dysfunctional system would not automatically produce the best results for our vulnerable children and young people. Instead it is time to consider a radical overhaul of how, when and by whom child protection and statutory mental health services are provided.

None of this research would have been possible without either the huge and generous co-operation of Kids Company, the children and young people they work with, the experts and many witnesses who contributed to our Review, or the extraordinary exertions of the CSJ's Senior Policy Specialist, Adele Eastman, who has, singlehandedly, pulled all this evidence together and written the report.

Detailed though this report is, it is not, and could not have been, comprehensive. That would have required greater resources than any think tank has to offer. Yet such an understanding of the problem is urgently required – as are comprehensive solutions to it. These solutions are neither obvious nor easy. This is why we are calling on all political parties to commit to the establishment of a Royal Commission to advise on the wholesale redesign of social care and statutory mental health services for vulnerable children and young people, which should report by the end of 2017, and, most importantly, ask how best to recreate parental support for these children and young people in the public space.

The campaigners of the late nineteenth century exposed the adversity faced by children orphaned and left destitute by slum life and cholera epidemics. Their efforts and campaigns led, over time, to renewed public responsibility for the vulnerable young in Britain's burgeoning cities. The efforts and campaigns of their heirs can surely achieve the same today.

Centre for Social Justice, June 2014

Special thanks

The CSJ would like to thank the many individuals and organisations who gave evidence to this Review and shaped its recommendations.

The author would also like to extend her deep gratitude to the following, without whose support this report would not have been possible:

The remarkable children and young people who so courageously, and with enormous trust, shared their experiences, in the hope of helping others.

Camila Batmanghelidjh, who provided a critical window through which we were able to gain a more informed understanding of the devastating 'childhoods' survived by many vulnerable children and young people.

Darren Howe, a barrister from 1 Garden Court chambers, whose contribution to this report, as one of its experts, has been boundless.

The other experts who have also dedicated vast amounts of time, expertise and knowledge to our report, including Mitchell Woolf (solicitor at Scott-Moncrieff & Associates Ltd), Paul Patterson (Public Health Manager, Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)), Dr Karen Broadhurst (Senior Lecturer in Socio-Legal Studies, University of Manchester), a Senior Manager in a Children's Services Department, and a Service Development Manager at BSMHFT.

David Smellie and Henry Sainty, Partners at Farrer & Co LLP Solicitors, who so generously advised on various aspects of the report.

Numerous individuals who shared their expertise and insight, including Dame Moira Gibb, Dame Clare Tickell, Isabelle Trowler, Tim Loughton MP, Andrew Webb, Jan Tallis, Angela Gascoigne, Dr Peter Fuggle, Dr KAH Mirza, the senior Forensic Child and Adolescent Mental Health Services clinician, the experienced independent social work consultant and expert witness, Councillor Georgie Cooney, Chris Callender, Professor Corinne May-Chahal, Dr Zoe Cameron, Headteachers of special schools, and others who wish to remain anonymous.

The social workers and medical practitioners, who placed their trust in us, and exposed the nature and extent of challenge faced on the frontline – as well as providing examples

of good practice, in the hope of affecting positive change for vulnerable children and young people.

The many staff at Kids Company who committed their precious time, knowledge and understanding, to assist with our case review, including Deepti Patel; and those who gave evidence to our Review.

The other voluntary sector organisations, and their practitioners, who also critically shared their invaluable insight and experience, including School-Home Support (SHS), XLP, IntoUniversity, Enthusiasm Trust, YoungMinds, and Twenty Twenty, and those who wish to remain anonymous.

The solicitors and barristers who shone a powerful light on the injustices faced by many vulnerable children and young people – including two solicitors who also kindly assisted with Chapter Four.

Amina Hussain, who tirelessly provided crucial administrative support over two months, and played an integral part in the report's delivery.

Francesca Romano and John Schwartz at Soapbox for their efforts in designing the report.

Executive summary

Introduction

> *'I'm always upset, I'm on the verge of doing something drastic … I feel disgusting … I done coke [two] days ago, I'm not [Callie] no more – a lot has happened to me on the streets, I just want my own space … that's my last chance with happiness, I'm always hungry, I don't get no sleep … I'm losing it on a real.'*
>
> **Callie**

The Centre for Social Justice's (CSJ) seminal work on poverty in the UK, *Breakthrough Britain* (2007), revealed that five pathways to poverty – family breakdown, worklessness, educational failure, addiction and serious personal debt – were holding people, families and communities in poverty. During the course of that research we became aware that children in care had some of the worst outcomes of any group in our society. Not only had they suffered from particularly acute family breakdown, they were also much less likely to do well at school, and much more likely to suffer from addiction and worklessness. Consequently, in 2008 we published a diagnosis of the problems experienced by our nation's children in care, *Couldn't Care Less*, which looked at ways in which policy makers could improve their lives. Then, in 2011, in *Completing the Revolution: transforming mental health and tackling poverty* we looked at how far too many people in the UK are unable to access the mental health treatment they need to make a full recovery.

In 2012, Camila Batmanghelidjh, the CEO of Kids Company, raised a number of serious concerns regarding, in particular, child protection and statutory mental health provision. She informed us of some extremely worrying information that heads of various services and senior professionals had shared with her – of very serious and highly consequential concerns about shortfalls in services to vulnerable children and young people. Camila explained that these senior individuals had informed her that they felt they could not share their concerns elsewhere due to being worried about their job security and future prospects. She felt that social workers and other statutory professionals were being blamed generally but that what was important was to acknowledge the existence of systemic problems which presented those individuals from delivering the quality of service they would like to deliver. We determined to explore this further.

> *'There is an assumption that children are either in care or with their biological parents who are functioning. But in the middle there are the "lone children" – who are not in foster care or with functioning parent(s). Games are played over whether the lone child can be*

tipped over to be cared for but agencies play games so that they are not taken into care. There is no philosophy in social care and no truth regarding the scale of the problem.'

Camila Batmanghelidjh, CEO, Kids Company, in evidence to the CSJ

The focus of our report is on child protection and mental health, including:

1. the experience of vulnerable children and young people in terms of their contact with statutory services – essentially children's social care (social care), and mental health provision (for example, primary care, Child and Adolescent Mental Health Services (CAMHS)), and Adult Mental Health Services (AMHS);[1] and
2. the interface between the voluntary sector and statutory services in relation to the former working with vulnerable children and young people, and their efforts to secure support for them from the latter.

This report addresses the plight of lone children, amongst others. It looks at how and why many vulnerable children and young people are slipping through the net, and being denied any or appropriate care, protection and/or support from some statutory services. We started by performing a detailed analysis of the cases of 20 high risk and vulnerable children and young people who have been supported by Kids Company. We sought to establish the complexity and severity of their needs, their experience in relation to contact with statutory services, and the nature and extent of support provided by Kids Company. We present summaries of five of those cases below. Those cases have been reviewed by two legal experts in the field, who very generously shared their expertise and time without charge. They found a litany of missed opportunities and legal failings. Whilst the children and young people whose cases we reviewed were living in London, and whilst all local authorities are different, our conversations with many witnesses – including experts – around the country, as well as our literature review and survey with ten voluntary sector organisations (VSOs), have showed us that numerous issues raised by these cases are felt far more widely.

Good practice clearly exists in child protection and statutory mental health systems in some areas. The commitment, passion and determination of many social workers and statutory mental health practitioners is remarkable. Our eyes have been opened wider to the extent of complexity and challenge that they face, as they often battle to deliver services to our vulnerable children and young people in the midst of major public sector reform, and in a fiercely constrained financial climate. However, our report has revealed a stark picture of some social care and statutory mental health services heaving under the current pressures, and failing to take a child or young person-centred approach.

This report does not claim to be a definitive study of child protection and statutory mental health services in England. However, it does shed light on profoundly worrying systemic issues within the statutory services that ought to care for, protect and/or support our vulnerable children and young people. The consequences of failing to do so are severe. Just as the

1 Our report covers children and young people up to the age of 25. We use the definition of a 'child' contained in the Children Act 1989 – i.e. for those who have not yet reached their 18th birthday. We refer to those who are 18 or over as 'young people' throughout the report

instability of their parents' lives impinged upon their own childhoods, so many of them are on the brink of parenthood themselves. The following report is not just about supporting and helping to heal the pain and suffering of marginalised children and young people in England, it is also about preventing the next generation of family breakdown and dysfunction before it begins.

CSJ Review and Analysis of 20 Kids Company cases[2]

'Background: a room, before redecoration, selected from [Kids Company's] "Colour a Child's Life" Programme. A [two]-year-old child slept in this bed: her family was assessed by social [care], but did not receive statutory support for [five] years;' Kids Company, *Kids Company Report for Government March 2011–2013*, London: Kids Company, 2013, pp14–15

The level of vulnerability of the children and young people whose cases we reviewed, and the risk to which they were exposed, was deemed by Kids Company to be high.[3] It is literally impossible to describe in words the trauma and devastation that they have endured in their short lives – in their home and/or local environment. Theirs is a 'childhood' that no child should ever have to experience. We have provided a mere glimpse into the living hell that some are surviving, through the case summaries and snapshots contained in our report.

2 All of the quotes, case summaries, and snap shots in the report have been anonymised, to protect the identities of the children and young people, as well as their parents and any other individuals and professionals involved in their lives who feature in the material. All of the quotes, case summaries, and snap shots have been approved for inclusion in the report by each of the children and young people and/or their parent

3 None of these children or young people's circumstances were constant, and at any given time the level of risk to which they were exposed varied. However, they are not considered by Kids Company to have fallen below the level of high risk during the period covered by the CSJ's Review. In one of the cases, the child's level of risk was initially deemed to be low risk but became high risk. For definitions of the risk level used by Kids Company see Appendix 3

Examples of the type of maltreatment that some of these children and young people have suffered – without receiving adequate support from social care – are as follows:

- A seven-year-old boy feeling forced by his mother to steal milk for his baby sibling, and abandoned by social care following his arrest – left to live with his mother (addicted to crack cocaine) for a decade in conditions of extreme neglect, and in a chronically chaotic and violent environment, while his younger siblings continue to live with her to date. He developed anger and substance misuse (cannabis) difficulties.

  'Dad used to fight with [my mum's partner] a lot. My mum used to hit dad all the time, with severe blows. She stabbed him, put a cup in his face, dashed him in the skull with rollerblades. But daddy was an angel. He never used to … hit my mum back … It was very bad because I used to go to school and when I came back I always used to see blood – on the wall or on my dad's face.'

- A teenage girl, sexually abused from when she was a young child – left to experience serious physical, emotional and sexual abuse over years, and for periods living with her father who introduced her to each of the men who sexually abused her; she self-harmed, made a number of suicide attempts, and was hospitalised in an Adolescent Psychiatric Unit – before finally being placed in care at the age of 14.

  'I want to be a little girl. I did not have the chance as I had to grow up and look after myself …'

- A six-year-old boy, found by Camila in his underpants in the snow – left living with his mother (addicted to crack cocaine), losing his father to an alcohol overdose at the age of eight, suffering severe neglect – without food, with rotting teeth, and surviving off the food and shelter provided by neighbours; he witnessed a violent incident in his home between drug dealers, before being rendered homeless at the age of 17 after his mother reportedly set fire to the home.[4] Now, at 23, he is recognised as having developed obsessive compulsive disorder (OCD), high levels of anxiety and delayed emotional development.

  'There was no fun in my childhood. To be honest, there was no childhood … I literally feel like I was born an adult, just … smaller.'

- A young girl – severely neglected and physically abused by her mother, repeatedly seen with her siblings searching for food in rubbish bins, raped in her early teens by a man in her community, and encouraged by her mother to find money to help feed her mother's drug addiction – *'even if she had to sell herself'* – until finally being placed in care at the age of 14, after repeatedly attempting suicide.

4 He disclosed that his mother set fire to the home

Chapter 1: Frontline child protection

'The truth of social work today is that the … kids are so lost … I can honestly say, as a social worker, that kids are not at the forefront of what I do …'
Social worker, in evidence to the CSJ

'The system is completely overwhelmed.'
School-Home Support (SHS) practitioner, in evidence to the CSJ

From our research, it is clear that frontline child protection work in some local authorities is under huge pressure, and that many social workers face multiple challenges to effective practice.

- Our research suggests that there is a bigger child protection problem in England than the statistics indicate. This is in circumstances where some social care services are, according to some of our witnesses, '*overwhelmed*,' *'in crisis'* and *'at breaking point'*;

- Issues of concern exist regarding a lack of prioritisation, identification and understanding of some vulnerable children's social care needs;

- The rhetoric and aspiration with respect to early intervention is clearly not being realised in some areas of the country. Consequently, the severity of some vulnerable children and young people's needs are being allowed to escalate;

'You have well-meaning professionals who are trying their best but can't deal with it, so it tips over into crisis and the local authority are taking the child into care … If you had proper children in need services, you could have prevented that. If you kept the child at home and supported them properly, it would be better for the child (probably particularly for the teenage years) and the people that get early help, get better early help.'
Senior Manager, in a Children's Services Department, in evidence to the CSJ

'With neglect and emotional abuse, you tend to get inter-generational behaviour, which is why it should be addressed. It's a great area of need. The irony is that if [social care] addressed the children in need, they'd be more likely, certainly in the longer term, to stem the flood of work they have to do.'
An experienced Independent Social Work Consultant and Expert Witness, in evidence to the CSJ

- Higher thresholds are now being applied in some local authorities than previously meaning that it is harder for some vulnerable children to gain access to services that could help them;

'Social [care] are so stretched, and the thresholds have gone up so far, that you rarely work with [them] now in anything but a complete crisis situation.'
Headteacher, in evidence to the CSJ

- Some social care teams remain trapped in a process-, incident-driven culture that does not prioritise the importance of creating and building relationships with vulnerable children and young people, and developing an understanding of the root of their difficulties;

> *'They would just come up with more things for us to do … I used to think "have they read the Munro Report?" because they kept giving me more forms to fill in and the child was lost. It is just about their forms and statistics so they can look good.'*
> **Social Worker**

> *'It's not just that many social workers are not as confident in their skills as we need them to be, but that the whole system doesn't recognise that … it's about forming relationships.'*
> **Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, in evidence to the CSJ**

- In some areas we heard of concerning reports that some social workers are not taking an appropriate approach towards vulnerable parents, children and young people, including failing to investigate and address parental difficulties, and failing to take a child or young person-centred approach.

> *'Throughout my whole childhood, [my mum] couldn't look after me. I had to look after myself but at the same time I was looking after myself, I was the one supporting her and not social [care]. I made plans myself for how I could help my mum. I tried a sympathetic plan, I tried an aggressive plan, and I tried a runaway plan – for example, when I was 15 and went to [stay with a relative]. That was one of my plans – to run away and tell her I'd never see her again – and for her to be clean for a year at least before I would see her again. Another plan was to give my mum the choice: me or the drugs. I said that to my mum. As heartbreaking as it was at the time, she chose the drugs. She didn't say it but her actions told me that. I can understand it's an addiction but an addiction can be broken with the right support.'*
> **David, in evidence to the CSJ**

> *'… kids are getting big problems because no-one is dealing with their parents. Unless we can get to a point where we can support the parents to support their kids, we're just building up more and more problems.'*
> **CEO, SHS, in evidence to the CSJ**

- A recurring theme of our evidence was that the voice of the vulnerable child or young person is not being heard;

> *'They could have given me a hug and asked me why I was crying afterwards. It's simple. I'm a child. I don't know nothin'. I only know what my mum and dad have told me, and what the streets have taught me. Social [care] could have easily sat me down. Kids aren't dumb, they're smart. They know what's goin' down and I had my assumptions. But I blacked it out and when I got older I realised I couldn't run away from it. It's inside and waiting to break out.'*
> **Michael, in evidence to the CSJ**

- A particularly disturbing predicament exists for many children in need, who are either being kept out of social care altogether or, if they do gain access to services, various methods are being deployed by some social care teams to avoid giving them the necessary care and support. Some cases are being left to drift until an incident occurs which lifts them up to the child protection threshold; some can end up in care proceedings;

  '… from what I hear and from my experience, it's really common for care proceedings to come out of a scenario where, potentially, if social [care] had provided appropriate support under S.17 to the family at an earlier stage, those care proceedings might not have become necessary.'[5]
  Solicitor, in evidence to the CSJ

- We discovered failings in relation to other cohorts of vulnerable children and young people: including alarming evidence of children who were at risk of or suffering street gang violence, but were not treated as child protection cases. A number were not even designated as children in need. It seems that older children (i.e. 14- to 17-year-olds) are getting the worst deal in terms of social care support and/or protection than any other age group. We also found continuing shortfalls in the support afforded to care leavers;

- Most of the cases which feature in our evidence involve families with long-standing and entrenched problems who have been known to social care for many years and about whom cumulative concerns have arisen. All too often critical opportunities to intervene early and to carry out effective preventative work were missed, all too often with severe consequences for the children and young people who were in desperate need of help;

- We found repeated evidence of staggering delay and shortfalls, in some cases over many years, in the care, protection and/or support afforded to some vulnerable children and young people by some social care services. Some of these are powerfully demonstrated by the key legal failings and missed opportunities which are included within our case summaries.[6]

Chapter 2: Statutory mental health provision

'Attempted suicide leaves a huge emotional scar … I haven't shared it with CAMHS. The only reason I've shared this is because you are finding out what does or doesn't help young people.'
Child, in evidence to the CSJ

'We're sitting on a ticking time bomb in this country; I honestly believe that in many areas we have turned our backs on children and parents experiencing hopelessness and despair … These children are the parents of tomorrow.'
CAMHS clinician, in evidence to the CSJ

5 Children Act 1989, Section 17
6 See pages 30 to 43 of this report

There is a high prevalence of childhood mental health disorder in the UK. One in 10 children aged between five and 16 has a diagnosable mental health problem.[7] These include (but are not limited to):

- Between one in every 12 and one in 15 deliberately self-harm;
- Approximately 290,000 have an anxiety disorder;
- Almost 80,000 suffer from severe depression;
- Just over 510,000 have a conduct disorder;
- Just over 132,000 have severe attention deficit and hyperactivity disorder (ADHD).[8]

Our review of Kids Company's cases revealed that the vulnerable children and young people with mental health problems broadly had two different types of experience when it came to the provision of statutory support. They essentially either:

- failed to gain the care and support that they needed (and in circumstances where they were receiving social care intervention), or

- were given some care and support but it was short lived and/or sporadic, and appears to have failed to address their needs.

Our wider research into the provision of mental health services raised a number of particular serious concerns:

- It appears that society is faced with a bigger problem to address than the available national statistics indicate. There is an absence of comprehensive and up-to-date data available on the prevalence of mental health problems in children and young people in England;

- Issues of concern exist regarding a lack of prioritisation, identification and understanding of some vulnerable children and young people's mental health problems;

- There is a stark contrast between the aspiration and reality for early intervention, with a crisis response being taken towards severe mental health problems in some areas – meaning that some children and young people are not seen until their needs have become acute;

7 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, pxxi. YoungMinds has estimated that this amounts to almost 850,000 children; YoungMinds Mental Health Statistics [accessed via: http://www.youngminds.org.uk/training_services/policy/mental_health_statistics (07.02.14)]

8 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, cited in YoungMinds Mental Health Statistics [accessed via: http://www.youngminds.org.uk/training_services/policy/mental_health_statistics (07.02.14)]. "'Conduct disorder" is the official, psychiatric term for serious antisocial behaviour' – for example, in American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV*, Arlington, Virginia: American Psychiatric Association, 1994, cited in Hagell A et al, *Key Data on Adolescence 2013*, London: Association for Young People's Health, 2013, p84. More recently, it has been established that the majority of those who self-harm are aged between 11 and 25 years old; Mental Health Foundation, *The truth about self-harm: for young people and their friends and families*, London: Mental Health Foundation, 2006; Association for Young People's Health, *Adolescent self-harm*, London: Association for Young People's Health, 2013 – both are cited in Hagell A et al, *Key Data on Adolescence 2013*, London: Association for Young People's Health, 2013, p82. However, it is noted in *Key Data on Adolescence 2013*, that in light of self-harm being 'a very private behaviour and a very sensitive topic … there is a shortage of reliable information about young people who do not make use of [A&E] or other services'

'I understand that CAMHS are busy with very disturbed children, but … there's a lot of evidence that if you can support [them] in the early stages of their mental health problem, you can head it off at the pass, or at least prevent it from being so severe.'
GP, in evidence to the CSJ

- The barriers that some vulnerable children and young people with mental health problems continue to face in accessing, engaging with and obtaining appropriate care and support from primary and secondary care services can be high. Furthermore, we have discovered deeply distressing evidence of some vulnerable children and young people with complex, severe and enduring mental health needs failing to be given the necessary statutory support to meet those needs. Numerous witnesses have informed us that CAMHS' thresholds have become higher in some areas;

'It's often a tortuous course to get into CAMHS. There are some CAMHS services that will only accept referrals from particular organisations … It's a way of gate keeping what comes into CAMHS …'
CAMHS clinician, in evidence to the CSJ

- A lack of continuity of care and support, and consistency of relationship exists for some vulnerable children and young people with mental health problems, in some primary and secondary care services. It appears that some medical practitioners are struggling to develop an informed understanding of the circumstances and needs of some vulnerable children and young people. Notably, one GP told us that increasingly, practitioners never see the same person twice;

- A major problem that can be faced by vulnerable children and young people with mental health problems is making and attending appointments. Many are growing up in dysfunctional and chaotic home environments, and do not have a functioning parent to support them. Some do not know how to reach the CAMHS clinic (which are sometimes highly inaccessible), cannot afford the travel expense, and have no one to explain the importance of or to accompany them to the appointments. Indeed, traditional practice models and a lack of continuity of care and consistency of relationship, can compound pre-existing barriers faced by many vulnerable children and young people, and their parents, to their meaningful engagement with such services;

- Particular cohorts of vulnerable children and young people are not being afforded timely and/or appropriate care and support – including children with conduct disorder. Conduct disorder is the most common mental health problem in childhood. Half of all children

with it develop anti-social personality disorder as adults, and it is associated with a 70-fold increased risk of being imprisoned by the age of 25;[9]

'These kids are at risk of developing serious problems – they are impulsive, have emotional difficulties, and are struggling to negotiate the developmental expectations. They often come from families that are unable to provide firm, consistent care and control. Kids with "conduct disorder" … are the ones who are not getting a proper service across the whole of CAMHS. That is a big reality …'

Dr KAH Mirza, a senior CAMHS clinician and academic working at the Maudsley NHS Trust, in evidence to the CSJ[10]

- Other cohorts include children and young people who are exposed to street gang violence, and those with dual diagnosis. In addition, more of a focus is being placed on cognitive behavioural therapy in some areas, as opposed to tailoring treatment to the individual needs of vulnerable children and young people;

- The long-standing issue of transition from CAMHS to AMHS persists in some areas. Many vulnerable children and young people continue to face significant challenges in successfully negotiating a transition between the services and can find that they do not meet the threshold for care and support from AMHS.

'… the CAMHS cut off. There are still places where nobody can be found to support you if you're 16 to 18. It is an absolute scandal …'

Andrew Webb, President of ADCS, in evidence to the CSJ[11]

Chapter 3: The voluntary sector

'The statutory system is at breaking point …'

VSO, in evidence to the CSJ

'My big thing at the moment is that … in some instances, we [the voluntary sector] are the canaries down the mine and we ought to understand that. If we are in this particular place where thresholds are going up … we are the early warning in a way, of when the system is about to fall over.'

CEO, VSO, in evidence to the CSJ

9 NICE, *Antisocial personality disorder: Treatment, management and prevention* (CG77), January 2009; cited in Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages; Supporting document – The economic case for improving efficiency and quality in mental health*, 2011, p6 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (18.02.14)]; Ferrgusson DM et al, Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood, *J Child Psychol Psychiatry*, 46, 2005, pp 837–849; cited in Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages; Supporting document – The economic case for improving efficiency and quality in mental health*, 2011, p6 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (18.02.14)]

10 It should be noted that the views expressed by Dr Mirza throughout this report are his individual views, and do not represent those of South London and Maudsley NHS Trust, or any other organisation that Dr Mirza works for

11 At the time of publication, Andrew Webb is no longer the President of ADCS

The CSJ believes very strongly in the power of the voluntary sector to tackle social breakdown – much of our research is informed by our Alliance of 350 frontline, poverty-fighting charities. Some VSOs are offering critical support and, in many cases, a lifeline to some of the most marginalised in our society. They can be extremely adept at securing the engagement of vulnerable parents, children and young people, through the relationship and trust that they are able to build with them – often providing continuity of care and support. Some VSOs are also giving essential support to statutory services by acting as a bridge – helping vulnerable parents, children and young people to access and engage with them. They are also trying to build up resilience within vulnerable families – supporting parents to support their children.

However, we have seen the severe challenges that some VSOs are experiencing at the interface with statutory services, in engaging with them to help secure the best possible outcomes for vulnerable children and young people:

> *'The voluntary sector is seen as a hindrance in a way … It would be really great to sit down and work with the voluntary sector, because they've got skills and knowledge and different perspectives. We just haven't got the time, and there isn't that respect of the voluntary sector. They are seen in a particular light, and doing certain things. Those things tend to be advocating for the young person in a way that impacts on us …'*
>
> **Social worker, in evidence to the CSJ**

- A key recurring finding across our Kids Company case review was social care's failure to adequately investigate or give sufficient weight to information provided by the VSO – to the detriment of the relevant vulnerable children and young people. Consistent with our key findings from the case review, evidence submitted by other VSOs revealed that some social care teams are not being receptive to their attempts to share valuable information, and their concerns are not being listened to or appropriately actioned. Furthermore, they can experience a lack of transparency and poor communication, and a lack of professional respect and understanding of the nature of the VSOs' work by some social care teams. This is detracting from the focus on the vulnerable children and young people;

> *'I recognise the disrespect from both sides … It is one of the things that really has to change … I think one of the tensions is that social workers have a huge set of responsibilities that nobody else has in child protection. It is their responsibility, and people should respect them for that … But I also know we can be very badly behaved, and dismissive of the huge help that the third sector can bring in … It's those classic things about reminding oneself that you're all in the same business actually and the end goal is the same …'*
>
> **Isabelle Trowler, Former Director of Morning Lane Associates, in evidence to the CSJ**

- Some VSOs are facing challenges around referrals for vulnerable children and young people. This can be due to higher thresholds and/or CAMHS only accepting referrals from particular organisations – to the exclusion of some VSOs. Some expressed frustration to us at not being able to refer directly into their local CAMHS – including one VSO, which is a provider of Tier 2 mental health services;

- A recurring theme that has emerged from our evidence, is that the potential for many VSOs to work in partnership and collaborate with social care and statutory mental health services is being seriously under-utilised. Despite bold statements made in statutory guidance, we have found deeply concerning signs of, for example, the voluntary sector's voice often going unheard or unheeded by statutory services. This is having an extremely worrying impact on some VSOs, with devastating consequences for our vulnerable children and young people. Vital opportunities are being lost to enhance the quality of assessments undertaken by social care and statutory mental health services, and the efficacy of their support, interventions and outcomes;

  'It's very rare that we make referrals to social [care] unless we need to … it's a last resort. If we are saying to a local authority "we need your help on this", there's a reason for that. We have concern … I think that's why collaborative working is key. Local authorities need to come and sit down and have a discussion with us, and see what we do and what our processes are. We can learn from them as much as they can learn from us.'
  VSO, in evidence to the CSJ

- The disgraceful reality is that VSOs can find themselves left holding some children and young people who are highly vulnerable, traumatised, and with serious and complex needs, who need to receive timely and appropriate care, protection and/or support from statutory services. All the while their behaviour can escalate, their needs can become more entrenched, and they can become exposed to continuing or increasing risk, harm and/or distress;

  'There's a lot more room for [working in partnership] to be realised. It does have to be seen as a partnership and a team working thing, rather than "them and us …" We are potentially building a surrogate family around this child and trying to help them.'
  Witness, in evidence to the CSJ

- Several issues of concern emerged from our evidence regarding the impact of commissioning arrangements on some VSOs, including: by some local authorities over funding for their local approach to the Troubled Families Programme, and the need for commissioners to promote partnerships between statutory services and VSOs, and to understand the different cultures and competing agendas of the statutory and voluntary sectors. We also heard about the adverse impact that some commissioning arrangements are having on some vulnerable children and young people.

Chapter 4: The legal and regulatory framework

> *'From our perspective, it looks very much like there's an army of people out there being paid a fortune in children's services, legal services, at management levels … who actually aren't there to provide services for children, they're there to prevent services being provided for children. So their role is to do assessments to make sure that children in need don't get services, which is just utterly Alice in Wonderland stuff.'*
> **Barrister, in evidence to the CSJ**

> *'You ring up the local authority saying my client's been sexually abused by her sister's boyfriend for six years, was taken into care, was subject to domestic violence from her brother, her sister and her father, and now you're saying she's not vulnerable and she has no needs. And she doesn't need to be safeguarded. It's like what have you missed? What don't you get?'*
> **Solicitor, in evidence to the CSJ**

This chapter focuses on the evidence submitted by legal professionals and other witnesses, on legal issues relating to vulnerable children and young people, and on the relevant legal and regulatory framework. They have shone a particularly powerful and shocking light on the brutal reality and injustices that are being suffered by many.

- According to our evidence, some local authorities are operating unscrupulous and unlawful practices. Some are flagrantly disregarding, circumventing and contravening the very legislation and statutory guidance which provides for the care, protection and/or support of vulnerable children and young people. We were astounded by the number and nature of legal failings and missed opportunities which were identified by the legal professionals' review of Kids Company cases;

- We were left incredulous by the lengths to which some local authorities are going, either completely to withhold or restrain services from being provided. This was, for example, repeatedly apparent in the context of supporting homeless 16- and 17-year-olds. Our research revealed unlawful practice by some local authorities in respect to their joint housing protocols. Some are deceiving vulnerable 16- and 17-year-olds, by failing to provide them with the correct, comprehensive information on their available options;

- Our evidence demonstrates a staggering lack of accountability by local authorities with respect to vulnerable children and young people. As highlighted throughout our report, the voluntary sector is in a weak position in being able to exercise its influence with social care.[12] However, some VSOs, along with legal professionals, are performing a critical role in holding them to account, and helping vulnerable children and young people to obtain the support to which they are entitled by law. Our research highlighted a host of situations necessitating legal challenge by solicitors in response to local authorities failing to comply with their legal obligations;

12 For example, an analysis of local authority duties towards VSOs in the context of conducting assessments, the membership of core group meetings and attendance at child protection conferences, and the latter's weak position in each respect, can be found at Appendix 6

'When a manager … gets a solicitor's letter, or the threat of a judicial review [(JR)], they will respond. They know that if they don't, it is going to cost the local authority thousands … Management where I am now, and the legal team, I don't know how robust they are to defend themselves. They clearly can't be because the moment that letter lands on the table, they start running. They run for the hills and they start caving.'

Social worker, in evidence to the CSJ

- Serious concerns also exist over the lack of knowledge, understanding and application of the relevant law on the part of some social workers, those in more senior positions and even some local authority lawyers. We were given examples of cases where social workers had failed to understand and apply the relevant thresholds – including in relation to significant harm and care proceedings. One solicitor told us:

  '… what social workers are doing, they're waiting until it crosses that significant harm threshold but doing nothing in the meantime beyond checking whether the threshold has been met or not.'

- Some people we have taken evidence from are concerned that aspects of the statutory guidance *Working Together to Safeguard Children 2013* may increase inconsistency, confusion, delay and potentially unlawful practice in meeting the needs of vulnerable children;

- Fundamental concerns exist in relation to the proposed changes to funding for JR proceedings, and their potential impact on vulnerable children and young people. A main concern is that it will prevent their access to justice. Evidence in our report robustly demonstrates the critical need for vulnerable children and young people to have access to high quality legal advice, and to JR. We believe that the potential impact on them of specialist legal firms ceasing to exist (as feared) could be devastating;

  '… there may be firms that take a view immediately that it's just not viable to do the work anymore. I think what's more likely is that firms will continue to try and do the work but that over the next few years you'll see a lot of the legal aid firms that do the work that we do going out of business. Ultimately what that means is that for the sorts of client that you're talking about in your report, there won't be legal aid.'

  Solicitor, in evidence to the CSJ

  'We're dealing with a very small number of [local] authorities where there happen to be solicitors that know what they're doing … There are whole parts of the country where there are none. Literally none … In total I would say you're looking at 25 lawyers, solicitors and barristers combined … nationally. Maybe 30 at a push. If any of those … solicitors fall away then there really is big trouble. The momentum of the legal challenges and the possibilities will be virtually nil.'

  Barrister, in evidence to the CSJ

- In light of the unscrupulous and illegal practices which have emerged on the part of some local authorities during our research, we are highly concerned for the multitude of vulnerable children and young people who have no Kids Company or equivalent voluntary sector support or specialist legal advice available to them. This reinforces the vitally important role that Ofsted has to play – in securing an informed understanding of the reality of experiences of vulnerable children and young people across the country. However, significant criticism has been raised by various witnesses over how Ofsted conducts its assessments of services and reaches its conclusions;

- The legislation regarding mental health is surprisingly weak, and seems to be increasing the vulnerability of some children and young people. Statutory mental health services operate within a looser framework than social care. Statutory duties tend to be very general in their nature, and much seems to be subject to guidance, and local interpretation and negotiation. This adds to the complexity of the problem. Furthermore, the lack of cooperation between some social care and statutory mental health services, and lack of coordinated holistic support, is presenting some vulnerable children and young people with additional challenges, as well as VSOs and other agencies that are trying to support them. Tragically, the mental health problems of some remain undiagnosed until they reach a fitness to plead stage of criminal justice proceedings. However, even then, some continue to slip through the net of appropriate care and support.

Recommendations

Our overarching recommendation is that a Royal Commission be established in the next Parliament to radically re-think and advise on the wholesale re-design of social care and statutory mental health services for vulnerable children and young people. Reporting by the end of 2017, this Commission should decide how society can best re-create the parental experience for them in the public space. The Royal Commission should establish the extent of vulnerability that the system needs to address, and identify and build on existing best and innovative practice. In addition, the Royal Commission should be informed and its considerations shaped by the Taskforce which we understand is due to be launched by Kids Company in the interim.

We need an innovative, whole-system approach to be taken towards vulnerable children and young people. It has become all too evident that the existence of lone children is a reality that must be addressed. We believe that consistent care provided by relevant statutory and non-statutory agencies working together to function like substitute parents for vulnerable children and young people is key.[13]

13 Where it is not possible to also work with their parents

In pursuing its work the Royal Commission should also consider:

- How the role of social workers should be defined (what exactly do we, as a society, want social workers to do?);[14]
- Whether adults' and children's social care services are constructed in the right way;
- How to improve the integration of child and adult mental health services;[15]
- How to create a joined-up financial strategy across the board – money should not be in separate pots but in an 'ever moving' pot, with clear and joint accountability;
- How to promote a more effective and intelligent use of data on vulnerable children and young people being exercised by all relevant statutory and non-statutory agencies, and their maximising the data to help secure optimal outcomes for them.

The problems exposed by our report demand a huge step change to reduce the vulnerability of many children and young people in England, and correct the abhorrent failures by which they are suffering.

14 We note the point raised by Sir Martin Narey in his recent report to the lack of 'a satisfactory definition of children's social work,' and the recommendation he makes for such a definition to be drafted; Narey M (Sir), *Making the education of social workers consistently effective, Report of Sir Martin Narey's independent review of the education of children's social workers*, February 2014, p13 and p43 [accessed via: https://www.gov.uk/government/publications/making-the-education-of-social-workers-consistently-effective (27.05.14)]

15 *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p116–118

Kids Company Cases

Profile

> *'If I didn't have Kids Company, I would be on a wrong path … I wouldn't have the educational potential without them … Everyone needs support in some way … I think I would be homeless without them … Even though I am doing well, they still … care to send someone to see me once each week – it's a constant thing – it's not some random person every couple of weeks – it's a set plan.'*
> **David, in evidence to the CSJ**

> *'Kids Company has done its best for me. Without Kids Company, I would have been dying out there – living like a tramp – and would have gone into the crime world and worked my way up the ladder.'*
> **Michael, in evidence to the CSJ**

Founded in 1996, Kids Company provides practical, emotional and educational support to vulnerable inner-city children and young people in London and Bristol. Its services reach 36,000 children and young people and some of their family members.[1] The VSO seeks to replicate the comfort and support of a strong, loving family environment for those who are experiencing, or who are at risk of, neglect, abuse and trauma. The ethos of Kids Company is that it will never turn any child away. However, its services 'are heavily oversubscribed, with demand outstripping capacity. The [VSO] struggles to maintain its open-door policy.'[2]

In a recent study by University College London (UCL) , of 79 children and young people supported by Kids Company:

- One in 10 reported having been shot or stabbed in the past year;
- Half reported having seen someone being shot or stabbed in their community in the past year;

1 Kids Company analysis (unpublished), January 2014
2 Jovchelovitch S, and Concha N, *Kids Company: A diagnosis of the organisation and its interventions, Final Report*, London: The London School of Economics and Political Science, September 2013, p6

- One in four reported having seen a friend or relative being shot or stabbed in their community in the past year;[3] and
- One in five reported being shot or stabbed in their lifetime.[4]

Queen Mary, University of London, evaluated Kids Company between 2005 and 2008.[5] The statistics below illustrate some of their findings.

A sample of case histories reveals Kids Company clients experiencing the following difficulties:[6]

- 83 per cent complex trauma during childhood;
- 84 per cent homelessness;
- 82 per cent substance misuse;
- 81 per cent criminal involvement;
- 71 per cent social care involvement, 33 per cent of these being child protection cases;
- 58 per cent non-engagement with statutory education.

The outcomes of Kids Company street-level centre interventions included:[7]

- 89 per cent engaged with therapy;
- 89 per cent improved anger management;
- 94 per cent reduced level of substance misuse;
- 95 per cent improved emotional well-being;
- 90 per cent provision of/improved accommodation;
- 90 per cent reduced criminal involvement;
- 89 per cent gang involvement stopped;
- 100 per cent engagement with key worker;
- 81 per cent achieved academic attainment;
- 91 per cent returned to education;
- 86 per cent engaged with work experience;
- 69 per cent engaged with work.

3 These findings from the research (unpublished) were shared by Charlotte Cecil, Developmental Risk and Resilience Unit, University College London, at Kids Company's annual conference held at the London School of Economics and Political Science, on 26 September 2013 [accessed via: http://www.lse.ac.uk/newsAndMedia/videoAndAudio/channels/publicLecturesAndEvents/player.aspx?id=2029; Audio 13.40 Session (13.01.14)]

4 UCL, *Experience Of Adversity: Preliminary Descriptive Findings* (unpublished), June 2013

5 Gaskell C, '*Kids Company Helps With The Whole Problem*,' Kids Company Research and Evaluation Programme, London: Queen Mary, University of London, April 2008

6 A detailed analysis was undertaken of 120 case files of Kids Company clients aged 12 and over; Ibid, pp51–52

7 A sample was taken of 240 clients receiving intensive interventions, from the overall client group of 749 accessing Kids Company's street-level centres, The Arches II and Urban Academy, at the time. Ibid, pp62–63. Kids Company has confirmed an up-to-date figure: that 5,979 clients are allocated to The Arches II (4,608 of whom have received key working support/direct contact with Kids Company; 5,979 are all of those supported through the centre); 1,447 new clients were assessed at The Arches II in 2013

The model

> *'Kids Company combines flexibility and staff commitment to enable absolute focus on the needs of vulnerable children; they offer to the child the knowledge that someone cares, loves and will not give them up, irrespective of any challenging and unstable response that may come back from the child.'*[8]

A recent study conducted by the London School of Economics and Political Science (LSE), *Kids Company: A diagnosis of the organisation and its interventions*, established that Kids Company:

- '… acts as mediators, facilitating communication between the interfaces sustained with clients, their social environment and the statutory sector.
- … works as brokers, translators and advocates giving visibility to the invisible …
- … works with an absolute focus on the child and total commitment to the power of healthy attachment to change lives. They act as parents by proxy supporting the client unconditionally and providing nurturing and loving relationships.
- … interventions aim to re-define the relational patterns experienced by children in need, offering positive attachment and unconditional support based on perseverance, the practice of love and long-term commitment to the relationship established.
- … is unafraid of using a language of emotions; it brings back to the debate about children in need the frequently absent language of emotional care and unconditional love as central for containment, healing and positive sociability.
- … uses cutting edge neurological and psychological evidence to inform its delivery and to design service provision. It integrates biological and psychosocial theories to better understand clients. It actively collaborates with researchers in academic institutions and its database is informing new research on developmental adversity and third sector interventions.
- … presents an exemplary model of psychosocial scaffolding interconnecting the emotional and practical scaffolding of delivery with the scaffolding of relations between clients and their families. Looking after staff so that staff can look after vulnerable children and families is paramount for the model of Kids Company. These different chains of scaffolding hold together the overall vision of Kids Company.'

8 Jovchelovitch S, and Concha N, *Kids Company: A diagnosis of the organisation and its interventions, Final Report,* London: The London School of Economics and Political Science, September 2013, p8

Delivery and interfaces

- 'The [VSO] provides flexible and in-depth tailored engagement, adjusting its practices to the needs of individual clients on the ground. It combines a bottom-up, situation-led approach to theoretical and empirical evidence on the behaviour of vulnerable children.

- Therapy and the creative arts play a substantial role in the work of Kids Company enabling vulnerable children to expand cognitive and emotional skills and develop non-verbal languages to elaborate their experiences.

- Kids Company works with public services in areas such as social [care], schools and the NHS, including local GPs, hospitals and mental health centres. It bears witness to the level of services delivered to vulnerable children and aims at holding the state accountable to children …

- Kids Company enjoys an internal environment where plurality of perspectives, multidisciplinary practice and openness to situations enhance bold decision-making, a doer's attitude and flexibility to accommodate the challenging and demanding realities of clients…

- From documents and paper work, which clients often have difficulty understanding, to help at school, therapy and parenting by proxy, Kids Company helps to construct a gateway through which children and young people can enter the social order, develop trust and form healthy attachments to adults.'[9]

One child (then aged 13) has stated 'Kids Company is a lifeline for a lot of people. If there was no Kids Company a lot of people would be on the street with nowhere to go for help. There should be a Kids Company in every city.' In fact, 97 per cent of children and young people found Kids Company effective in supporting their difficulties.[10]

CSJ review of Kids Company cases

Kids Company offers a unique 'wraparound' model of care for each child or young person. Key workers play a critical role in this. They are considered to be cutting edge by Kids Company because they work across social care, education and health, with vulnerable children and young people who face some of the most challenging circumstances. They offer them the opportunity to form an attachment through a 1:1 relationship, providing sustained emotional support as well as practical help and advice.

Across the cases we reviewed, Kids Company has offered a huge range of practical, emotional, therapeutic, educational and financial support to vulnerable children and young people. A brief summary of the nature and extent of support provided by key workers includes, by way of example:[11]

9 Ibid, pp6–7

10 Gaskell C, '*Kids Company Helps With The Whole Problem,*' Kids Company Research and Evaluation Programme, London: Queen Mary, University of London, April 2008, p4

11 Aspects of this support also relate to the mental health needs of some of the vulnerable children and young people, as discussed later in the report

- Seeking to establish and build a trusted relationship with the child/young person, and providing them with consistent and, at times, intense practical and emotional support;
- Communicating with the child/young person regularly – and, in a number of cases, daily during certain periods, and visiting them at home regularly – and, in a number of cases, almost daily during certain periods;
- Visiting the child/young person in their children's home, their hostel, in custody, or in hospital;
- Seeking to ensure that their basic needs are met – for example, Claire's key worker brought her (amongst other items) a bed, bedding, soap, shampoo, a towel, two teddy bears, and a few books;
- Accompanying the child/young person to appointments with a dentist or GP;
- Attending meetings with, and/or accompanying the child/young person to meetings with (for example): social care, school or other educational settings, secondary care services, their foster care placement or hostel, and solicitors;
- Supporting the child/young person to engage and progress with their education;
- Supporting the child/young person to resolve their homeless crisis, and their housing and/or benefits issues, including accompanying them to appointments;
- Supporting the child/young person during criminal proceedings – for example, accompanying them to court, and to engage with the Young Offending Team (YOT);
- Supporting the child/young person to refrain from involvement with street gangs.[12]

Given the extent of complexity and severity of the needs of some of the vulnerable children and young people whose cases we reviewed, various senior members of staff have also been assigned to support them.

Where it has been possible, Kids Company has provided support to a number of vulnerable parents of children whose cases we reviewed. For example, Kids Company has tried to help improve the quality of several children's home lives by giving their mothers aspects or a combination of emotional, therapeutic, financial and practical support.

12 Examples of the nature and extent of support provided by Kids Company feature in various case summaries and snapshots of cases throughout the report

Case Study One: Claire (16-years-old)[13]

'I want to be a little girl. I did not have the chance as I had to grow up and look after myself…"

Claire first suffered sexual abuse as a young child. The perpetrator of her initial abuse received a custodial sentence. While she was at primary school, and living with her mother, Maria, Claire disclosed that Maria had physically and emotionally abused her. Having begun a child protection investigation, social care told Maria about Claire's allegations while she remained in Maria's care, thereby exposing her to the risk of further physical assaults.

Maria alleged that Claire's father Lewis, from whom she was separated, had threatened to kill her and Claire. Claire expressed suicidal ideation and told her social worker that she had been self-harming. A referral was made to Child and Adolescent Mental Health Services (CAMHS), from which point Claire's case remained open with them. Social care concluded that it would designate Claire's case as a child in need as opposed to a child protection case. Following a further allegation of physical abuse, Claire was removed from Maria's care, and stayed with a family member.

At the age of 12, Claire told Kids Company about her repeated suicide attempts, before then moving into a flat with Lewis. Concerns arose over Lewis' substance misuse and parenting capacity, which Kids Company reported to social care. Not only did Lewis live in the same building where Claire was first sexually abused, but Claire was also exposed to potential abuse by various men staying at Lewis' flat, now with access to Claire. In spite of Claire's further suicide attempts, problematic attendance at CAMHS, allegation of sexual abuse by another man, and referrals from Kids Company, Claire's school, CAMHS and the police, social care closed her case. This was in the face of disagreement by all other agencies, and despite the risk to Claire of sexual abuse. Kids Company had also expressed various concerns, including that Lewis had introduced Claire to each of the men who had sexually abused her. Social care felt that other agencies could manage Claire's needs.

Kids Company made further referrals to social care, reiterating that Claire remained at risk of significant harm. All professionals voiced their concerns to the social worker about Lewis' parenting capacity, and Claire staying with him as a permanent arrangement. Yet the social worker claimed to be unaware of these concerns. After Claire's further attempted suicide and a child psychiatrist's advice that her family could not keep her safe, Claire's case was simply transferred to the family support team in social care. A safeguarding plan subsequently agreed was deemed to be inadequate by Claire's CAMHS psychotherapist. After expressing her intention to commit suicide, Claire was transferred to an Adolescent Psychiatric Unit, to keep her safe until social care put a suitable safeguarding plan in place.

Claire was finally placed on the Child Protection Register (CPR). However, in spite of this and concerns expressed by solicitors (instructed by the Official Solicitor) about social care's safeguarding plan, Claire was discharged from the Psychiatric Unit into the care of a relative

13 An analysis of mental health issues in Claire's case can be found in Chapter Four

who lived in the same building as the man convicted (and now released) for Claire's initial sexual abuse. After seeing him the next day, Claire self-harmed. She then ran away from home, alleging that she had been physically assaulted by her family members. She told Kids Company that she wanted to be placed in foster care because she did not feel safe at home.

Claire was ultimately placed in a children's home, at which point social care told Kids Company that it had to drastically reduce its contact with Claire. Claire was upset about this and how she felt she had been treated. She was subsequently arrested for assaulting a member of staff at the children's home and for criminal damage. After being transferred to another children's home, Claire repeatedly absconded from it – because she said she did not feel safe there. She also said that she felt unheard and that the only way she could be heard was to run away. She came to Kids Company because she said she knew the staff cared about her, that she could trust them and that they would listen to and not blame her. Kids Company was asked by social care to cease all contact with Claire. Kids Company responded that if Claire no longer wished to have contact it would respect her decision, but if Claire wished to call Kids Company, it would not refuse to speak to her.

Key legal failings/missed opportunities

1. Failure to protect Claire following her report that she had been physically and emotionally abused by Maria. The local authority failed to take the legal steps available to remove Claire from home prior to informing Maria of the allegations Claire had made, thereby exposing Claire to the risk of further physical assaults.

2. It may be argued that the failure of the local authority to act when Claire was being physically and emotionally abused by Maria amounts to a significant missed opportunity, given that Claire clearly felt let down and lost trust and confidence and did not trust the local authority to act in her interests from that point.

3. Erroneously concluding that Claire was no longer a child in need when, in reality, there was no person exercising parental responsibility, and Claire was a child at risk of significant harm.

4. Failure to undertake a child protection investigation, convene a legal planning meeting or issue care proceedings, despite clear and repeated evidence of Claire suffering, and being at risk of suffering sexual abuse and sexual exploitation.

5. Failure to provide a core assessment within the 35 days required.

6. Failure to adequately investigate or give sufficient weight to information provided by the voluntary sector.

7. Failure to seek information from VSO providing services, and active opposition to the involvement of that VSO, in breach of the Framework for the Assessment of Children

in Need and their Families (2000) (*2000 Assessment Framework*) and, as VSO is a major provider of services to children in the local authority area, also breach of guidance given in the case of *R V (AB and SB) v Nottingham City Council*.[14, 15]

8. Failure to invite VSO to attend or provide a report for the child protection conference (CPC). Significant failing under the Working Together to Safeguard Children (2010) *(2010 WTSC)*.[16]

9. Failure to produce robust safeguarding plan in preparation for discharge from hospital resulting in CAMHS psychotherapist refusing discharge.

10. Failure to issue care proceedings and obtain parental responsibility for Claire, resulting in Claire being detained in hospital on a psychiatric ward and then being discharged to the care of the family (in the building where the perpetrator of the initial sexual abuse suffered by Claire was residing).

11. Erroneously concluding that the threshold criteria for the issue of court proceedings had not been met, leading to a delay of five months before care proceedings were issued.

12. Failure to cooperate and coordinate with health in order to produce an holistic assessment of Claire's needs in accordance with the local authority's duties under S.17 Children Act 1989 (CA 1989).[17]

Case Study Two: Daniel (17-years-old)[18]

'I should be in a secure unit because it would be better than everything social [care] are putting me through.'

Daniel's father, Lloyd, is a drug addict and used to beat Daniel's mother, Emma. He was also physically abusive to Daniel, who remembers being hospitalised by him. The father of Emma's youngest children, Jacob, is an alcoholic. He used to hit Emma, and was abusive to Daniel. Daniel and his siblings witnessed the domestic violence. When Daniel was 11, his school referred him to Kids Company after he became at risk of permanent exclusion, and admitted to anger problems and a history of abuse. Daniel moved between the home of Emma, who found it difficult to cope with his behaviour, and a relative.

Daniel agreed that he would attend after-school homework club, and anger management classes – to be provided by his school. It was also agreed that he would be placed on a behaviour management programme. Kids Company repeatedly chased the school to put in place the agreed support for Daniel but it was not provided. All the while, he got into more

14 Please see legal foreword
15 R V (AB and SB) v Nottingham City Council [2001] EWHC 235
16 Please see legal foreword
17 Ibid
18 An analysis of mental health issues in Daniel's case can be found in Chapter Four

trouble. Having previously attended a number of psychotherapy sessions at Kids Company, Daniel wanted to resume this at school. After finally confirming its agreement to this, the school never responded in relation to the time that Daniel's therapy could be held.

After Jacob threatened to kidnap the youngest children (following a previous attempt), Kids Company made a referral to social care. Kids Company also believed that Daniel was at risk of physical and emotional harm by Jacob's threatened return. Social care took six days to confirm that it would not undertake an assessment of the children, on the basis that the police and legal services were already involved and Jacob was not yet in the country.

From the age of 13, Daniel received threats from boys who were associated or involved with different gangs. His friend survived an attack in which he was repeatedly stabbed. After the fatal stabbing of a member of the gang that had attacked his friend, Daniel received death threats because he was believed to know the perpetrator. Daniel became involved in offending behaviour, and was charged with robbery. He was then severely assaulted by some boys at his school. On his return, he was permanently excluded for committing a serious disciplinary offence. Just before this, Daniel had suffered a 'breakdown.' He is understood by Kids Company to have undergone a mental health assessment at CAMHS, followed by a period of counselling. Emma remained unsure about Daniel's mental health diagnosis.

After the YOT and CAMHS' involvement ceased, concerns arose over Daniel's behaviour, mental health, and attendance at his pupil referral unit (PRU). Emma told Kids Company that, although she loved Daniel, she could no longer have him in the home. At 15, Daniel presented himself as homeless. A social worker undertook an assessment which is understood by Kids Company to have related to his intended respite placement. Shortly before taking this up, Daniel was physically assaulted by a gang. His respite placement was abandoned on the basis that it was too close to the area in which the youths who had attacked him were based. Daniel was initially encouraged to seek housing support from a neighbouring local authority, on the basis that he was 'fleeing violence.' Social care then confirmed that he did not qualify for accommodation under S.20 of the CA 1989.[19] After he was arrested for burglary, social care offered Daniel B&B accommodation, which even the owner of the B&B believed was unsuitable for a vulnerable youth. Kids Company advised that temporary foster care would be more appropriate for Daniel. In contrast to what the family were telling Kids Company, the social worker and their line manager claimed that this was not something that Daniel or his family wanted.

With Kids Company's support, Daniel submitted JR proceedings against the local authority for failing to provide him with suitable accommodation. Despite the court ruling in his favour, social care initially failed to take the necessary action. However, it finally arranged a short-term respite placement with intensive support.

19 Please see legal foreword

Key legal failings/missed opportunities

1. Given the information available to the school, a Common Assessment Framework (CAF) should have been undertaken and a lead professional identified at an early stage.[20]

2. Failure to make a decision as to whether an initial assessment was required within the permitted 24 hours, it instead taking six days.

3. Failure to adequately investigate or give sufficient weight to information provided by the voluntary sector.

4. Failure to treat a child who is at risk of and/or has suffered street gang violence, as a child at risk of significant harm.

5. Failure by local authorities to cooperate in the provision of S.17 services and S.20 accommodation, to enable a child at risk of significant harm by way of street gang violence to be accommodated in a safe area.

6. Failure by social care to provide appropriate accommodation. The provision of Bed and Breakfast (B&B) or unsupported hostel accommodation is not suitable for a vulnerable child.

7. Relying on unlawful considerations: (a) demonstrating evidence of a change of lifestyle or attitude is not a lawful consideration in the assessment of a child's need for accommodation; and (b) blaming a child for his own situation and the concept of 'fault' is not a lawful consideration when assessing a child's need for accommodation.

8. Contempt of court by the failure of the local authority to comply with the terms of the order of the High Court.

9. Failure to cooperate and coordinate with health in order to produce an holistic assessment of Daniel's needs in accordance with the local authority's duties under S.17.

10. Lack of coordinated holistic support for Daniel both before the involvement of YOT, and then after its involvement, when those services that had been put in place fell away.

Case Study Three: Michael (24-years-old)[21]

> *'… we became the street and got caught up in a life full of crime which we shouldn't have. I used to be so kind and good … But the pain I used to see. I was angry but I didn't know what to do …'*

20 CAFs and lead professionals are discussed in Chapter Four
21 A longer version of Michael's case summary can be found at Appendix 4

Michael has never seen or spoken to his father. His mother, Diane, has a history of emotional and mental health problems and a crack cocaine addiction. Michael has lived in extreme conditions of poverty and neglect, in a chronically chaotic and violent environment. In the previous borough in which the family lived, Michael and his siblings were on the CPR from birth for several years; Michael and a sibling were placed under the category of neglect, and another sibling under the category of physical abuse. Michael was first arrested as a young child for stealing milk for his baby sibling:

> *'The baby was crying and my mum told me to get some [baby milk], but she told me in a way that I felt I had to rob it – she didn't give me any money … I felt alone … I asked myself "how come social [care] don't help me?"'*

When Michael was 12, a health visitor made a referral to social care, after Diane told her that she was struggling to cope with the eldest children's behaviour. Michael was truanting from school and involved in offending behaviour. Such was the concern over Michael's home environment, that YOT was advised by the police not to visit the home as it was 'too dangerous to attend.' The children told Kids Company about the extreme violence taking place between the two men living in the house – Donald and Francis, and involving Diane. They described horrific scenes with injuries which resulted in significant bleeding by one of the adults. Michael regarded Francis, the father of one of his siblings, as his father:

> *'Dad used to fight with [Donald] a lot. My mum used to hit dad all the time … She stabbed him, put a cup in his face, dashed him in the skull with rollerblades … it was very bad because I used to go to school and when I came back I always used to see blood – on the wall or on my dad's face.'*

Diane initially reported that Francis was her current partner, and denied being married to Donald. This was contrary to what Francis and the children had told social care. The risks identified by social care included Donald being regarded as 'an issue.' The children were placed on the CPR under the category of neglect. Diane subsequently confirmed that she was married to Donald, with whom she was having a relationship, and that Francis was her previous partner. The violence continued. Kids Company made a further referral to social care, reporting that Donald was a drug dealer, who provided drugs to the whole household, and that Francis and Donald often fought and stabbed each other, making the children very disturbed. Social care focussed their attention on Diane and Francis, while Donald remained firmly in the background. Having decided that a referral for Michael to CAMHS would be followed up by therapeutic counselling, a social worker is recorded, nine months later, as having spoken to Michael about counselling, and been told that he did not want to attend it.

Michael stopped attending school:

> *'… how could I go … when I was worried about my dad? Then I decided, f*** it, I'm not going to school anymore … Once I made that decision, that was the time I started to smoke weed and to get involved in the fights – I'd pick up a knife and stab someone or pick up a chair and hit Donald.'*

His school was recorded by social care as not co-operating with the child protection process. Contrary to Kids Company's advice, Michael and his siblings were removed from the CPR after just over a year (except for one sibling who was removed earlier). Social care decided to work with the children on a child in need basis, but later no longer even considered them to be children in need. Kids Company submitted another referral, reporting Diane's suspected crack cocaine use and disappearance for days, and Donald's physical fights with Michael and a sibling, and with Diane. It also reported Diane's alleged attempt to stab Michael, and its continuing concern for the younger children. Michael says that social care never spoke to him about the alleged stabbing.

At 16, Michael formed what he described as a '*friendship gang*' who '*had each other's backs if anyone dissed them.*' They would '*beat [Donald] up*' if Michael needed protection. Diane threw Michael out of the house due to his fights with Donald. Homeless, Michael was placed by Housing in a B&B whose inhabitants were reportedly using crack cocaine. Only after JR proceedings were threatened by solicitors instructed on Michael's behalf, did social care offer to carry out a S.17 assessment. However, it subsequently abandoned the assessment on the basis that Michael did not contact his social worker or keep his appointments.

Aged 18, Michael had a number of violent fights with Donald, who he says threw knives at him and tried to strangle him:

> '*I lost it. We had the fight. I beat the s*** out of [him] … I cracked his eye socket with a punch and threw him down the stairs. Then I jumped on his head and my mum did too. I beat him bad that day.*'

But Michael decided it had to stop. He was worried about repeating the cycle and did not want his siblings to see him fighting with Donald.

Key legal failings/missed opportunities

Failure to undertake a core assessment prior to the initial CPC despite evidence concerning significant harm available.

1. Failure to undertake a core assessment following the initial CPC despite a recommendation from the conference to do so.

2. Failure to undertake a core assessment by the time of the third Review CPC, some nine months after the initial CPC – 195 working days having passed, when a core assessment was required within 35 working days.

3. Inappropriate reliance by social care on a parenting program undertaken by YOT, when that program had not included all the adults providing care for, or posing a risk to, the children. This program was not an alternative to a core assessment as it did not comply with the *2000 Assessment Framework.*

4. Failure to undertake a child protection investigation, convene a legal planning meeting or issue care proceedings, despite clear and repeated evidence of all the children in the family witnessing or being involved in violence within the home, including stabbings, and the mother's frequent absences from the home due to suspected drug misuse.

5. Failure by social care to treat Michael as a child in need and accommodate him under S.20, which also thereby deprived him of necessary support under the leaving care provisions.

6. Failure to adequately investigate or give sufficient weight to information provided by the voluntary sector.

7. Failure to cooperate and coordinate with health in order to produce an holistic assessment of Michael's needs in accordance with the local authority's duties under S.17.

8. Failure to provide therapeutic counselling in a timely manner following a referral for services (this would not result in health having a legal duty to have provided this service within an expressly defined or reasonable period of time).

Case Study Four: David (23-years-old)[22]

> *'There was no fun in my childhood. To be honest, there was no childhood … I literally feel like I was born an adult, just … smaller.'*

Kids Company first raised the alarm with social care over David's neglect when he was six years old. It had concerns over his mother Patricia's substance misuse, the unsuitability of his home environment and his lack of care. David recalls that social care '*visited sometimes*' but that '*nothing really happened.*' He had wanted to tell the social worker about Patricia's substance misuse but he did not – he thinks he *'was scared to. They kind of gave up and disappeared.*'

Sarah, one of David's neighbours, first met David when he was 12, and became concerned about his welfare. She called social care to raise her concerns that he appeared to be very neglected, was with Sarah and her husband, Bill, almost daily, and always ate at their home. Sarah recalls *'social [care] were really awful. They asked if David had bruises. When I said no but that he had signs of neglect, I was told that if he had no bruises there was no reason for social care to go around.'* Several months later, David came to Sarah one day in a lot of pain – his front teeth were rotting. Sarah arranged to take him to a dentist for treatment.

David does not remember social care as much from the age of 13 – *'They visited once every couple of months, if that.'* Sarah and Bill were so concerned that they made another referral to

22 A longer version of David's case summary can be found at Appendix 5

social care. When Patricia was informed of this she banned David from seeing them for five months. After he then 'bumped into' Sarah and Bill, David confided in Sarah that he had been befriended by a man who he had met on the bus whilst truanting from school. Sarah alerted Patricia. It transpired that the man was a paedophile. Shortly after this, David was placed on the CPR under the category of neglect. However, little changed in David's life – *'… it was the same thing as before and after, as in nothing was happening … about anything.'* He was taken out by a charity worker for an activity once a week, but otherwise continued to live with Patricia, whose substance misuse David says remained unchanged.

Attempts by Sarah, Bill and Kids Company to persuade social care to intervene more effectively in David's case proved unsuccessful. Sarah stated, in a letter to social care, that it had been involved in David's case for eight years, and seemed totally complacent about his case. She also stated that David had not been to school for seven months. Sarah was present when David, aged 15, told his social worker about Patricia's verbal and emotional abuse, that she was using Class A drugs, that dealers frequently visited their home, and that he wanted to go away and stay with family. David recalls *'[the social worker] was very dismissive … it was like [they were] trying to persuade me in a manipulative way [to stay at home] … Nothing changed.'* When social care told David that he could not stay with family unless Patricia agreed, David arranged a ticket himself and left London. However, he subsequently had to return home to Patricia because he had nowhere else to go. Again, David felt that social care's intervention did not result in anything changing at home with Patricia's substance misuse, and that it was more outside of the home.

When David was 17 he witnessed a violent incident involving drug dealers at Patricia's home. Several months later, Patricia reportedly set fire to the home, rendering it uninhabitable and David homeless.[23] He was deeply traumatised and extremely vulnerable. When social care proposed to place him in a hostel, Kids Company intervened and arranged temporary accommodation for him itself. Sarah and Bill then privately fostered David shortly before he turned 18. Social care subsequently closed their file on David. Sarah recalls *'he was in a terrible state. He was totally outside of society, had no life and no friends.'* The CEO of Kids Company recalls that David was chronically traumatised, unable to participate in normal procedures and very frightened.

> *'From the time I met him as a six-year-old, standing in the snow in just his underwear, I tried to get social services, the police, both the primary and secondary school settings, as well as the [PRU], to see his needs were more than the system was acknowledging. I was worried about him and used to take him out once a week for half a day so that he could have some kind of interaction beyond being at home with his drug addicted Mum. But I felt everywhere I went there was a brick wall. Years later I found out that social [care] had labelled me as "oppositional" for raising the alarm, and that's probably why the schools wouldn't respond. It was as if I was being described as part of the problem. This is the way voluntary sector workers are sometimes disempowered. We don't get to see what's in the files of the children, or what is being said about the concerns we raise. I couldn't understand why he was being visited occasionally by social workers, yet he was being failed so profoundly.'*
>
> **Camila Batmanghelidjh, CEO of Kids Company, in evidence to the CSJ**

23 This was disclosed by David

Key legal failings/missed opportunities

1. Failure, when David was 12 years old, to undertake an initial assessment and, within ten days, to reach a decision as to whether a core assessment was necessary. There is no legal requirement for bruising to be seen on a child before a duty to assess arises.

2. Decision by social care to disclose the identity of a person making a child protection referral deprived David of an important source of support, and deprived social care of a reliable source of information. Outside of court proceedings, there is no legal requirement for the source of a referral to be revealed to a parent.

3. Failure by social care/Chairperson of CPC to invite VSO to CPC, thereby depriving CPC of a key source of information.

4. Failure to adequately investigate or give sufficient weight to information provided by the voluntary sector.

5. Failure to escalate intervention beyond CPC. Child protection plan not effecting any improvement and repeated referrals were made to social care by the voluntary sector concerning significant harm but no care proceedings were taken, and David remained at home suffering significant harm.

6. Failure by social care to provide appropriate accommodation. The provision of B&B or unsupported hostel accommodation is not suitable for a vulnerable child.

'Accommodation selected for [Kids Company's] "Colour a Child's Life Programme;"' Kids Company, *Kids Company Report for Government March 2011–2013*, London: Kids Company, 2013, p62

'Accommodation selected for [Kids Company's] "Colour a Child's Life Programme;"' Kids Company, *Kids Company Report for Government March 2011–2013*, London: Kids Company, 2013, p62

7. Failure by social care to provide S.20 accommodation thereby deprived David of necessary support under the leaving care provisions.

8. Failure to investigate Patricia's parenting capacity and drug issues.

9. Failure to provide support having agreed that it should be put in place.

Case Study Five: Callie (24-years-old)[24]

> *'I'm always upset, I'm on the verge of doing something drastic … I feel disgusting … I done coke [two] days ago, I'm not [Callie] no more a lot has happened to me on the streets, I just want my own space … that's my last chance with happiness, I'm always hungry, I don't get no sleep … I'm losing it on a real.'*

Callie's father left her mother, Penny, when Callie was an infant. Callie believes she was taken into care when she was a young child. She has often expressed that she feels unloved by Penny. Violence reportedly took place in the home, with Penny being the most likely perpetrator of it towards her partners. At ten, Callie began to smoke skunk. She ran away from home a few times, and feels she has been on her own since she was 12. She was repeatedly fixed-term excluded from school. At 14, Callie was seriously sexually assaulted on two separate occasions, within hours of each other; she did not tell the police or Penny.

At 16, Callie self-referred to Kids Company. The next month she became homeless after her relationship with Penny broke down. Callie spent time on the streets and buses, before being taken in by friends. Kids Company helped to meet some of her basic needs. Callie was initially placed in a hostel by a second local authority (as distinct from the first local authority where she had lived with Penny), and subsequently in a B&B hotel, pending the outcome of her homeless application.

Callie began to access psychotherapeutic support at Kids Company. She had recently stopped drinking – several cans of beer and about a litre of whisky a day. She had also cut down on her consumption of skunk, which she had been smoking heavily. She disclosed to Kids Company that she had been self-harming, had been stabbed, and felt frustrated that every time she went out people were *'fighting, stabbing or being shot.'* Kids Company described Callie as:

> *'an incredible young woman with lots of potential for her future… she is intelligent, articulate and is motivated and active, in trying to overcome the severe disadvantages she has faced, and is currently facing, in her life.'*

The second local authority decided that Callie was not homeless, and discharged its duty towards her, on the basis that it believed she could live with Penny when she was ready. Kids Company submitted a referral to social care in the first local authority, and requested a S.17 assessment to be undertaken, as Callie was due to become homeless the next day. Kids Company highlighted that the emotional therapy that Callie had received had revealed that she was not in a safe environment at home. It also attached a report from its Integrative Child Psychotherapist which stated that 'the lack of safety, stability and support in relation to [Callie's] housing situation [had] had a serious impact on her mental health; she [had] been self-harming… and [had] expressed suicidal ideation.'

Callie became homeless again after the second local authority terminated her contract at the B&B hotel. Social care in the first local authority responded to Kids Company's referral

24 A short discussion of issues regarding Callie's dual diagnosis can be found in Chapter Two

by stating that if Callie intended to return to the borough to live, then she should contact its youth housing service. Social care confirmed that it would be taking no further action and that her case would be closed. Callie had nowhere to go. Kids Company arranged some emergency accommodation for her. In the meantime, Callie went to the youth housing service in the first local authority, which advised her that the second local authority had a duty to accommodate her while she appealed against its decision. Kids Company submitted an appeal on Callie's behalf. Being of no fixed abode, Callie was not in receipt of any benefits and survived on donations from Kids Company.

Solicitors requested a formal review of the second local authority's decision, and threatened to consider JR proceedings if it failed to act in accordance with its duty to provide Callie with temporary accommodation. Callie was considered to be in an 'exceptionally vulnerable state' by a Kids Company psychologist. The second local authority's decision was quashed on review and it accepted its duty to Callie. However, by this stage Callie was considered to be in a 'distraught state' by Kids Company. She refused the interim accommodation offered to her by the second local authority, and decided instead to stay with and help Penny, who Callie said was depressed and in rent arrears. Within a few weeks Callie had attempted suicide. Days later, Penny locked Callie out of the home. She travelled on the buses all night.

After Callie told Kids Company about her recent substance misuse, it located a therapeutic rehabilitation placement for her. However, within a few weeks, Callie was arrested for possession of Class A drugs with intent to supply, and possession of an offensive weapon, which she claimed was for her protection. Callie was convicted and received a three year prison sentence. Kids Company supported Callie whilst she was in prison, and liaised with her housing officer from probation in a third local authority, and her probation officer in prison, to try to ensure that appropriate accommodation was in place on Callie's release. It was agreed that the best environment for Callie would be supported housing, and female only accommodation due to her documented trauma from the age of 14 and high risk needs.

However, at 19, Callie was released with no accommodation in place. She was then offered supported housing in a fourth local authority – in a predominantly male hostel for ex-offenders returning to the community. Callie felt very depressed, lonely and isolated there. She began to drink heavily. The hostel soon raised concerns over Callie's lack of engagement with the staff and missed appointments. Callie also fell into rent arrears after failing to sign on. The hostel served Callie with a Section 21 Notice to evict her in two months' time. Callie's support worker at the hostel agreed that Callie's high risk needs and difficult behaviour could not be met by low to medium risk supported housing (as provided by the hostel). In the meantime, Callie's mental health diagnosis remained unclear.

The hostel decided to pursue Callie's eviction but offered her a 'window of negotiation' if she engaged with it. Callie took an overdose and was admitted to hospital. The hostel proceeded to issue a Claim for Possession of Callie's bedsit – which was withdrawn after being successfully challenged by solicitors. Within days of this Callie was picked up by the police, drunk and threatening to throw herself off a building. The hostel pursued Callie's eviction, serving a fresh Section 21 Notice on her. Callie was recalled to prison in the interim, in part for breaching the terms of her probation licence and for a public order offence. Not long after Callie turned 21,

she was issued with an Eviction Notice by the hostel, leaving her homeless again. Kids Company had multiple concerns around Callie's well-being at this time. A few days later she was sexually assaulted. This is when Callie said she felt she had three options: either to be sectioned, sent to prison, or death. Kids Company made a referral to the police but Callie ultimately decided she did not want to pursue the case.

After her eviction, Callie was offered emergency accommodation in a B&B hostel. She later told Kids Company that she did not take up the offer because things were *'mad…I really regret it; I should have.'* Her life went into crisis and she was difficult to engage. Callie began to stay with her partner, in their late father's flat, in a fifth local authority. The conditions in the flat were described as feral. Callie made an apparent suicide attempt. Within months, she and her partner were diagnosed with scabies. Both had been taking mephadrone (otherwise known as 'Miow Miow') which was affecting their teeth and skin. It was winter and there was no heating or water in the flat, which they were understood to have broken back into following their eviction from it.

After an argument with her partner, Callie expressed the desire to kill herself and was admitted to hospital. Kids Company's attempt to enlist the help of the psychiatrist who had been allocated to Callie, to discuss housing units and her follow up care, failed. The psychiatrist assessed Callie as having no suicidal thoughts or impulses to self-harm, and their impression was that her crisis had settled. Kids Company staff described Callie and her partner as being 'totally uncontained.' A housing referral to the sixth local authority where Callie had been in hospital failed. At 22, Callie was street homeless again. She had open sores down the side of her face and butterfly stitches having been stabbed in the face by her partner. She was believed to be heavily using Class A drugs and was woefully underweight. Kids Company secured Callie a placement in a residential rehabilitation centre. However, she expressed suicidal ideation and discharged herself after three days. At the time of the CSJ's review, Callie was still homeless and staying at her partner's hostel regularly – against its rules. She would climb into a suitcase and be carried secretly upstairs.

Key legal failings/missed opportunities

1. Failure by the second local authority to provide Callie with accommodation pursuant to S.20. When Callie was placed in a hostel by the second local authority she was 16 years old. A child without accommodation is a child in need. The second local authority should, therefore, have undertaken a S.17 assessment of Callie. Considering the circumstances of Callie's homelessness, she was a child in need in the area of the second local authority and her accommodation should have been provided under S.20.

2. Failure by original local authority to undertake a S.17 assessment and provide S.20 accommodation. Callie presented to the original local authority when she was 17 years old and requested a S.17 assessment. The original local authority failed to treat her as a potential child in need, and referred her immediately to Housing rather than treat her as a child entitled to assessment and services.

3. Missed opportunity arising from failure to explore Callie's mental health issues in spite of referral by Kids Company.

Legal foreword

Local authority duties to children and young people

The statutory schemes, that place responsibilities on local authorities for the provision of services to vulnerable children and young people are the Children Act 1989 (CA 1989), the Children Act 2004 (CA 2004), and the Children (Leaving Care)(England) Act 2000.[1] This legislation and connected statutory instruments divide the responsibilities to children and young people into three levels:

i. specific duties to a category of children that can be enforced against the local authority by any individual within that category;

ii. general duties to all children and young people that can be enforced against the local authority by an individual only if the decision not to provide the service was 'unreasonable'; and

iii. discretionary powers that are not enforceable save that a local authority must not fetter its discretion by ruling out the exercise of a power without giving consideration to each individual case.

The differences between these three levels is of key importance in trying to understand how local authorities fail to provide the services that children and young people require, as is demonstrated by the case summaries and each chapter of this report.

The facts of the cases considered for the purpose of the detailed legal reviews occurred prior to March 2013.[2] This foreword explains the duties owed with reference to the *2010 WTSC*, and the *2000 Assessment Framework*, as it was the *2010 WTSC* that was in force at the time events occurred.[3, 4] Significant changes have been introduced by *Working Together to Safeguard*

1 It should be noted that the Children Act 1989, and the Children (Leaving Care)(England) Act 2000 also apply to young people where they are a 'former relevant child', as referred to later in the legal foreword

2 Six cases were reviewed – including those of Claire, Daniel, Michael, David and Callie

3 Department for Children, Schools and Families, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, Nottingham: Department for Children, Schools and Families, issued March 2010

4 Department of Health, Department for Education and Employment, Home Office, *Framework for the Assessment of Children in Need and their Families*, London: The Stationery Office, 2000

Children (2013) (2013 WTSC).[5] Time limits have been removed in favour of the introduction of a concept of timeliness, although the assessment should be completed no longer than 45 days from the point of referral. The *2000 Assessment Framework* has been abolished in favour of Local Protocols for Assessment. The impact of some of the changes introduced by the *2013 WTSC* on vulnerable children will be considered in Chapter Four.

It is not possible within this introduction to set out all the duties and powers that are available to ensure that children are safeguarded, and children and young people supported. Specific examples of key failures and missed opportunities are highlighted in the legal summary section following each case summary. However, before embarking on a consideration of the Kids Company cases, it is important to have firmly in mind that there are a number of duties owed by local authorities that **MUST** be met regardless of the financial cost to the local authority.[6] These include:

Duties to 'children in need'

a. **A specific duty to take reasonable steps to identify children 'in need' in their area**. Paragraph 1 of schedule 2 to the CA 1989 provides 'Every local authority shall take reasonable steps to identify the extent to which there are children in need within their area.'

   A child is to be considered to be 'in need' if he is:

   '(i) unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;

   (ii) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or

   (iii) he is disabled.' A child can be disabled by reason of physical or mental ill health.[7]

   This is a broad definition and a child who requires some level of service to achieve or maintain development should readily qualify as a child in need.

b. A general duty to safeguard and promote the welfare of children in need. Section 17(1) provides that "It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part):

   (a) to safeguard and promote the welfare of children within their area who are in need; and

5 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

6 Please note that highlighted text throughout the legal foreword denotes mandatory obligations on local authorities, which must be undertaken regardless of cost

7 Children Act 1989, Section 17(10)

(b) so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.'

This is a general duty to support children at home in the care of their family. It is only when it is not possible to safely leave children at home, the support and services provided under Part 3 of the CA 1989 having failed, that the local authority should consider its child protection powers under Part 4 of the CA 1989.[8]

c. **A specific duty to make an assessment of a child if that child may be in need of services.** In the case of *R(G) v Barnet LBC,* the House of Lords implied an assessment duty into section 17 of the CA 1989.[9]

d. **A specific duty to conduct the assessment using the *2000 Assessment Framework***. This was statutory guidance issued under the Local Authority Social Services Act 1970 (LASSA 1970). Local authorities were bound to follow it unless there was good reason not to do so.

- The decision to assess must be made within one day of the date when the child came to the attention of the local authority;
- The initial assessment must be completed within ten working days of the date when the child first came to the attention of the local authority;
- The assessment must objectively identify the child's needs. It should not shape the needs of the child around the services available;
- It is unlawful for a local authority to impose its own eligibility criteria to be satisfied before it will undertake an assessment;
- The initial assessment should identify the services that the child requires immediately, and whether a fuller 'core assessment' is required;
- The core assessment must be completed within 35 working days, and appropriate services should be provided while awaiting the completion of the core assessment.

Additional duties flow from the conclusions of the core assessment and in the manner of the assessment itself, examples include:

(i) if there are concerns that the child is at risk of significant harm, an enquiry must be conducted under section 47 of the CA1989. If the concerns do not reach the threshold of 'significant harm' then any identified needs must progress under the child-in-need system. Harm is defined as 'ill treatment or the impairment of health or development,'

8 I.e to make an application to the court to obtain a care order, supervision order, emergency protection order or child assessment order
9 R(G) v Barnet LBC [2003] UKHL 57

and includes 'impairment suffered from seeing or hearing the ill-treatment of another.'[10] Development is defined as 'physical, intellectual, emotional, social or behavioural development.' Health includes physical and mental health. 'Significant' is defined as 'considerable, noteworthy or important.'[11]

(ii) If the concerns do amount to a risk of significant harm, then a strategy discussion must be convened. The four flow-charts that were appended to the *2010 WTSC* are attached to this report.[12] These flow charts demonstrate the manner in which local authorities should have been managing their assessment and decision-making.[13]

(iii) The failure to have in place a systematic approach involving collaboration between all relevant agencies so as to achieve a full understanding of the child in his or her family and community context is unlawful.[14]

(iv) Assessments much address foreseeable future needs as well as present needs.[15]

(v) Severely challenging behaviour by a child resistant to the assessment process does not absolve the local authority of its duty to undertake the required assessment. It must try its best to comply with its statutory duties to the child; in the case of *R (J) v Caerphilly CBC*, Munby J stated 'the fact that a child is uncooperative and unwilling to engage, or even refuses to engage, is no reason for the local authority not to carry out its obligations under the Act and the Regulations. After all, a disturbed child's unwillingness to engage with those who are trying to help is often merely a part of the overall problems which justified the local authority's statutory intervention in the first place. The local authority must do its best.'[16]

e. A general duty to provide services to meet assessed needs if the assessment demonstrates that it is necessary to do so to 'secure the wellbeing of the child,' but no specific duty providing the child with a right to the services.

(i) Section 17(1) is a general duty that does not give rise to an absolute right to a service.'[17]

Para 4.1 of the *2000 Assessment Framework* required that the conclusion of an assessment should result in:

- An analysis of the needs of the child and the parenting capacity to respond appropriately to those needs;

10 Children Act 1989, section 31(9)
11 *Children Act 1989 Guidance and Regulations Volume 1: Court Orders*, London: Her Majesty's Stationery Office, March 1991, paragraph 3.19; and Humberside County Council v B [1993] 1 FLR 257
12 See Appendix 1
13 The revised flow charts appended to the *2013 WTSC* are also attached to this report, which provide the current guidance – at Appendix 2
14 R v (AB and SB) v Nottingham City Council [2001] EWHC 235
15 R (K) v Manchester [2006] EWHC 1196
16 R (J) v Caerphilly CBC [2005] EWHC 586
17 Children Act 1989, Section 17(1)

- Identification of where intervention will be required to secure the well-being of the child;

- A realistic plan of action (including the services to be provided) setting out who has responsibility for implementing the plan, a timetable for implementation and a process for review.

In the case of *R(VC) v Newcastle City Council (2012) 15 CCLR 194*, Munby LJ rejected an argument that the *2000 Assessment Framework* itself imposed a duty to provide a service that was assessed as being required. However, he said 'Any refusal to provide assessed services is, of course, amenable to challenge by way of judicial review in accordance with recognised principles of public law, one of which is that discretionary statutory powers must be exercised to promote the policy and objects of the statute.' At paragraph 26 he said 'where the assessment is to the effect that there is a need for services, any decision not to provide the assessed services will no doubt, and not least because a child is involved, be subjected to strict and, it may be, sceptical scrutiny, particularly if there is no available argument based on lack of resources.'

The *2013 WTSC* abolishes the *2000 Assessment Framework* and replaces paragraph 4.1 with a 'Focus on Outcomes' that requires:

- *'Every assessment should be focussed on outcomes, deciding which services and support to provide to deliver improved welfare for the child;*[18]

- *Where the outcome of the assessment is continued local authority children's social care involvement, the social worker and their manager should agree a plan of action with other professionals and discuss this with the child and their family. The plan should set out what services are to be delivered, and what actions are to be undertaken, by whom and for what purpose;*[19]

- *Many services provided will be for parents or carers. The plan should reflect this and set clear measurable outcomes for the child and expectations for the parents, with measurable, reviewable actions for them.'*[20]

(ii) If the assessment concludes that a service is necessary 'to secure the well-being of the child,' there is a discretion not to provide the service but whether it is unreasonable for the local authority not to provide a specific service, it having been assessed as necessary to secure the well-being of the child, will be case specific and the local authority's decision not to provide a service must take into account all the circumstances of the case.

f. A specific duty to produce a care plan setting out how assessed needs are to be met. A care plan must be produced on completion of a child in need assessment.

18 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, paragraph 49 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

19 Ibid, paragraph 50

20 Ibid, paragraph 51

If the case involves the risk of significant harm, then the CPC must produce a child protection plan if the conference concludes that the child is at risk of significant harm. If the case goes before a court, the local authority must produce a care plan for the court.

Duties to Accommodate Children

g. It is a specific duty that a local authority MUST provide accommodation to a child if the criteria in section 20(1) CA 1989 are met.

(1) The child must be 'a child in need' within the local authority's area who requires accommodation as a result of:

- there being no person who has parental responsibility for him; or
- his being lost or abandoned; or
- the person caring for him being prevented from providing him with suitable accommodation (for any reason including the parent being unable to function as a parent).

(2) This duty applies to all children under 18.

(3) Once the requirements of the section are satisfied there is an absolute duty to provide accommodation.

(4) Section 20 accommodation can include a wide range of different types of supported accommodation, including semi-independent living flats and houses, children's homes and foster care. However, B&B or hostel accommodation is deemed unsuitable for a child of 17 or younger (if being accommodated without a carer).[21]

(5) The local authority is required to take the child's wishes and feelings into account, although they are not determinative of the type of accommodation that is provided.[22]

(6) Section 17(6) CA 1989 specifies that services provided under that section can include the provision of accommodation. However, if a child is provided with accommodation under section 20 CA 1989, that child then becomes a 'looked after' child. If a child is 'looked after,' the local authority then owes additional general duties to the child under section 22 CA 1989, and also becomes liable to provide leaving care support under the Children (Leaving Care) Act 2000. *It is for this reason that local authorities will often seek to describe accommodation as provided under section 17 rather than section* 20.

21 Department for Communities and Local Government, Department for Children, Schools and Families, *Joint working between Housing and Children's Services: Preventing homelessness and tackling its effects on children and young people*, London: Department for Communities and Local Government, May 2008; and Department for Children, Schools and Families, Department for Communities and Local Government, *Provision of Accommodation for 16 and 17 year old young people who may be homeless and/or require accommodation: Guidance to children's services authorities and local housing authorities about their duties under Part 3 of the Children Act 1989 and Part 7 of the Housing Act 1996 to secure or provide accommodation for homeless 16 and 17 year old young people*, London: Department for Children, Schools and Families and Department for Communities and Local Government, April 2010

22 Children Act 1989, Section 20(6), Section 22(4) and 22(5)

(7) Local Authorities cannot avoid their responsibilities to children by labeling the accommodation provided as section 17 accommodation when the requirements of section 20 are satisfied.[23]

(8) Children aged 16 and 17 must be offered social care services and accommodation under section 20. They cannot simply be told to report to the Housing Department to be accommodated under housing legislation, unless the 16- or 17-year-old old refuses to be accommodated as a 'looked after child' under section 20.[24]

Duties to 'Looked After' Children

h. The general duties owed to 'looked after' children under section 22 CA1989 include:

(i) the general duty to safeguard and promote the child's welfare;

(ii) the general duty to promote the child's educational achievement;

(iii) the duty to maintain the child in respects other than the provision of accommodation;

(iv) the duty to make arrangements for the child to live with a parent unless this would be inconsistent with the child's welfare;

(v) the duty to place the child in 'the most appropriate placement' if the child is unable to live with a parent.

These general duties lead to a *specific* duty in requiring that a local authority undertake an assessment of the needs of the child. Regulation 4 of the Care Planning, Placement and Case Review Regulations 2010 requires that **a care plan must be prepared for a looked after child** and when assessing the needs of the child, the local authority must consider whether the child's placement meets the requirements of Part 3 of the CA 1989.[25]

Duties to Children Leaving Care

If a child is accommodated by a local authority and is therefore 'looked after' under section 20 CA 1989, and has been so accommodated for at least 13 weeks between the ages of 14 and 18, and at least one week has been on or after the child's 16th birthday, that child becomes entitled to a wide range of support under the terms of the Children (Leaving Care) Act 2000, the Children (Leaving Care) Regulations 2001 (2001 Regulations) or, since April 2011, the Care Leavers (England) Regulations 2010 (2010 Regulations).

23 R (G) v London Borough of Southwark [2009] UKHL 26

24 Ibid

25 The duties to children in need are provided under section 17 of the Children Act 1989, and the general duties to looked after children are provided under sections 22 to 23ZB of the Children Act 1989

The CA 1989 schedule 2 paragraph 19A provides 'it is the duty of every local authority looking after a child to advise, assist and befriend him with a view to promoting his welfare when they have ceased to look after him.'

If a child is accommodated for a short period, none of which exceeds four weeks and at the end of each period of accommodation that child returns to his parents, then the child is excluded from the definition of 'eligible child.'[26] The legislation also sets out duties to other categories known as 'relevant child' and 'former relevant child.'[27]

A 'relevant child' is a child who is no longer being looked after but prior to ceasing to be looked after had enough days accumulated to qualify for a leaving care package. The duties owed to an 'eligible child' as set out below are also owed to a 'relevant child.'

A 'former relevant child' is a young person aged 18 or over who has been an 'eligible child' or a 'relevant child' and, in relation to whom, the local authority was the last responsible authority for the provision of services. Former relevant children are entitled to the continued appointment of a person advisor, to reviews of their pathway plan and, under CA 1989, assistance by way of contributing to the expenses of living near the place where he is or will be employed, or where he is seeking employment or near to where he is or will be training.[28]

If a child is an 'eligible child' the local authority has the following duties:

i. **A specific duty to appoint a personal advisor for an eligible child if the child is over 16 years old**. This is an absolute duty and must be done forthwith or as soon as reasonably practicable. The personal advisor must 'possess a sound demonstrable understanding of human growth and development (in particular, being competent in understanding the insecurities faced by looked after children as they make their transition to adulthood).'[29] The personal advisor must be independent of the local authority.

j. **A specific duty to carry out a 'pathway assessment' and prepare a 'pathway plan'** that details the support that is to be provided for a child leaving care.

   (i) The CA 1989 schedule 2 paragraph 19B provides that the local authority is under a duty to 'carry out an assessment of his needs with a view to determining what advice, assistance and support it would be appropriate for them to provide him … (a) while they are looking after him; and (b) after they cease to look after him.' This assessment must be completed no more than 3 months after the date on which he reaches 16 years old or the date he becomes an eligible child after that age.[30]

26 Care Leavers (England) Regulations 2010, Regulation 3(3)
27 Children (Leaving Care) Act 2000
28 Children Act 1989, Section 23C(4)
29 Department for Education, *The Children Act 1989 Guidance and Regulations Volume 3: Planning Transition to Adulthood for Care Leavers*, London: Department for Education, October 2010
30 Care Leavers (England) Regulations 2010, Regulation 5(2)(a) and Children (Leaving Care) Regulations 2001, Regulation 7(2)(a)

(ii) The 2010 regulations provide that in carrying out the pathway assessment the local authority shall take account of:

(a) the child's health and development;
(b) the child's need for education, training or employment;

(c) the support available to the child from members of his family and other persons;
(d) the child's financial needs;
(e) the extent to which the child possesses the practical and other skills necessary for independent living; and
(f) the child's need for care, support and accommodation.

(iii) The 2010 regulations specify that the local authority must seek and take into account the views of a number of essential participants for the pathway assessment process, and this includes 'any other person whose views the responsible authority, or the child consider may be relevant' – such as a voluntary organisation working with the child.

(iv) Once the assessment is completed, the local authority has a duty to prepare a pathway plan.[31] This is to be completed as soon as possible after the assessment.

(v) '**A pathway plan must clearly identify the child's needs, and what is to be done about them, by whom and by when.** Or, if another aphorism would help, a pathway plan must spell out who does what and when.'[32]

(vi) If a pathway plan is prepared without a personal advisor having been appointed or with the social worker or another social worker with the same local authority purportedly appointed in the role of personal advisor, the local authority will have acted unlawfully and a fresh assessment will be required.[33]

The continuing duties to an eligible, relevant and former relevant child continue until the individual reaches the age of 21 unless the pathway plan sets out a program of education and training and, if so, the duties extend beyond age 21.

The case summaries highlight clear examples of poor decision-making; where value judgments appear to have been made that a child or young person does not deserve a service, their behaviour is such that it is decided that support should not be offered, or there is insufficient effort made to engage with a challenging child or young person which results in a ready acceptance by the local authority of a child or young person's rejection of services. However, the case summaries also provide examples of where local authorities have failed to understand their duties and powers or appear to have deliberately sought to interpret a situation as giving rise to the use of a 'power,' that it can chose not to deploy, rather than a situation that gives rise to a 'duty' that it must satisfy. In these times of austerity, decisions

31 Children Act 1989, schedule 2, paragraph 19B(4)
32 Words of Munby J in R (J) v Caerphilly CBC [2005] EWHC 586 (Admin)
33 R (A) v Lambeth LBC [2010] EWHC 1652

concerning the provision of services to children and young people are at risk of becoming resource-led rather than needs-led.

The case summaries also include examples where the child's situation was such that he or she was thought to be at risk of significant harm. When this assessment is made, the welfare of those children should be safeguarded by the local authority convening a CPC and/or by the issue of care proceedings. The lack of success of the CPC in securing support and services from local authorities on behalf of these vulnerable children can be seen from the facts of case summaries regarding Michael, Claire and David. In each case, crucial information concerning the child was not before the CPC due to a failure by the local authority to engage with Kids Company, and there being no method by which a VSO can compel a local authority to consult with it, to act upon information it provides if consulted, or to secure an invitation to a CPC concerning a child it is supporting. This is a lacuna in the child protection legislation and a matter that should be addressed. As is explained in Chapter Four of the report, the issue of a complaint to the local authority, whether formal or informal, does nothing to achieve necessary protection or the timely provision of services to a child or young person.

The only effective remedy available to the voluntary sector is to support the child in obtaining legal representation to enable the child to seek a JR of the action of the local authority. This sets the VSO and the child against the local authority in costly court proceedings, when all that is required is for the local authority to work cooperatively with, and give adequate weight to the role of the voluntary sector that, after all, has the most contact with and holds the most detailed information concerning the child.

Darren Howe
27 April 2014

Statutory mental health provision

Legal Framework

At its most fundamental level, sections 1 and 3 of the National Health Service Act 2006 (NHS Act 2006) provide general duties to provide health care for individuals.

Section 1(1) requires the Secretary of State for Health to continue the promotion of a comprehensive health service designed to secure improvement in (a) the physical and mental health of people in England, and (b) the prevention, diagnosis and treatment of illness.

Under section 3, the Secretary of State has a general responsibility to provide any services he considers to be necessary to meet the reasonable conditions of the NHS Act 2006. Section 3 states that he is responsible to provide the following services:

a. Hospital accommodation;

b. Other accommodation for the purpose of any service provided under the Act;

c. Medical, dental, ophthalmic, nursing or ambulance services;

d. Such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service;

e. Such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;

f. Such other services or facilities as are required for the diagnosis and treatment of illness.

Although the Secretary of State may have ultimate responsibility, these duties are delegated to local Clinical Commissioning Groups (CCGs). There are two categorisations of health service – primary and secondary care.

'Primary care services' are seen as covering the role of GPs, pharmacists, dentists and midwives who are invariably the first point of contact and will usually continue to be involved if a person receives secondary care. Section 83(1) of the NHS Act 2006 places CCGs under a duty to meet all the reasonable requirements of a patient and to provide primary medical services within their area.

'Secondary care services' are acute or specialist healthcare provided in a hospital or other secondary care services (for example, CAMHS and AMHS). The referral for secondary care services is usually made through a primary care provider with whom the individual is registered. Where an individual is not registered with a GP, it is based on where they are usually resident.

Unlike social care, which includes legislation that places specific duties on local authorities to make particular provision for children (see, for example, the Chronically Sick and Disabled Persons Act 1970 (CSDPA 1970)), there are no equivalent specific duties in mental health. However, a duty to act could be established where not to do so would amount to a breach of the child's human rights under the Human Rights Act 2000 (as would also be the case for social care).

The specific duty to assess the health care needs of a child or young person

As with social care, there is no specific provision in the NHS Act 2006 requiring the assessment of a child's health care needs; nor is there in relation to young people. However, it can be argued that such a duty exists.

This arises from, among other things, the finding of the House of Lords in the case of *R(G) v Barnet LBC,* which states that there is a duty to provide an holistic assessment of a child in need's social, educational and health care needs.[34]

34 R(G) v Barnet LBC [2003] UKHL 57

It can also be argued that if a health body did not put together an assessment of a child's or young person's needs it would not be able to ask itself the fundamental question, 'is it necessary to provide services to meet a particular need?' This would be contrary to a public law requirement that public bodies have regard to relevant considerations (or in other words, 'ask themselves the right questions before coming to a decision').

The role of CAMHS

CAMHS does not have its own statutory framework. It is provided via the NHS Act 2006 and the Mental Health Act 1983, which is concerned with people deprived of their liberty (i.e. under section) and is outside the scope of this Review. CAMHS is shaped by government policy.

In 2004, the Government published the *National Service Framework for Children, Young People and Maternity Services (The National Service Framework)* aimed at setting out national standards and best practice guidance in an attempt to provide standards, which public bodies should aspire to meet. The Secretary of State for Health set out in the foreword that:

> *'At the heart of this National Service Framework is a fundamental change in our way of thinking about children's health. It advocates a shift with services being designed and delivered around the needs of the child. Services are child-centred and look at the whole child – not just the illness or the problem, but rather the best way to pick up any problems early, take preventative action and ensure children have the best possible chance to realise their full potential. And if and when these children grow up to be parents themselves they will be better equipped to bring up their own children.'*[35]

This is called 'practice guidance' and is, in essence, advice as to what the law requires and how to achieve compliance. It does not need to be followed if there are good reasons to depart from it. Unlike 'statutory guidance' (such as the *2013 WTSC*, which is issued under section 7 of the LASSA 1970) where decision-makers can only depart from it if they can show that there is good reason to do so, 'practice guidance' allows public bodies more freedom not to follow it. Although, there must be a credible reason for doing so.[36]

The *National Service Framework* set out five core standards that apply to all children, young people and their parents and carers. They are 'Standard 1: Promoting Health and Well-being, Identifying Needs and Intervening Early;' 'Standard 2: Supporting Parenting;' 'Standard 3: Child, Young Person and Family-Centred Services;' 'Standard 4: Growing Up into Adulthood' and 'Standard 5: Safeguarding and Promoting the Welfare of Children and Young People.' There is a particular standard for children and young people with mental health problems – 'Standard 9: The Mental Health and Psychological Well-being of Children and Young People.' This states that:

35 Department for Education and Skills, and Department of Health, *National Service Framework for Children, Young People and Maternity Services: Core Standards*, October 2004, p2 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199952/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Core_Standards.pdf (06.06.14)]

36 See R v Islington LBC ex parte Rixon (1997-98) 1 CCLR 119

'All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality multi-disciplinary mental health services to ensure effective assessment, treatment and support for them and their families.'[37]

The *National Service Framework* was set up as a ten year plan, with the expectation being that health, social and educational services would have met the standards set out in the document by 2014. This aspiration will not be realised.

Previously, *Improvement, Expansion and Reform: The next 3 years (Priorities and planning framework 2003-2006)* was produced with the aim of developing a comprehensive CAMHS that would be available in all areas by 2006.[38] This would mean that in every area there would be clarity about how the full range of users' needs were to be met, whether it be the provision of advice for minor problems or the arrangements for admitting children or young people with serious mental illness to hospital. It was acknowledged that further improvements and developments would be required throughout the lifetime of the *National Service Framework*, and that the aspiration should be to continually improve and develop services in the context of multi-agency partnerships across the spectrum of need.

In 2004, a new document was published, which set out Standard 9 of the *National Service Framework (National Service Framework: Standard 9)*.[39] At Appendix 2 it sets out the vision for a comprehensive CAMHS, including underpinning principles. These include:

- Access to be available to all children and young people regardless of their age, gender, race, religion, ability, class, culture, ethnicity or sexuality;
- Commissioning of multi-agency services from commissioners who have requisite skills, knowledge, time and executive authority to undertake the task;
- Commissioning and delivery of services should be informed by a multi-agency assessment of need that is updated regularly and should include, among other things, the views of all stakeholders including children, young people and their families.[40]

Appendix 2 goes on to set out the range of services, workforce and skills, training and development and organisational arrangements.[41]

In 1995 the NHS Health Advisory Service published a thematic review of CAMHS entitled *Together We Stand*, which described a four-tier strategic framework for services.[42]

37 Department of Health, *CAMHS Standard, National Service Framework for Children, Young People and Maternity Services*, October 2004, p4

38 Department of Health, *Improvement, Expansion and Reform: The next 3 years, Priorities and planning framework 2003-2006*, October 2002 [accessed via: http://webarchive.nationalarchives.gov.uk/20040405042150/publications.doh.gov.uk/planning2003-2006/index.htm (23.12.13)]

39 Department of Health, *CAMHS Standard, National Service Framework for Children, Young People and Maternity Services*, London: Department of Health, 2004

40 Ibid, pp48–49

41 Ibid, pp50–52

42 NHS Health Advisory Service, *Together We Stand: Thematic Review of the Commissioning, Role and Management of Child and Adolescent Mental Health Services*, Her Majesty's Stationery Office, 1995

Accordingly, the four levels are:

1. Tier 1: A primary level of care.

2. Tier 2: A service provided by specialist individual professionals relating to workers in primary care.

3. Tier 3: A specialised multi-disciplinary service for more severe, complex or persistent disorders

4. Tier 4: Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units.

Appendix 1 of *National Service Framework: Standard 9* explains that the term CAMHS can be used in two ways. The first way is 'a broad concept embracing all services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies.'[43] It is covered by Tier 1. It includes those services whose primary function is not mental health care and refers to GPs, health visitors, school nurses, social workers, teachers, juvenile justice workers, voluntary agencies and social care.

The second way, 'applies specifically to specialist [CAMHS] at Tiers 2, 3 and 4, also including specialist social care, educational, voluntary and independent provision for children and young people with mental health problems. For these services, the provision of mental health care to children and young people is their primary function. They are mainly composed of a multidisciplinary workforce with specialist training in child and adolescent mental health.'[44]

National Service Framework: Standard 9 contains sections on (i) mental health promotion and early intervention; (ii) partnerships with children, young people and families; (iii) access and location of services; (iv) improving service equity; (v) partnership working; (vi) developing high quality multi-disciplinary CAMHS teams; (vii) planning and commissioning services; and (viii) training and development.[45]

With respect to 'access and location of services,' it should be noted that there is some scope for self-referrals being made rather than solely through GPs, which is commonly the case. This is referred to in paragraph 6.1; in addition, paragraph 6.5 states that 'Primary Care Trusts and Local Authorities address the need to take services closer to children and young people (e.g. by providing school-based and family/health-centre-based services) especially where parental co-operation presents difficulties, and consider the need for self-referral through a number of entry points to CAMHS at Tiers 1 and 2.' [46]

43 Department of Health, *CAMHS Standard, National Service Framework for Children, Young People and Maternity Services*, London: Department of Health, 2004, p44
44 Ibid
45 Ibid, pp10–41
46 Ibid, pp15–16

Paragraph 6.6 also states, with respect to access to specialist CAMHS (i.e Tier 2, 3 or 4), that 'Waiting too long for a service is clearly unhelpful. The parent, child or young person may be less willing to take up a service where the wait has been excessive. Similarly, there is a risk that a condition may deteriorate and become more difficult to treat.'[47]

With respect to emergency out-of-hours services, paragraph 6.9 states that 'Children and young people with urgent mental health needs may present to a range of agencies during out-of-office hours. These include emergency duty social workers, police, general practitioners and other primary health care professionals and community workers. Professionals working in these agencies need to be able to make an initial assessment of the child or young person's needs and be able to make appropriate referral to specialist services if required.'[48]

Cooperation between health and the local authority

There is a clear recognition that health and social care should cooperate with each other. Section 10 of the CA 2004 states that each children's services authority should make arrangements to cooperate with its relevant partners. The list of relevant partners is set out at section 10(4) of the CA 2004.

Section 82 of the NHS Act 2006 also states that health bodies and local authorities must cooperate with each other in order to secure and advance health and welfare. There is an argument for stating that local authorities have a clear responsibility to take the lead role in assessing and ensuring that needs are met in accordance with an assessment under section 17 of the CA 1989. Similarly, the CCG may act as the lead agency where the child is considered to have needs that are sufficiently severe and complex so that it is concluded that the child is eligible for continuing health care needs.

As there is no statutory duty on the local authority or health to act as the lead agency there is a greatly increased chance that a vulnerable child will slip between the gaps in the services. There is no reason why a complaint or, if necessary, a JR challenge could not be brought against the local authority and/or the CCG, challenging their failure to co-operate and coordinate their activities.[49]

National Service Framework: Standard 9 comments on the difficulties of forming partnerships across agencies. Paragraph 8.2 states:

47 Ibid, p17

48 Ibid, p18

49 Complaints can be made about the services received from local authorities and/or NHS bodies. Bringing JR proceedings is considered to be a last resort and, we are advised, should only be taken if alternative remedies, such as through the local authority's complaints procedure, in accordance with section 26 of the Children Act 1989, or the NHS complaints procedure, have been pursued. If a complainant is not satisfied with the outcome of their complaint, it can then be taken to the Local Government Ombudsman (LGO) with respect to maladministration, or the Health Services Ombudsman (HSO). However, whether one pursues a case before the LGO or HSO may depend on a number of factors including the length of time that it will take to resolve a dispute, and whether the dispute concerns legal issues. However, resolution through complaints procedures/LGO or HSO should only be used where the alternative remedies will be 'convenient and effective.' Where the case is serious or urgent it is often the case that there is not enough time to pursue other complaints procedures or they will not produce an effective remedy. In such circumstances the court is likely to accept that the only appropriate remedy is through the bringing of a challenge by way of JR

'Partnership working across agencies working with children and young people with mental health problems can be a challenging task. The lack of understanding of the respective roles, duties, responsibilities and organisation of the different agencies and professionals and of their different language, may lead to poor communication, misunderstandings and frustration. Effective partnership working can improve children and young people's experience of services and lead to improved outcomes. There is a continuing role for universal services once a child or young person has been referred to specialist CAMHS, and ensuring that partnership working is effective is particularly important in these situations.'[50]

National Service Framework: Standard 9 section relating to planning and commissioning services states:

'10.1 Effective commissioning is a multi-agency activity that requires that the commissioners have the requisite skills, knowledge, time, and executive responsibility to undertake the task.

10.2 There should be full participation and ownership of the commissioning process by health, social services and education with participation as appropriate by other key partners such as youth justice. In many areas, this participation and ownership will be secured through the Children and Young People's Local Strategic Partnership, or equivalent body.'[51]

The transition from child to adult services

A good practice guide on effective transition from children's to adult services for young people with complex health needs called *Transition: Moving on Well* was published in 2008.[52] It highlighted at the outset that evidence was emerging that, ' … a good transition can improve health-related quality for young people with complex health needs and disabilities.'[53] Conversely, it stated that 'A poor transition out of children's services with lack of continuity and follow-up may lead to a disengagement with health services and can have serious outcomes for young people as well as incurring additional health service costs.'[54] The health transition plan should be considered as part of a broader transition plan that links closely with education and social care. The practice guide explains the planning process, which should be started by the time a child is thirteen and updated continuously. It states that:

'The planning process needs the involvement of an integrated multi-disciplinary team of people (including the GP) who have the appropriate training, expertise and skills and who are able to cross-refer to provide coordinated care. Successful planning is person centred

50 Department of Health, *CAMHS Standard, National Service Framework for Children, Young People and Maternity Services*, London: Department of Health, 2004, p25

51 Ibid, p38

52 Department for Children, Schools and Families, and Department of Health, *Transition: Moving on Well: A good practice guide for health professionals and their partners on transition planning for young people with complex health needs or a disability*, February 2008 [accessed via: http://www.bacdis.org.uk/policy/documents/transition_moving-on-well.pdf (25.02.14)]

53 Ibid, p9

54 Ibid, p10

and recognises that the young person's needs will change over time. It may be a simple or complex process depending on the young person's condition and the range of services required.'[55]

National Service Framework: Standard 9 states that 'The Care Programme Approach is used on discharge from in-patient care and on transition from child to adult services.'[56]

The United Nations Convention On The Rights Of The Child (UNCRC)

The impact of the UNCRC, a human rights treaty, should not be underestimated. It has been ratified by almost every country in the world, including every European country. Its substantive provisions are unusually far-reaching and cover not only civil and political rights but also economic, social and cultural rights. The comprehensive rights contained within the UNCRC do not consider the child in isolation but recognise the interrelationships that exist between the child, the family (or those who have day to day care of the child) and the State. Underpinning the UNCRC is a set of general principles that apply to all the other rights contained within the UNCRC. These principles are that in all matters concerning children, the child's best interests shall be a primary consideration (Article 3(1)); non-discrimination (Article 2); respect for the views of the child (Article 12); the survival and development of the child (Article 6(2)); and the evolving capacities of the child (Article 5).

The UNCRC was ratified by the UK on 16 December 1991. It has not been incorporated into UK law like, for example, the European Convention on Human Rights, which was incorporated through the Human Rights Act 1998. However, by ratifying the UNCRC, the UK has accepted to be bound by the provisions contained within it. For instance, on 6 December 2010, the Minister for Children and Families gave an assurance that the UNCRC will be given due consideration when making legislation and policy that affects children.

The application of the UNCRC in the UK has been developed on an ad hoc basis primarily through the decisions of courts, which have applied rights contained in the UNCRC. This has included decisions concerning, for example, the separation of mothers from their babies in prison mother and baby units; the appropriateness of the placement of a child in a Young Offenders Institution; the unnecessary delay between a child being charged and brought to trial; freedom from inhuman and degrading treatment and punishment, and the importance of the voice of the child in issues that fundamentally affect his or her family life. The courts have highlighted the importance of the UNCRC in their decision-making. In the case of *Smith (FC) v Secretary of State for Work and Pensions*, the House of Lords stated that:

'Even if an international treaty has not been incorporated into domestic law, our domestic legislation has to be construed so far as possible so as to comply with the international

55 Ibid, p11

56 Department of Health, *CAMHS Standard, National Service Framework for Children, Young People and Maternity Services*, London: Department of Health, 2004, p22

obligations which we have undertaken. When two interpretations of these regulations are possible, the interpretation chosen should be that which better complies with the commitment to the welfare of children which this country has made by ratifying the [UNCRC].'[57]

The courts have in recent years provided a clearer understanding of the meaning of the important principle of the best interests of the child. In the case of *ZH v Secretary of State for the Home Department*, it was noted in the Supreme Court that a primacy of importance must be accorded to a child's best interests.[58] A Judge went on to explain that:

'This is not, it is agreed, a factor of limitless importance in the sense that it will prevail over all other considerations. It is a factor, however, that must rank higher than any other. It is not merely one consideration that weighs in the balance alongside other competing factors. Where the best interests of the child clearly favour a certain course, that course should be followed unless countervailing reasons of considerable force displace them. It is not necessary to express this in terms of a presumption but the primacy of this consideration needs to be made clear in emphatic terms.'

Article 19 of the UNCRC states, with respect to safeguarding and child protection, that:

1. *'Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.*

2. *Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.'*

The UNCRC also contains a number of provisions relating to mental health. For instance, Article 23 concerns the right of children with physical and mental health needs to special care; Article 24 recognises the right of children to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health; Article 27 recognises the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development; and Article 29 states that a child's education is to be directed towards the development of the child's personality, talents and mental and physical abilities to their fullest potential.

57 *Smith (FC) v Secretary of State for Work and Pensions [2006] UKHL 35*
58 *ZH v Secretary of State for the Home Department [2011] UKSC 4*

Main introduction

'The frontline is really stretched – more so than I have ever seen it stretched. It is stretched to breaking point.'
Dr Karen Broadhurst, in evidence to the CSJ

'We're in crisis.'
School-Home Support (SHS) practitioner, in evidence to the CSJ

'I have this vision of children caught up in the equivalent of a game of statutory swing ball which flings them from service to service, putting into place boundaries designed to keep them out, rather than help them … There is a focus on increasingly short-term interventions using poorly qualified workers who are faced with tackling what are chronic long-term problems. These problems are often complex and multi-generational but six sessions if you are lucky is the only thing you will be offered. Dependency in any service is discouraged or frowned on; it's almost a dirty word …'
CAMHS clinician, in evidence to the CSJ

Our report was prompted by Camila Batmanghelidjh, CEO of Kids Company, who raised a number of serious concerns regarding, in particular, child protection and statutory mental health provision. The CEO informed us of some extremely worrying information that heads of various services and senior professionals had shared with her – of very serious and highly consequential concerns about shortfalls in services to vulnerable children and young people. The CEO explained that these senior individuals had informed her that they felt they could not share their concerns elsewhere due to being worried about their job security and future prospects. The CEO felt that social workers and other statutory professionals were being blamed generally, but that what was important was to acknowledge the existence of systemic problems which presented those professionals from delivering the quality of service they would like to deliver. We determined to explore this further.

'A realistic first step for them … would be to seriously listen to the child, by talking and listening and taking both stories into account. I had my story of my mum's drug use and my mum had her story of my so-called behaviour issues. They should have a … way to figure out who's telling the truth … and from there make judgement calls on what they find – to not just dismiss because, if someone is younger, apparently they lie more but it's not the case in

most situations … Social [care] should have not only made a plan for me – to help divert my attention from the traumatic events of my childhood, they should also have made a plan … for my mum to help her. Because in the end, it was my mum who needed the help more than me. If you've got parents who can look after themselves, you've got parents who can look after you; if a parent can't look after themself, they don't have the right to look after a child.'

David, in evidence to the CSJ

A brief policy context

Reforms

Child protection

Following the tragic death of Peter Connelly (also known as 'Baby P') in 2007, a fundamental programme of social work reform was launched. In November 2008, Lord Laming was commissioned by the previous Government to report on the progress made in England 'to implement effective arrangements for safeguarding children.'[1] The Social Work Task Force, set up in December 2008, recommended comprehensive reform of the social work system to enable social workers to practise confidently and safely. Following publication of the previous Government's implementation plan in March 2010, the Social Work Reform Board was established, and tasked with implementing the Task Force's recommendations, and driving forward improvements in frontline child protection practice.

In June 2010, Professor Eileen Munro was asked by the current Government to conduct an independent review of child protection in England.[2] Professor Munro subsequently made 15 recommendations to:

> *'… help to reform the child protection system from being over-bureaucratised and concerned with compliance to one that keeps a focus on children, checking whether they are being effectively helped, and adapting when problems are identified.'*[3]

These were considered to 'fit well' with the work of the Social Work Reform Board.[4] In the meantime, The College of Social Work was established, as recommended by the Task Force, with a key role in progressing and ensuring the realisation of the reforms.

1 Lord Laming published his report in March 2009. He reported that there were '…real challenges still to address in safeguarding and child protection…;' Laming Lord, *The Protection of Children in England: A Progress Report*, London: The Stationery Office, March 2009, p10

2 Professor Munro published her first report in October 2010, which found that 'The problem is that previous reforms have not led to the expected improvements in frontline practice. Moreover, there is a substantial body of evidence indicating that past reforms are creating new, unforeseen complications;' Munro E, *The Munro Review of Child Protection Part One: A systems analysis*, London: The Stationery Office, 2011, p5. Professor Munro published her interim report in February 2011; Munro E, *The Munro Review of Child Protection: Interim Report: The Child's Journey,* London: Department for Education, February 2011

3 Munro E, *The Munro Review of Child Protection: Final Report: A child-centred system,* London: Department for Education, May 2011, p5

4 Social Work Reform Board, *Building a safe and confident future: Maintaining Momentum*, Progress report from the Social Work Reform Board, June 2012, p10 [accessed via: https://www.gov.uk/government/publications/building-a-safe-and-confident-future-maintaining-momentum-progress-report-from-the-social-work-reform-board (12.05.14)]

Since then, key further developments have included the introduction of the Assessed and Supported Year in Employment (AYSE) for newly qualified social workers. This is underpinned by the Professional Capabilities Framework – which was developed by the Reform Board, for further professional development during a social worker's career. In addition, the Government has published the revised Working Together to Safeguard Children statutory guidance (i.e. the *2013 WTSC*), and appointed a Chief Social Worker for Children and Families, Isabelle Trowler (as well as a Chief Social Worker for Adults, Lyn Romeo) – to lead the Government's reform programme of the profession. The Frontline training scheme has also been introduced to 'recruit the highest-achieving graduates and train them as social work leaders in a specially tailored programme.'[5] Recruitment began in September 2013, with training for the first cohort to start in the summer of this year.

Mental health[6]

The Coalition Government has embarked on what it has described as 'a new era for public health.'[7] The Government set out its plans for reforms in the NHS in England in the White Paper *Equity and Excellence: Liberating the NHS*, in *Liberating the NHS: Legislative Framework and Next Steps,* and in the *Operating Framework for the NHS in England 2010/11*, together with the *Health and Social Care Act 2012*.[8]

The White Paper, *Healthy Lives, Healthy People: Our Strategy for Public Health in England,* set out the Government's strategy for public health – 'the first … to give equal weight to both mental and physical health.'[9] It proposed a radical new approach towards 'seizing opportunities for better health,' and reducing inequalities in health – placing local government and local communities at the heart of improvements.[10]

No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages emphasised the Government's ambition to create parity of esteem between mental and physical health services. It stated the importance of promoting good mental health, and preventing mental illness through early intervention – 'particularly in the crucial childhood and teenage years.'[11] It recognised that early interventions, 'particularly with vulnerable children and young people, can improve lifetime health and

5 GOV.UK, Press Release, *First ever chief social worker for children and fast-track training to lead social work reform*, 17 May 2013 [accessed via: https://www.gov.uk/government/news/first-ever-chief-social-worker-for-children-and-fast-track-training-to-lead-social-work-reform (12.05.14)]

6 An overview of key Government policy on mental health between 1997 to 2010 can be found in Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011

7 HM Government, *Healthy Lives, Healthy People: Our strategy for public health in England*, Norwich: The Stationery Office, November 2010, p4

8 Department of Health, *Equity and Excellence: Liberating the NHS*, Norwich: The Stationery Office, July 2010; Department of Health, *Liberating the NHS: Legislative Framework and Next Steps*, Norwich: The Stationery Office, December 2010; Department of Health, *Revision to the Operating Framework for the NHS in England 2010/11*, Norwich: The Stationery Office, June 2010; Challenges and national priorities in implementing the first full year of transition were set out in the *Operating Framework for the NHS in England 2011/12*, and the business and planning arrangements for the NHS – in its final year of transition to the new commissioning and management system were set out in the *Operating Framework for the NHS in England 2012/13*. These are available at: https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2011-12; and https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13

9 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p2 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (12.05.14)]

10 HM Government, *Healthy Lives, Healthy People: Our strategy for public health in England*, Norwich: The Stationery Office, November 2010, pp4–5

11 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p2 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (12.05.14)]

wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime.'[12, 13]

These ambitious social work and public health reforms have been proposed in the midst of a heavily restricted financial climate, where huge focus has been placed on the need to save money, and reduce current and future costs to the public purse.

Local authorities have been hit hard. Whilst acknowledging, back in November 2012, the 'strenuous efforts made by individual local authorities to minimise the impact of cuts on their child protection services,' the Education Committee expressed its concern that 'this position might prove difficult, if not impossible, to maintain as authorities are forced to find further savings in future years.'[14] Ofsted has since reported that data from the Institute for Fiscal Studies on the central government funding allocation to local government reveal a '26.6 [per cent] reduction in local authority budgets in the five years from 2010.'[15] However, according to the Association of Directors of Children's Services (ADCS), 'despite significant reductions nationally in funding for local authority children's services, local authorities have protected (and in some cases increased) spending on children's social care in order to meet increased demand.' ADCS added:

> *'… how local authorities have managed to do this varies and it is difficult to demonstrate from the finance data returned, how local authorities are funding their statutory duties in the face of rising demand.'*[16]

Edward Timpson MP, the Children's Minister, recently reported that, to date, spend on children's care had 'generally been protected' in Children's Services.[17]

The NHS is also facing enormous challenges. *No Health Without Mental Health*'s companion document – *The economic case for improving efficiency and quality in mental health*, states that:

> *'Although the NHS as a whole was protected from cuts in the 2010 Spending Review, rising demand means that the NHS has to find up to £20 billion in efficiency savings by 2014. As nearly 11 [per cent] of England's annual secondary care health budget is allocated to mental health care, the mental health sector cannot be exempt from having to make savings.'*[18]

12 Ibid, p9

13 A brief overview of key developments since 2008, specifically in relation to children and young people, and further information on *No Health Without Mental Health*, can be found in Chapter Two

14 The Education Committee recommended that 'the Government commission work to monitor the impact of the current economic situation and cuts in local authority services on child-safeguarding;' House of Commons Education Committee, *Children first: the child protection system in England*, Fourth Report of Session 2012/2013, Volume 1, 7 November 2012, p59 [accessed via: http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/137.pdf (12.05.14)]

15 Institute for Fiscal Studies, *The Squeeze Continues*, June 2013; cited in Ofsted, *Social Care Annual Report 2012/2013*, 15 October 2013, p8 [accessed via: http://www.ofsted.gov.uk/resources/social-care-annual-report-201213 (12.05.14)], and Ofsted, *In the child's time: professional responses to neglect*, March 2014, p9 [accessed via: http://www.ofsted.gov.uk/resources/childs-time-professional-responses-neglect (12.05.14)]

16 The Association of Directors of Children's Services Limited, *Safeguarding Pressures Phase 3*, p61 [accessed via: http://www.adcs.org.uk/download/news/adcs-sg-pressures-p3-report-final.pdf (21.05.14)]

17 Speech by Edward Timpson, MP, at the launch of the NSPCC's report *How Safe Are Our Children? 2014*, London, 1 April 2014

18 Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages, Supporting document – The economic case for improving efficiency and quality in mental health*, February 2011, p3 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (21.05.14)]

It recognises that although future costs of mental ill health are expected to double in real terms over the next 20 years, 'some of this cost could be reduced by a greater focus on whole-population mental health promotion and prevention, alongside early diagnosis and intervention.'[19] However, as discussed later, some CAMHS services are experiencing significant budget cuts, and concerning evidence exists in relation to their impact – on CAMHS practitioners, and vulnerable children and young people, amongst others.[20]

The scope of the report

Our report covers children and young people up to the age of 24. We use the definition of a 'child' contained in the Children Act 1989 – i.e. for those who have not yet reached their 18th birthday. We refer to those who are aged 18 or over as 'young people' throughout the report.[21]

The focus of our report is on child protection and mental health, including:

1. the experience of vulnerable children and young people in terms of their contact with statutory services – essentially children's social care (social care), and mental health provision (for example, primary care, CAMHS, and Adult Mental Health Services (AMHS)); [22] and
2. the interface between the voluntary sector and statutory services in relation to the former working with vulnerable children and young people, and their efforts to secure support for them from the latter.

> *'Kids Company fills the gaps left open by the state and its services, welcoming and containing children and young people that are abandoned and excluded from school, from social [care] and other statutory institutions.'*
>
> **LSE, *Kids Company: A diagnosis of the organisation and its interventions*[23]**

CSJ review and analysis of 20 Kids Company cases

Part of our research involved the CSJ focussing on 20 cases of high risk and vulnerable children and young people supported by Kids Company, with a view to capturing:

19 McCrone P et al, *Paying the Price: The cost of mental health care in England*, London: King's Fund, 2008, cited in ibid, p4

20 As discussed in Chapter Two

21 It is possible that a child (as defined in this report) could be accessing AMHS, and that a young person (as defined in this report) could be accessing CAMHS – we therefore refer to children and young people in the context of both CAMHS and AMHS. We note that ' … there is still considerable variation across the country in the cut-off point between CAMHS and AMHS' – in some areas, CAMHS continues up to 18 years of age, whereas in others it ends at 16, in others it ends at 16 if an individual is out of school, and at 18 if they are still in education; Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Volume Two: Practical mental health commissioning, 2012, p7 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20%28March%202012%29.pdf (10.02.14)]. YoungMinds states that 'The transition from CAMHS to AMHS is subject to extreme local variation, with some … making the transfer to [AMHS] at 16, some at 16 if not in school or 18 if in school, and some at 18 … '; YoungMinds, *CAMHS Transition* [accessed via: http://www.youngminds.org.uk/about/our_campaigns/transitions (14.02.14)]

22 It should be noted that our Review has extended wider than child protection services, in an effort to understand the pressures and challenges faced in a fuller context

23 Jovchelovitch S, Concha N, *Kids Company: A diagnosis of the organisation and its interventions, Final Report*, London: The London School of Economics and Political Science, September 2013, p7

- The complexity and severity of the children and young people's needs – contextualised within their family and/or local environment;
- Their experience in relation to contact with statutory services; and
- The nature and extent of support provided by Kids Company.

We appreciate that, in conducting our Review, we have had the benefit of hindsight and of knowing what the impact on the children and young people has been, as a result of decisions made by or lack of intervention on the part of the relevant statutory services. We acknowledge hindsight bias and outcome bias.[24] However, even taking these into account, our report has produced a number of recurring legal failings and missed opportunities, so that we consider our Review to be a reliable source in indicating some of the ways in which some vulnerable children and young people are being failed by some statutory services.

Legal review and analysis

Six of the 20 cases have also been subject to the review and detailed analysis of two legal experts in the field. The key legal failings and missed opportunities on the part of the relevant local authorities and statutory mental health services are included within each of the case summaries.[25] It should be emphasised that these do not contain all of the legal failings and missed opportunities that were revealed as a result of the legal experts' review.

Further research

In addition to reviewing 20 Kids Company cases, the CSJ interviewed frontline and senior professionals and other key individuals – predominantly from the social care and statutory health sectors, and the voluntary sector. We also interviewed individuals from the education sector (special schools), various academics and members of the legal profession, as well as vulnerable children and young people.

We sought evidence on any problems or pressures which may exist in the systems, the interface between the voluntary sector and social care and statutory mental health services, the challenges seen from both perspectives, and how these might be best addressed to ensure the most effective social care and statutory mental health provision for vulnerable children and young people.

In addition, we conducted a survey with ten VSOs. The purpose of this was to explore their experience at the interface with statutory services; and that of the vulnerable children and young people they work with, as well as their parents (where relevant) – regarding their contact with statutory services. The VSOs that submitted evidence to our Review comprise a mixed profile

24 'Hindsight bias' and 'outcome bias' are described as follows in The Department for Education's Training and Guidance on *Improving the Quality of Serious Case Reviews*, June 2013: 'Hindsight bias occurs when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident. Outcome bias occurs when the outcome of the incident influences the way it is analysed. For example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. If people are judged one way when the outcome is poor and another way when the outcome is good, accountability becomes inconsistent and unfair'

25 See pages 30 to 43. The CSJ has obtained permission to include five of the six case summaries in this report

– ranging from grassroots/local (in London and other parts of England), to both small and large national VSOs. A couple of the VSOs campaign on behalf of vulnerable children and young people, and conduct research into the issues which affect them. A couple provide a wide range of services to support large numbers of vulnerable children, young people and their families. Most emphasise the importance of an early intervention approach in their work. One VSO helps to address both social care and mental health problems; a number provide solely mental health services – including, for example, counselling. Some focus on providing emotional, practical and educational support – for those from disadvantaged backgrounds, and/or who are at risk of or have been excluded from school – including helping to address their social care needs. Some of the VSOs also work in partnership with schools and provide training and support for their staff. Most of the VSOs provide mentoring; some also provide family support services. A couple provide services to help divert vulnerable children and young people from crime – including gang members, or those at risk of being recruited to gangs.

We also undertook an extensive literature review.

The scale of the problem – what we do and do not know

CSJ Review and Analysis of 20 Kids Company cases[26]

The level of vulnerability of the children and young people whose cases we reviewed, and the risk to which they were exposed, was deemed by Kids Company to be high.[27] The case summaries and snapshots in our report provide a mere glimpse into the trauma and devastation that they have endured in their short lives – in their home and/or local environment.

Where details were available from Kids Company's records, we found parental substance misuse (alcohol and/or drugs) in 70 per cent of the cases, domestic violence in 70 per cent, parental mental ill health in 65 per cent, parental criminal activity in 60 per cent, abuse (sexual, physical and/or emotional) in 80 per cent, neglect in 75 per cent, mental health problems in 100 per cent, truanting in 50 per cent, fixed-term and/or permanent exclusion from school in 35 per cent, exposure to or experience of street gang violence in 50 per cent, and offending behaviour in 60 per cent.

Over half of the children and young people lived in extreme poverty – some in homes with very poor and unhygienic living conditions. Fathers were absent in most of the cases, and where contact did exist it was often of an intermittent or negative nature. In various cases, children were living with vulnerable mothers, some of whom had very serious difficulties of their own (for example, substance misuse, mental health problems). Some of the children and young people had no-one to arrange or take them to an appointment to a variety of health services.

26 All of the quotes, case summaries, and snap shots in the report have been anonymised, to protect the identities of the children and young people, as well as their parents and any other individuals and professionals involved in their lives who feature in the material. All of the quotes, case summaries, and snap shots have been approved for inclusion in the report by each of the children and young people and/or their parent

27 None of these children or young people's circumstances were constant, and at any given time the level of risk to which they were exposed varied. However, they are not considered by Kids Company to have fallen below the level of high risk during the period covered by the CSJ's Review. In one of the cases, the child's level of risk was initially deemed to be low risk but became high risk. For definitions of the risk levels used by Kids Company see Appendix 3

Where they were not seen by a GP (or were seen irregularly), were out of school for prolonged periods of time, were not being given any or adequate support from social care and/or secondary statutory mental health services, they became more isolated from the help and comfort that they desperately needed. Ever more invisible, with voices growing dangerously more feint, many were abandoned to their vulnerability, suffering, and pain. However, thankfully they were able to draw on the support offered by Kids Company.

In seeking their consent to include the case summaries and snapshots contained within the report, the reaction of the children and young people, where they have vocalised it, was one of feeling affirmed. One exclaimed *'I can hear my voice!'* For years, many have been denied acknowledgement of what they have suffered. Now they have a legitimate and trusted means by which to share the extent and nature of their experiences, and the pain they have felt. With remarkable courage and generosity, they have embraced this as an opportunity to do what they can to help others.[28] Several of the children and young people stated that they are willing to share their stories because they do not want other children to suffer what they have.

Wider context

Some examples of the numbers of children at risk of abuse and neglect:

- parental substance misuse (drugs): 250,000 to 978,000
- parental substance misuse (alcohol): 920,000 to 3.5 million
- parental mental ill health: 50,000 to more than 2 million[29]
- domestic violence: 1,796,244
- in the care system: 60,447
- with a physical or mental impairment: 811,460[30]

It is important to note, as highlighted by Professor Munro, that whilst research has shown that:

> *'certain features of family life are associated with adverse outcomes for children and young people… it is also known that many children and young people affected by these factors nonetheless thrive. This is important because it indicates that these circumstances do not make harm inevitable.'*[31, 32]

28 As have a number of their mothers, who have also experienced profound adversity and struggle, in being willing for their, and their children's experiences, to be exposed through our report

29 Jütte et al, *How Safe Are Our Children? 2014*, March 2014, p14 [accessed via: http://www.nspcc.org.uk/Inform/research/findings/howsafe/how-safe-2014_wda101852.html#download (21.05.14)] It should be emphasised that not all parents with mental health problems will be neglectful of or abusive towards their children. The NSPCC report states that 'The vast majority of parents with a mental health problem do not abuse their children;' Tunnard J, *Parental mental health problems: messages from research, policy and practice*, Dartington: Research in Practice, 2004, cited in *How Safe Are Our Children? 2014*, p13

30 These figures have been taken from *How Safe Are Our Children? 2014*. The report states 'Our knowledge about the number of children who experience these risks is based on limited research, statistical data, or estimates based on adult population data that does not report whether the adults have children. Where data does exist on individual risk factors it rarely tells us about other further risks to the child.' The report explains that it shows 'some of the data that is available about the numbers of children in the UK that fall into the different risk groups,' and adds that 'Children may fall into multiple risk groups;' ibid, p14. We have included reference to some of those groups above

31 Munro E, *The Munro Review of Child Protection: Final Report: A child-centred system*, London: Department for Education, May 2011, p70

32 The NSPCC states that 'The evidence on risk is inconsistent and limited. We cannot say that any single factor – or collection of factors – *causes* maltreatment and we are far from being able to predict who will perpetrate abuse or who will experience it. It *is* nonetheless possible to identify certain contexts and environments that are more frequently associated with child abuse and neglect.' For further discussion on the warnings that come with discussion of risk, please see the NSPCC report: Jütte et al, *How Safe Are Our Children? 2014*, March 2014, p10 [accessed via: http://www.nspcc.org.uk/Inform/research/findings/howsafe/how-safe-2014_wda101852.html#download (21.05.14)]

The prevalence of abuse and neglect:

- currently at risk of abuse: approximately 43,140 children;[33]
- neglect:

    - A major piece of NSPCC research on the prevalence of child abuse and neglect in the UK found that: one in seven children aged 11–17 have been neglected, and almost one in 10 have experienced severe neglect; and that 16 per cent of 18- to 24-year-olds had been neglected at some point in their childhoods, and nine per cent had experienced severe neglect.[34]

    - According to research undertaken by Action for Children, up to one in 10 children across the UK suffers from neglect. Neglect is known to be the most common form of child abuse in the UK. However, the VSO has highlighted the fact that local areas do not routinely collect accurate data about neglect – with the result that 'the true scale of neglect can remain hidden.'[35] Furthermore, its survey of local areas found that 'most areas do not routinely collect data about the children of parents who come to the attention of adult services.'[36]

    - Ofsted has also recently raised concern over the extent of child neglect not being understood. The local areas visited by Ofsted during its thematic inspection were reported to have had 'difficulty in identifying the prevalence of children in receipt of services for neglect.' It added 'This is of significant concern. The number of children subject to child protection plans in the category of neglect was known, but will be an underestimation of the extent of neglect. There will be children who are not yet in receipt of a statutory child protection service but who are being offered earlier help and those whose need or protection plans address other more obvious concerns, such as physical abuse who may also be suffering from neglect.[37]

Safeguarding, child protection and mental health: other risk factors

- Educational exclusion: there were 5,170 permanent exclusions and 304,370 fixed-term exclusions during the academic year 2011/2012. These are the official statistics published by the Department for Education.[38] However, as the CSJ has previously highlighted, we do not consider

33 The NSPCC states that 'We do not know exactly how many children in the UK have been abused.' However, it refers to the number of children who are subject to child protection plans in order to establish how many are known to be at risk of abuse 'right now' in England. We have updated the figure which was available on their website with the number of children subject to a child protection plan as at 31 March 2013 – as referred to in Chapter One; NSPCC, *Incidence and prevalence of child abuse and neglect*, July 2013 [accessed via: http://www.nspcc.org.uk/Inform/research/statistics/prevalence_and_incidence_of_child_abuse_and_neglect_wda48740.html (12.05.14)]

34 The researchers interviewed 1,761 young people aged 18 to 24, and 2,275 children aged 11 to 17, as well as 2,160 parents of children aged under 11; Radford L et al, *Child Abuse and neglect in the UK today*, London: NSPCC, 2011, cited in NSPCC, *Incidence and prevalence of child abuse and neglect*, July 2013 [accessed via: http://www.nspcc.org.uk/Inform/research/statistics/prevalence_and_incidence_of_child_abuse_and_neglect_wda48740.html (12.05.14)]

35 Action for Children, *Child Neglect: The Scandal That Never Breaks*, March 2014, p1 and p21 [accessed via: http://www.actionforchildren.org.uk/media/867879 1/child-neglect-the-scandal-that-never-breaks.pdf (07.05.14)]

36 Action for Children, *The state of child neglect in the UK: Recommendations for the UK Government,* London: Action for Children, 2013, cited in Action for Children, *Child Neglect: The Scandal That Never Breaks*, March 2014, p21 [accessed via: http://www.actionforchildren.org.uk/media/867879 1/child-neglect-the-scandal-that-never-breaks.pdf (07.05.14)]

37 Ofsted's report explored the effectiveness of arrangements to safeguard children who experience neglect, with a specific focus on those aged ten and under. Inspectors visited 11 local authority areas and examined 124 cases; Ofsted, *In the child's time: professional responses to neglect*, March 2014, pp4–5 [accessed via: http://www.ofsted.gov.uk/resources/childs-time-professional-responses-neglect (12.05.14)]

38 These are the latest statistics available. We note that 162,400 pupils received one or more fixed-term exclusions; Department for Education, Statistical First Release, *Permanent and fixed period exclusions from schools and exclusion appeals in England*, 2011/12, 25 July 2013 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224893/SFR29-2013.pdf (12.05.14)]

these statistics to provide an accurate reflection of what is happening in some schools due, for example, to illegal exclusions being carried out in some – for which no statistics exist.[39] However, the Children's Commissioner for England estimates that 'several hundred schools in England may be excluding children illegally, affecting thousands of children every year.'[40]

- Gangs: the London Metropolitan Police Service reported, in 2012, 'that they had identified 259 violent youth gangs … in 19 gang-affected boroughs. These gangs ranged from organised criminal networks involved in Class A drug dealing and firearms supply, to street gangs perpetrating violence and robbery and were noted to be responsible for 17 [per cent] of robberies, 50 [per cent] of shootings and 14 [per cent] of rapes in the Capital.' In 2013, 21 police forces in England identified a total of 323 youth gangs within their areas.[41] However, 'there is no comprehensive national figure of the number of [youth] gangs, or the number of [children or] young people involved or associated with gangs.'[42]

- Sexual exploitation by gangs and groups: the Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, reported that 2,409 children were confirmed as victims of child sexual exploitation (CSE) by gangs and groups between August 2010 and October 2011. Evidence submitted to the Inquiry suggests that 'in any given year the actual number of children being abused is far greater than the 2,409 that have been confirmed.' In addition, at least 16,500 children were identified as being at high risk of CSE between April 2010 and March 2011.[43]

Impact

'… [complex] families are often repeating a generational cycle; the founding family members typically have a psychosocial background that was also damaging and dysfunctional. Such backgrounds contain risk factors from both the family and wider social environment. Environmental risk factors include poverty, homelessness, lack of educational opportunities and poor housing. Familial risk factors include: neglect, abuse (sexual, physical and psychological), substance misuse, domestic violence, divorce and parental separation, illness (mental or physical) and disability. Various core needs in the children of such families cannot be met and the psychological and behavioural effects of these omissions may then be transferred to the next generation.'[44]

39 Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, September 2011, pp36–41

40 Office of the Children's Commissioner for England, '*Always Someone Else's Problem,' Office of the Children's Commissioner's Report on illegal exclusions*, April 2013, p4 [accessed via: http://www.childrenscommissioner.gov.uk/content/publications?search=exclusions (23.04.14)]

41 Pitts J, 'Reluctant Criminologists: Criminology, Ideology and the Violent Youth Gang,' *Youth and Policy*, 109, 2012, pp27–45 cited in Beckett H et al, '*It's wrong … but you get used to it,' A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England*, University of Bedfordshire and the Office of the Children's Commissioner for England, November 2013, p10 [accessed via: http://www.childrenscommissioner.gov.uk/content/publications/content_745 (21.05.14)]. The information provided by the police forces in 2013 was in response to a request for information from the Office of the Children's Commissioner for England, as part of their Inquiry into Child Sexual Exploitation in Gangs and Groups; Office of the Children's Commissioner for England, *Final Report of Office of The Children's Commissioner for England Two Year Inquiry into child sexual exploitation in gangs and groups*, London: Office of the Children's Commissioner for England, 2013

42 Beckett H et al, '*It's wrong … but you get used to it,' A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England*, University of Bedfordshire and the Office of the Children's Commissioner for England, November 2013, p10 [accessed via: http://www.childrenscommissioner.gov.uk/content/publications/content_745 (21.05.14)]

43 Office of the Children's Commissioner for England, '*I thought I was the only one. The only one in the world.' The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, Interim Report*, November 2012, p9 [accessed via: http://www.childrenscommissioner.gov.uk/content/publications/content_636 (21.05.14)]

44 *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p118

The CSJ's earlier work has demonstrated the extreme impact that family breakdown and family dysfunction has on a child's development.[45] *The Next Generation* considered the degree of damage that this can inflict by the age of three.[46] Medical evidence suggests that childhood maltreatment and early adverse experience affect the brain's functioning.[47]

The association of maladaptive and traumatic childhood experiences with adult psychopathology has been firmly established with robust estimates of 30 per cent of all adult mental disorder accounted for by childhood adversities (predominantly childhood abuse, neglect and parental mental illness).[48] Reviews examining differing types of childhood trauma often conclude that whilst all may contribute risk for later mental ill-health such as psychosis or post-traumatic stress disorders (PTSD), 'emotional abuse' in childhood may have a particularly damaging impact.[49] This has led to a realisation that the severe stress associated with abuse during childhood can impact negatively on brain development and increase risk for a range of both physical conditions (for example, obesity; heart disease) and mental health problems (for example, suicide risk; drug and alcohol abuse; depression; PTSD) and may involve epigenetic influences.[50]

> *'Certainly, when you look at child protection, the most damaging area of abuse is neglect and emotional abuse. The lifelong outcomes for children that live with neglect and emotional abuse are even more negative than those that live with physical and sexual abuse. [That] is counterintuitive, because a lot of people think sexual abuse is the most permanently damaging in terms of the intensity of the damage. But in fact, the outcomes for those living with emotional abuse and neglect are even worse and much more likely to be inter-generational.'* [51]
>
> **An experienced Independent Social Work Consultant and Expert Witness, in evidence to the CSJ**

The report *Decision-making within a child's timeframe* states:

> *'… relative to physically abused children, neglected children have more severe cognitive and academic deficits, social withdrawal and limited peer interactions, and internalising (as opposed to externalising) problems.'*[52]

45 Centre for Social Justice, *Breakdown Britain*, London: Centre for Social Justice, 2006; Centre for Social Justice, *Breakthrough Britain*, London: Centre for Social Justice, 2007

46 Centre for Social Justice, *Breakthrough Britain: The Next Generation*, London: Centre for Social Justice, 2008

47 McCrory E et al, Research Review: The neurobiology and genetics of maltreatment and adversity, *The Journal of Child Psychology and Psychiatry*, 51:10, 2010, pp1079–1095

48 Kessler et al, Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys, *The British Journal of Psychiatry,* 197, 2010, pp378–385

49 See, for example, Larkin W, Read J, Childhood trauma and psychosis: Evidence, pathways, and implications, *J Postgrad Med*, 54, 2008, pp287–293; and Ackner S, et al, Emotional Abuse and Psychosis: A Recent Review of the Literature, *Journal of Aggression Maltreatment & Trauma*, 22:9, 2013, pp1032–1049

50 McGowan PO, Szyf M, The epigenetics of social adversity in early life: implications for mental health outcomes, *Neurobiol Dis*, 39(1), 2010, pp66–72; Read J et al, Time to abandon the bio-bio-bio model of psychosis: Exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms, *Epidemiol Psichiatr Soc*, 18(4), 2009, pp299–310; and Mehta D et al, Childhood maltreatment is associated with distinct genomic and epigenetic profiles in posttraumatic stress disorder, *Proc Natl Acad Sci U S A*, 110(20), 2013, pp 8302–8307

51 Reference is made in *Decision-making within a child's timeframe*, to two systematic reviews of literature exploring the evidence on neglect and emotional abuse. The reviews concluded that these types of abuse are associated with the most damaging long-term consequences; however, they are also the most difficult to identify; Daniel B, et al, *Recognizing and Helping the Neglected Child: Evidence-Based Practise*, London: Jessica Kingsley Publishers, 2011; Rees G, et al, *Adolescent Neglect: Research, Policy and Practise*, London: Jessica Kingsley Publishers, 2011 – cited in Childhood Wellbeing Research Centre, *Decision-making within a child's timeframe: An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment*, Working Paper 16 (Second Edition), London: Childhood Wellbeing Research Centre, February 2013, pp56–57

52 Hildyard KL, Wolfe DA, 'Child neglect: developmental issues and outcomes,' *Child Abuse and Neglect 26*, 2002, pp679–695 cited in Childhood Wellbeing Research Centre, *Decision-making within a child's timeframe: An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment*, Working Paper 16 (Second Edition), London: Childhood Wellbeing Research Centre, February 2013, p57

The NSPCC commissioned report, *Neglect and Serious Case Reviews,* explored the circumstances in which neglect can also be 'catastrophic and have a fatal or seriously harmful outcome for a child.' The report revealed that neglect is far more prevalent in serious case reviews than had previously been understood.[53]

Previous work published by the CSJ demonstrates that core developmental needs of children include secure relational attachment and emotional responsiveness.[54] Conversely, where a child's experiences are negative, for example, in the context of an abusive or neglectful family environment, their overall human development can be hindered. The extent of this can vary significantly depending on the existence of certain factors in their family background and surrounding environment.

> *'Attachment is classified as "secure", "insecure" or "disorganised" … It is estimated from population samples that around two-thirds of children are securely attached. These children have better outcomes than non-securely attached children across all domains, including social and emotional development, educational achievement and mental health.*
>
> *Children who receive caregiving that is erratic or intrusive typically develop "insecure anxious-ambivalent" attachments … Children who receive caregiving that is rejecting or punitive typically develop "insecure anxious-avoidant" attachment … Children who receive caregiving that is described as being "atypical" and involves distorted parenting practices (including neglect, abuse and maltreatment) typically develop disorganised attachments. This is usually in the context of parents being severely stressed (for example, those who are subject to domestic violence, engage in substance misuse or have significant mental health problems) … Around 80 [per cent] of children who suffer maltreatment are classified as having disorganised attachment. A disorganised classification is strongly predictive of later social and cognitive problems, and psychopathology.'*[55]

We know that one of the serious consequences of a child's inability to form strong early attachments is that they often struggle to regulate their own emotions, which has a clear affect on behaviour.[56]

53 University of East Anglia, commissioned by NSPCC, *Neglect and Serious Case Reviews*, January 2013, p7 and 9 [accessed via: http://www.nspcc.org.uk/Inform/resourcesforprofessionals/neglect/neglect-scrs-pdf_wdf94689.pdf (21.05.14)]. The University of East Anglia looked at the period 2005 to 2011, using a narrow definition of officially substantiated neglect. Of the 645 serious case reviews analysed, it found neglect in 16 per cent, or approximately one in six (101). The child had been the subject of a child protection plan for neglect at some point in his or her life in each of those cases

54 Centre for Social Justice and Smith Institute, *Early Intervention: Good Parents, Great Kids, Better Citizens*, London: Centre for Social Justice and Smith Institute, 2009, p22

55 NICE, *Children's attachment: final scope,* pp3–4 [accessed via: http://www.nice.org.uk/nicemedia/live/14174/66022/66022.pdf (21.05.14)]. Please note that we refer throughout our report to children and young people who experience insecure or disorganised attachment as having 'attachment problems.' NICE states (at pages 4 to 5 in the aforementioned document) that, in addition to the three classifications referred to above, a number of types of 'attachment disorders' have been defined

56 Crittenden P M, Ainsworth M, Attachment and child abuse, 1989 in Cicchetti D and Carlson V (eds.), *Child Maltreatment: Theory and research on the causes and consequences of child abuse and neglect*, New York: Cambridge University Press, pp432–463, cited in Sternberg KJ, et al, Type of violence, age, and gender differences in the effects of family violence on children's behavior [sic] problems: A mega-analysis, *Developmental Review*, 26, 2006, p90

'Insecure attachment in the early years has been directly associated with troubled behaviours, unhappy or tormented relationships and lack of emotional intelligence in childhood, teenage years and adulthood, including depression and anxiety; low self-esteem; a lack of confidence to explore; a lack of self awareness; a lack of capacity for emotional regulation and a lack of empathy and compassion.'[57]

Our key findings

'I see hollow eyed social workers carrying too heavy a case load.'
Witness, in evidence to the CSJ

' … now with domestic violence, we've got so much of it … and sexual abuse and children displaying sexualised behaviour … before it was a really big thing. Now it's nothing. It's just part and parcel, to the point where they … give us very limited training when, in reality, families affected by it need specific support from highly trained professionals. Otherwise we are not delivering good outcomes but removing children and breaking up families without proper interventions suited to meet their needs.'
Social worker, in evidence to the CSJ

' … because of the way the whole statutory system is imploding at the moment, inevitably every service is haemorrhaging cases down to the next level – trying to push cases down and down and down to whoever they can, with the result that caseworkers who came in with very generic skills are given really difficult, complex cases to manage. Children who are self harming, who are depressed, with chaotic families and they don't have the first clue how to manage them. They tell me it wasn't what they signed up for and they understandably get very anxious and overwhelmed by it.'
CAMHS clinician, in evidence to the CSJ

Our child protection system is considered to be one of the safest in the world, and society's expectations of it are high.[58] Despite the stream of tragic cases that have featured in the media of child deaths, neglect and abuse in recent years, research shows that children are, in many ways, safer than they were in the previous generation.[59] Good practice clearly exists in child protection and statutory mental health systems in some areas across England. We have been hugely encouraged by the commitment, determination and courage of many social workers and statutory mental health practitioners, who are working incredibly hard and effectively, under immense pressure. Our eyes have also been opened wider to the extent of complexity and challenge that they face, as they often battle to deliver services to our vulnerable children and young people in the midst of major public sector reform, and in a fiercely constrained financial climate.

57 Centre for Social Justice and Smith Institute, *Early Intervention: Good Parents, Great Kids, Better Citizens*, London: Centre for Social Justice and Smith Institute, 2009, pp49–50

58 Pritchard C, Williams R, Comparing Possible 'Child-Abuse-Related-Deaths' in England and Wales with the Major Developed Countries 1974–2006: Signs of Progress?, *British Journal of Social Work*, 2009, pp1–19

59 Jütte et al, *How Safe Are Our Children? 2014*, March 2014, p4 [accessed via: http://www.nspcc.org.uk/Inform/research/findings/howsafe/how-safe-2014_wda101852.html#download (21.05.14)]

60 Ibid, p8

'… social care services are increasingly forced into playing the role of "watching and waiting" for the point at which children are at risk of very significant harm, acting as an emergency service, a service of the last resort. Not only is this approach more costly, it is also less effective.'

NSPCC, How Safe Are Our Children? 2014[60]

However, our research has revealed a stark picture of social care and statutory mental health services, in some areas, heaving under the current pressures, and failing to take a child or young person-centred approach. Many vulnerable children and young people are knocking on their door, some in desperate need of care and support, only for that door to remain firmly shut. Some statutory services are leaving them them abandoned to their problems, or referring them to other services, some of which are not equipped to meet their needs. We have discovered systemic failure in child protection systems in some local authorities. As a result, many vulnerable children and young people – some of whom are considered to have serious, complex and enduring needs – are not being afforded timely or appropriate care and support. Worse still, some of those who are considered to be at risk of significant harm are not being protected – adequately, or at all. At the same time, our findings highlight how the potential for the voluntary sector to work in partnership with social care and statutory mental health services – to help maximise on the outcomes for vulnerable children and young people – is woefully under-utilised in some areas.

A number of endemic problems clearly exist in some of our more deprived, urban areas. However, the cases which have surfaced during the course of our Review – in Oxford, Rochdale and Bradford, amongst others – serve to highlight concerns about the complexity of problems faced in other areas of the country, and that services are not able to rise to the challenge. In addition, the findings in Ofsted's first stand-alone *Social Care Annual Report* make for very sobering reading in terms of the quality of child protection practice in some local authorities.[61] So too, do the findings of its more recent second tranche of inspections under the new inspection framework.[62] We believe that it is essential and timely for a broader range of services to look closely at their systems, and to address any early warning signals that may exist, before any such problems revealed by our report potentially become entrenched in their areas.

There have clearly been some positive developments in child protection systems in some areas following the fundamental reforms proposed by the Munro Review. A number of encouraging examples of innovative practices exist – for example, the Hackney model, as well as intensive adolescent focussed services that have been established by other local authorities to prevent family breakdown.

61 As discussed further in Chapter Four; Ofsted, *Social Care Annual Report 2012/2013*, 15 October 2013 [accessed via: http://www.ofsted.gov.uk/resources/social-care-annual-report-201213 (12.05.14)]

62 This included Coventry's children's social care being judged as inadequate by Ofsted; Community Care, *Ofsted publishes latest wave of new-style children's social care inspections*, 21 March 2014 [accessed via: http://www.communitycare.co.uk/2014/03/21/ofsted-publishes-first-wave-new-style-childrens-social-care-inspections/#.U3FOvMZ4Xnc (12.05.14)]

63 All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, 3 December 2013, p8 [accessed via: http://www.basw.co.uk/appg/ (21.05.14)]

'Baby Peter's death should have been a watershed for safeguarding children but the subsequent reform agenda appears disconnected from the needs of those people who rely on social work services. If social workers on the frontline of practice are not feeling the difference, then how can we hope for improved outcomes for the vulnerable children and families they work alongside?'[63]

However, the reforms are clearly facing severe challenges. A number of significant, longstanding difficulties persist. The All Party Parliamentary Group (APPG) on Social Work has commented, in its *Inquiry into the State of Social Work* report, that:

'Excessive bureaucracy continues to work against, not in support of, practitioners. ICT systems remain not fit for purpose. Dangerously high caseloads for too many social workers mean serious risks for the people who need their assistance. Low morale is not unique to social workers but if it is endemic across the profession, as some witnesses describe, then the ability of these practitioners to provide high quality services to families themselves confronting depression, poor self-esteem and even despair, must be questioned.'[64]

More recently, whilst acknowledging that changes have been made, Action for Children has expressed concern that:

'… many of Munro's suggested reforms have yet to be implemented, or have been undermined by other factors … The changes put forward in the Munro Review have been undermined by a lack of funding. We know professionals are working in an unstable environment, within restricted, and in some cases still reducing, budgets. This is creating difficult decisions for local areas on how best to invest limited resources.'[65]

Progress has undoubtedly been made in various respects with improving mental health services for children and young people in this country. Again, we have discovered examples of good practice in a number of areas. However, the reforms to mental health services are also experiencing extreme difficulties. In May, The Observer reported that according to a recent study produced by NHS England: 'Only a quarter of children with mental health conditions are receiving the treatment they need,' and that it stated 'multiple reviews have identified the same problems.' It also refers to the study as quoting 'the concerns of mental health teams across the country.'[66]

64 Ibid, p7

65 Action for Children, *Child Neglect: The Scandal That Never Breaks*, March 2014, p27 [accessed via: http://www.actionforchildren.org.uk/media/8678791/child-neglect-the-scandal-that-never-breaks.pdf (07.05.14)]

66 The Observer, *England's child mental health services 'failing three-quarters of kids;' 'Cinderella service' hit by budget cuts and increasing demand*, 18 May 2014 [accessed via: http://www.theguardian.com/society/2014/may/18/child-mental-health-services-under-pressure (21.05.14)]

Indeed, the Chairs of London's 10 mental health and community health services trusts spoke out publicly in April. They expressed their concern over recent studies which have shown a reduction in funding for mental health services in England of 'two per cent in real terms over the past two years – the first drop in a decade.' They added:

> *'This year mental and community health services are also having to find additional savings compared with acute hospitals. At a time when our services are under increasing pressure, these are retrograde steps which will not help to realise the Government's ambition of high-quality mental health services provision.'*[67]

With our justifiably high expectations of social care based in statute, and statutory mental health services also subject to legal duties and responsibilities – whilst the demands on those services, in some areas, is escalating at the same time as local authority budgets and resources are decreasing, they are in an impossible position. Our evidence demonstrates that some social care and statutory mental health services are overwhelmed and under intense pressure on various fronts. We understand that this is, in part, due to budget cuts and rising caseloads, coupled (in the case of social care) with a system that continues to demand high levels of recording and audit. However, we believe that the challenges faced are about more than just the cuts; there are also other fundamental issues at stake.

> *'I don't think it's because these are bad people, they are in a bad system. The system is created by people, and these targets that are being passed down effect social workers, schools, housing officers, probation officers … all of this is generating a culture in which people don't look at the people that they should be serving. There are obviously honourable exceptions to this … But you think why isn't everybody working in this way? I think it comes down to quality of leadership.'*
>
> **Witness, in evidence to the CSJ**

It is important to emphasise that most social workers and statutory mental health practitioners want to do a good job for vulnerable children and young people. However, the constraints placed on them by the systems in which they are required to operate can prevent or hinder them from doing so. Whilst we do not, in any way, seek to excuse the concerning child protection practice that has surfaced during our Review, we believe that this is largely due to the pressures on social workers, as opposed to any inherent malice on their part. It is imperative that effective solutions are found to confront such poor practice, and to support social workers and those in more senior positions to make the right decisions by vulnerable children and young people. We heard how many feel deeply uncomfortable about the quality of care and service they are able to provide. Indeed, this can drive some of them out of their profession.

67 London Evening Standard, *More support for mental health*, 8 April 2014, p47

'The number of children in care each year does not even scratch the surface of the problem. There is an assumption that children are either in care or with their biological parents who are functioning. But in the middle there are the "lone children" – who are not in foster care or with functioning parent(s). Games are played over whether the lone child can be tipped over to be cared for but agencies play games so that they are not taken into care. There is no philosophy in social care and no truth regarding the scale of the problem.'

Camila Batmanghelidjh, CEO, Kids Company, in evidence to the CSJ

Our report addresses the plight of lone children, amongst others. The basic emotional and practical needs of many of these vulnerable children are not being met. Countless numbers are still living with their parents and receiving negligible, if any, care and support – or, in some cases, protection. The fact that many are still living with parents who are not functioning and who are struggling to parent them positively, can present the children with severe and unrelenting difficulties. The Government and Labour party are talking about integrating care and whole person care but one incredibly important category is not being discussed in this area, and is often being overlooked – lone children.[68]

It should be noted that our report has focussed on vulnerable children and young people who have legal status in this country. However, we must also recognise the plight of those with no legal status – some of whom are in what one VSO described as '*the hidden families*' – who are not eligible to receive care, protection and/or support from statutory services.

We appreciate that the pressures and problems referred to in our report will not necessarily be experienced in all local authorities across the country, or in the same context or to the same extent. Much will depend on their particular demographic and the level of demand on their services, amongst many other factors. The challenges faced by some local authorities, for example, in inner city areas where there is a high level of deprivation, will be more intense than others. However, some pressures will manifest themselves in different ways. For example, some local authorities have a significant amount of deprivation in rural areas, in isolated communities, where individuals have little or no access to transport or facilities. We also appreciate that there are some areas in England that do not have a voluntary sector presence.

It must also be emphasised that our report does not provide a wholesale review and analysis of child protection and statutory mental health provision across the country. Nonetheless, we believe that it provides an important insight into some serious failings within statutory services in some areas of London, and other parts of England on which we have received evidence. This report will undoubtedly make for uncomfortable reading at times. However, it reflects the shocking reality of what is being experienced by many vulnerable children and young people in some parts of the country.

68 For example, the Government's care and support White Paper, refers to the health and wellbeing of looked after children and young people, and better integration at the key transition point of moving from CAMHS to AMHS – with reference to those with special educational needs; HM Government, *Caring for our future: reforming care and support*, July 2012, p42 and p60 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf (09.05.14)]

During our Review, we have discovered evidence, for example, of:

- Systems '*in crisis*' and '*at breaking point;*'
- The rhetoric and aspiration with respect to early intervention not being realised in some areas of England. A lack of intervention and support continues to persist for many neglected children, and children and young people with emerging mental health problems;
- Higher thresholds being applied in some local authorities. We heard of children who are being held at Team Around the Child (TAC) and CAF level who ought to be receiving children in need services, and of those who are being categorised as children in need who ought to be on child protection plans. We have been stunned by the complexity and severity of need on the part of some vulnerable children and young people who have not gained access to some social care and/or statutory mental health services;
- Some social care teams are struggling to break away from a target-driven culture towards effective developmental practice that aims to optimise positive outcomes for vulnerable children and young people. A greater emphasis is being placed on process in some local authorities, than on the importance of social workers searching for a greater truth about the child's situation through building a relationship and soliciting meaningful information. As one social worker told us: '*We're probably scared to ask the child what they think of the situation … Sometimes a social worker may be scared to ask to see a child by themselves;*'
- Barriers to some vulnerable children and young people in accessing, engaging with and obtaining appropriate care and support from primary care and secondary care services;
- Concerning approaches towards vulnerable parents, children and young people by some social workers and statutory mental health professionals;
- Delay and serious shortfalls in the care, protection and/or support afforded to some vulnerable children and young people. Certain cohorts are being particularly failed – for example, children in need, and children with conduct disorders;
- Barriers to VSOs working in partnership and collaborating with social care and CAMHS;
- Unscrupulous and unlawful practice within some local authorities;
- A lack of accountability by local authorities with respect to vulnerable children and young people;
- A lack of cooperation between some social care and statutory mental health services; and
- Poor commissioning practice.

We must not shy away from the painful truths revealed by this report. To do so would be another abhorrent injustice and tragedy inflicted on the vulnerable children and young people. They deserve us to exercise the same courage in facing up to and addressing the problems which exist within the relevant systems in some parts of our country, as they demonstrate daily in enduring and surviving their 'childhoods.'

chapter one
Frontline child protection

1.1 Introduction

> *'The truth of social work today is that the … kids are so lost … I can honestly say, as a social worker, that kids are not at the forefront of what I do …'*
>
> **Social worker, in evidence to the CSJ**

> *'The system is completely overwhelmed.'*
>
> **SHS practitioner, in evidence to the CSJ**[1]

The Munro Review into child protection, which the Government launched in 2010, was widely welcomed and provided hope for positive change to the child protection system. Undoubtedly some progress has been made. We are aware of good and innovative practice and, in some areas, improvements in child protection practice.[2] However, the proposed reforms face a number of persistent challenges – for example, to reducing the excessive bureaucracy at a local authority level, which obstructs the effective practice of many social workers. The reforms have also coincided with a deep recession. While local authority budgets are decreasing, and social care budgets remain stretched, demand for social care services is understood to be escalating. With public expenditure levels relating to child protection and safeguarding in 2012/2013 now at approximately the same level as in 2006/2007, the NSPCC has observed that: 'A contraction in public spending to [2006/2007] levels would not be so significant for child protection were it not for the extraordinary increase in demand for services over this period.'[3]

1 From the national VSO, School-Home Support (SHS)

2 For example, the following evaluation showed that a number of local authorities are showing charity, sensitivity and skill; Forrester D et al, *Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's* Services: *Final report of a comparative study of practice and the factors shaping it in three local authorities*, University of Bedfordshire and Tilda Goldberg Centre for Social Work and Social Care, June 2013 [accessed via: http://www.beds.ac.uk/__data/assets/pdf_file/0011/258491/Final-Report-RSWv3-19072013.pdf (15.01.14)]

3 Please note that emphasis on the text is NSPCC's; Jütte et al, *How Safe Are Our Children? 2014*, March 2014, pp4–6 [accessed via: http://www.nspcc.org.uk/Inform/research/findings/howsafe/how-safe-2014_wda101852.html#download (21.05.14)]

Since 2008 the number of children subject to a child protection plan has risen by 48 per cent.[4] Since 2007, care applications have increased by a staggering 70 per cent. A total of 998 care order applications were received in February 2013 – the highest ever recorded for a single month.[5]

Ofsted reports a rise in the total volume of activity by local authorities since 2008. It recognises that this is not replicated in every local authority equally.[6] The NSPCC has reported seeing a 40 per cent increase in the number of people raising concerns of child abuse and neglect in the past three years.[7] However, there is alarming evidence – highlighted throughout our report – that many vulnerable children are being exposed to continuing or greater risk or harm in some local authorities. The disturbing truth is that, battling under enormous pressure, and often in the absence of appropriate resources and support, many social workers are struggling to protect them.

We have been told that the frontline is '*stretched to breaking point*,' that the '*whole statutory system is imploding*' with '*every service … haemorrhaging cases down to the next level*,' and that '*we're in crisis*'. Indeed, alarm bells have been raised by many of those on the frontline, amongst others, for some time.[8, 9, 10]

Community Care Survey 2013

'Three quarters of child protection social workers do not have the time or resources to prevent vulnerable children from coming to serious harm, while child protection ends at 14 in some [local] authorities …'

Some headline statistics include: 88 per cent state that budget cuts in their local authority have left children at increased risk of abuse, 73 per cent state that they lack the time, support or resources to prevent children from experiencing serious harm, and 64 per cent state that they were very or quite uncomfortable with the level of risk they are managing.[11]

4 This figure relates to the number of children subject to a child protection plan as at 31 March 2013, which has risen to 43,140 from 29,200 since 2008; Department for Education, *Characteristics of Children in Need in England: 2012/2013, Data Quality and Uses*, October 2013, p9 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253543/SFR45-2013_Data_Quality_And_Data_Uses.pdf (11.01.14)]

5 All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, The British Association of Social Workers on behalf of the All Party Parliamentary Group on Social Work, 3 December 2013, p6 and p14 [accessed via: https://www.basw.co.uk/appg/(26.05.14)]

6 Department for Education, *Characteristics of children in need in England: 2011/2012*, 31 October 2012, available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/219174/ sfr27-2012v4.pdf, cited in Ofsted, *Social Care Annual Report 2012/2013*, 15 October 2013, p8 [accessed via: http://www.ofsted.gov.uk/resources/social-care-annual-report-201213 (16.01.14)]. The Ofsted report states that 'Some individual local authorities have seen activity drop and some local authorities have seen a dramatic increase in their volume of work'

7 Family Law Week, *Lack of child protection resources are worrying, says NSPCC*, 24 November 2013 [accessed via: http://www.familylawweek.co.uk/site.aspx?i=ed121352 (15.01.14)]

8 The British Association of Social Workers and Social Workers Union, *The State of Social Work 2012*, May 2012 [accessed via: http://cdn.basw.co.uk/upload/basw_23651-3.pdf (11.01.14)]. The survey was undertaken with 1,100 social workers across the UK, 865 of whom were social workers in England

9 Community Care, *Community Care survey*, 19 November 2013 [accessed via: http://www.communitycare.co.uk/2013/11/19/community-care-survey-exposes-rising-thresholds-leaving-children-danger/#.UtGFtMh-SYK (11.01.14)]. The survey was undertaken with 600 children's social workers and managers across the UK

10 All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, The British Association of Social Workers on behalf of the All Party Parliamentary Group on Social Work, 3 December 2013 [accessed via: https://www.basw.co.uk/appg/ (26.05.14)]

11 Community Care, *Community Care survey*, 19 November 2013 [accessed via: http://www.communitycare.co.uk/2013/11/19/community-care-survey-exposes-rising-thresholds-leaving-children-danger/#.UtGFtMh-SYK (11.01.14)]

The British Association of Social Workers, The State of Social Work 2012 (BASW Survey)

'The survey tells us three notable things: social workers are facing an administrative overload and are, as a result, spending less and less time with vulnerable children and adults; caseloads are quite simply unmanageable, posing imminent and serious risks to the people who need services; and the stresses on service providers, from the very top to the bottom, are creating an endemic culture of bullying, driving morale levels through the floor.'[12]

Some headline statistics include: 85 per cent have experienced notable cuts to services in the past 12 months, 88 per cent believe that lives could be put at risk by cuts to services, 80 per cent find it harder to practice effectively, 78 per cent have noticed jobs cuts or unfilled vacancies, 77 per cent have seen cuts to back office or preventative services, 65 per cent are concerned about the use of unqualified staff and have seen examples of unqualified workers taking on qualified functions, and 53 per cent fear that lack of support could have tragic consequences for service users.[13]

The latest statistics published by the Department for Education, for the year ending 31 March, 2013 reveal that:

- There were 593,500 referrals of children to social care departments – a decrease from 605,100 in 2012. The number of referrals to social care is at its lowest since 2009 to 2010, when the first full children in need census was undertaken.[14] Having peaked in 2010 to 2011 (at 615,000), they have since been declining;[15]

- 441,500 initial assessments were completed – a decrease from 451,500 in 2012;[16]

- There were 378,600 children in need as at 31 March 2013 – an increase from 369,400 in 2012. Abuse or neglect continues to be the most common primary need – with an increase to 47.3 per cent from 45.5 per cent in 2012; family dysfunction continues to be the second most common primary need – remaining, at 18.0 per cent, at a similar level as in 2012;[17]

- The number of children subject to a child protection plan rose to 43,140 as at 31 March 2013, from 42,850 in 2012. Neglect continues to be the most common initial category of abuse under which children are the subject of a child protection plan – with a decrease to

12 Fran Fuller, Chair of The British Association of Social Workers, quoted in Professional Social Work, *The State of Social Work 2012*, June 2012, p19

13 The British Association of Social Workers and Social Workers Union, *The State of Social Work 2012*, May 2012 [accessed via: http://cdn.basw.co.uk/upload/basw_23651-3.pdf (11.01.14)]

14 Department for Education, *Characteristics of children in need in England: 2012/2013*, Main Text, 31 October 2013, p6 [accessed via: https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-2012-to-2013 (11.01.14)]

15 The Department for Education states that 'Although the number of referrals peaked in 2010-2011 and is now declining, the number reported in CIN [i.e. the CIN census (2009/2010 onwards] is still higher than those reported in CPR3 [i.e. the aggregate CPR3 return (data up to 2008/2009)]. At the same time as the change in data sources, there was a lot of media interest in the "Baby P" case which is likely to have had an impact on the numbers of referrals received by local authorities. However, it is not possible to determine for certain if the scale of the increase in referrals was solely down to this, or if it was down to the change in data collection method;' Department for Education, *Characteristics of Children in Need in England: 2012/2013, Data Quality and Uses*, October 2013, p9 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253543/SFR45-2013_Data_Quality_And_Data_Uses.pdf (11.01.14)]

16 Department for Education, *Characteristics of children in need in England: 2012/2013*, Main Text, 31 October 2013, p6 [accessed via: https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-2012-to-2013 (11.01.14)]

17 Ibid, p2 and pp5–6 [accessed via: https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-2012-to-2013 (11.01.14)]

41.6 per cent of cases from 42.5 per cent in 2012; emotional abuse continues to be the second most common initial category – with an increase to 31.6 per cent of cases from 28.8 per cent in 2012;[18]

- The number of looked after children rose to 68,110 as at 31 March 2013, from 67,080 in 2012.[19] The number has steadily increased each year and is currently higher than at any point since 1985. The majority of looked after children – 62 per cent (in 2013) – are provided with a service due to abuse or neglect; the second most common reason is due to family dysfunction – at 15 per cent.[20]

However, our research suggests that we have a bigger child protection problem in this country than the statistics indicate. A key point to note is that the decline in overall referral numbers is at odds with practitioner experience reported, for example, in the aforementioned surveys and report, and anecdotal evidence submitted to our Review. This reveals escalating demand on social care services, higher thresholds due to increasing referrals, and a continuing rise in the number of children being referred to social care.'[21] The Government's statistics on referrals obviously relate to the national picture and, at a local level, there is some variation. However, the total still adds up to a decline. We believe that an important answer to the discrepancy between the statistics and evidence lies in how the Government defines a referral for the purpose of the Children in Need Census.[22] No data is, to the best of our knowledge (or NSPCC's), systematically collected on *initial* contacts to social care. We query what proportion of those are accepted as a referral. We suspect that the flow from initial contacts to accepted referrals must be changing, and that this is where thresholds are rising, although we are unable to prove this conclusively.

> The NSPCC estimates that for every child who is subject to a child protection plan (or, in other parts of the UK, on a child protection register), there are likely to be approximately eight other children who have suffered maltreatment.[23]

18 Department for Education, *Characteristics of children in need in England: 2012/2013,* Main Tables (Table D4), 31 October 2013 [accessed via: https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-2012-to-2013 (11.01.14)]; Department for Education, *Characteristics of children in need in England: 2011/2012*, Main Tables (Table D5), 31 October 2012 [accessed via: https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-year-ending-march-2012 (14.01.14)]

19 Department for Education, *Children looked after in England, including adoption*, National Tables (Table A1), Updated 11 December 2013 [accessed via: https://www.gov.uk/government/publications/children-looked-after-in-england-including-adoption (18.01.14)]

20 Department for Education, *Children looked after in England, including adoption*, Main Text, Updated 11 December 2013, p2 [accessed via: https://www.gov.uk/government/publications/children-looked-after-in-england-including-adoption (18.01.14)]

21 The British Association of Social Workers and Social Workers Union, *The State of Social Work 2012*, May 2012 [accessed via: http://cdn.basw.co.uk/upload/basw_23651-3.pdf (11.01.14)]; Community Care, *Community Care survey*, 19 November 2013 [accessed via: http://www.communitycare.co.uk/2013/11/19/community-care-survey-exposes-rising-thresholds-leaving-children-danger/#.UtGFtMh-SYK (11.01.14)]; All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, The British Association of Social Workers on behalf of the All Party Parliamentary Group on Social Work, 3 December 2013 [accessed via: https://www.basw.co.uk/appg/ (26.05.14)]; Jütte et al, *How Safe Are Our Children? 2014*, March 2014 [accessed via: http://www.nspcc.org.uk/Inform/research/findings/howsafe/how-safe-2014_wda101852.html#download (21.05.14)]

22 The Children in Need Census 2013/2014 Guide states that 'A referral is defined as 'a request for services to be provided by local authority children's social care' via the assessment process outlined in [the *2013 WTSC*] and is either in respect of a child not previously known to the local authority, or where a case was previously open but is now closed. New information about a child who is already an open case does not constitute a referral for the purposes of this return. *Reception and initial contact activity is not in itself a referral. Such activity may, or may not lead to a referral* [The Centre for Social Justice's emphasis];' The Children in Need Census 2013/2014 Guide, Version 2.1, September 2013, p.27 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253992/cin1314guidancev21webversion.pdf (15.01.14)]

23 Harker L et al, *How safe are our children?* London: NSPCC, 2013, pp5–6[accessed via: www.nspcc.org.uk/howsafe (14.01.14)]

Furthermore, research undertaken by the NSPCC, *How Safe Are Our Children?,* reveals that a significant gap remains between the number of children who are suffering abuse and neglect and those known to services. Practitioners have been found to experience difficulties in identifying emotional abuse and neglect, and to decide when a threshold for action has been reached.[24] According to Action for Children, there are signs that awareness of neglect has been improving; however over one third of social workers feel powerless to intervene in suspected cases of child neglect.[25] While neglect cases are allowed to drift, the suffering endured by the children can be profound. However, as highlighted by *Neglect and Serious Case Reviews*, the consequences could, potentially, be fatal.[26] Tragically, our evidence highlights a stark reality for many vulnerable children who are at risk of or suffering from abuse and/or neglect. In numerous cases where concerns were raised with social care, inappropriate and/or delayed action was taken in response to them.

Our research has uncovered multiple challenges to effective frontline child protection practice in some local authorities in London and other parts of England:

- The rhetoric and aspiration with respect to early intervention is clearly not being realised in some areas of the country, and issues of concern exist with respect to commissioning in this context;

- Higher thresholds are being applied in some local authorities;

- Some social care teams remain trapped in a process-, incident-driven culture. A greater emphasis is placed on process in some local authorities, than on the importance of creating and building relationships with vulnerable children and young people, and developing an understanding of the root of their difficulties;

- Concerning social work practice: namely, the approach of some social workers towards vulnerable parents, children and young people, including their failure to investigate and address parental difficulties, and failure to take a child/young person-centred approach. In so many cases the voice of the vulnerable child or young person is not being heard;

- Some children in need services are not working preventatively: we discovered a particularly disturbing predicament for many children in need, who are being overlooked by some social care services – they are either being kept out of social care altogether or, if they

24 Davies C, Ward H, *Safeguarding Children Across Services: Messages from Research on Identifying and Responding to Child Maltreatment*, London: Jessica Kingsley Publishers, 2012, cited in Brown R, Ward H, *Decision-making within a child's timeframe: An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment*, Working Paper 16 (Second Edition), London: Childhood Wellbeing Research Centre, February 2013, p56

25 Action for Children, *Child neglect in 2011: An annual review by Action for Children in partnership with the University of Stirling*, January 2012, p9 [accessed via: http://www.actionforchildren.org.uk/media/2760817/childneglectin2011.pdf (18.01.14)], Action for Children, *Child Neglect: The Scandal That Never Breaks*, March 2014 [accessed via: http://www.actionforchildren.org.uk/media/8678791/child-neglect-the-scandal-that-never-breaks.pdf (07.05.14)]; Action for Children, *The state of child neglect in the UK: An annual review by Action for Children in partnership with the University of Stirling*, January 2013, p10 [accessed via: http://www.actionforchildren.org.uk/media/5120220/2013_neglect_fullreport_v12.pdf (15.01.14)]

26 University of East Anglia, commissioned by NSPCC, *Neglect and Serious Case Reviews*, January 2013, pp7–9 [accessed via: http://www.nspcc.org.uk/Inform/resourcesforprofessionals/neglect/neglect-scrs-pdf_wdf94689.pdf (14.01.14)]

do gain access to services, we heard of various methods used by some social care teams to avoid giving them the necessary care and support, and of their cases being left to drift;

- Failings in relation to other cohorts of vulnerable children and young people: including children at risk of or suffering street gang violence, older children (i.e. 14- to 17-year-olds), and care leavers.

Most of the cases which feature in our evidence involve families with long-standing and entrenched problems who have been known to social care for many years and about whom cumulative concerns have arisen. All too often critical opportunities to intervene early and to carry out effective preventative work were missed; all too often with severe consequences for the children who were in desperate need of help.

We found repeated evidence of staggering delay and shortfalls, in some cases over years, in the care, protection and/or support afforded to some vulnerable children and young people by some social care (and statutory mental health) services. Some of these are powerfully demonstrated by the key legal failings and missed opportunities which are included within case summaries one to five above.[27]

1.2 Challenges to frontline practice

JOSEPH (15 years old)

Joseph went to CAMHS as a child to be assessed for his special educational needs (SEN), but was reportedly not made fully aware, during this process, of CAMHS' duty to report safeguarding concerns to social care.[28] CAMHS made a referral to social care, raising their concerns about the impact of domestic violence on Joseph. Joseph's mother, Anna, told social care that she had suffered domestic violence by Joseph's father, whose substance misuse had increased dramatically. She also reported that Joseph had witnessed much of this and had tried at times to intervene to protect her. Social care understood that Anna was suffering from domestic violence that was so severe that she was in fear of her life, and that Joseph and his sibling were also at risk of significant harm from physical violence by their father, and were also being harmed whilst trying to protect Anna. During this period, Anna was employed doing shift work, during which time the children remained in the care of their father. Social care reportedly advised Anna to leave her job and relocate to another area – where she had no family or support structure. Anna declined to do this.[29] Social care told her that child protection procedures could be started if she remained at home. Anna was subsequently considered by social care to have engaged well in the process of phoning the police and with a domestic violence project, and to have ended her relationship with Joseph's father. It appears that the children were not regarded as children in need.

At primary school, Joseph was issued with repeated fixed-term exclusions for his behaviour. He became progressively involved in fights – at school and at home. Two of these resulted in a child being taken to hospital; and one involved Joseph fetching a knife from home with which he then threatened people. In the meantime, Joseph began art therapy at Kids Company for anger management, at which

27 See pages 30 to 43
28 This information was disclosed by Joseph's mother
29 Ibid

his attendance was initially infrequent and then became regular. Kids Company referred Joseph for a research project at a children's hospital where he received a diagnosis which included conduct disorder, ADHD and features of OCD. It recommended that Joseph should be assessed and managed by his local CAMHS. Kids Company queried whether Joseph had CAMHS involvement.

After starting secondary school, Anna told Kids Company that Joseph's father was regularly coming to the home being abusive in front of the family. Joseph had said he was scared to go to school and leave Anna in case something bad happened to her. He told Anna he could not wait to get older so that he could confront his father. Joseph's school made a referral to social care; a core assessment was completed. Anna reported that Joseph had missed months of school as a result of repeated fixed-term exclusions, and that she was concerned about his possible association with gangs in the area. At this stage, Anna had to stop working and attending university, following repeated calls from Joseph's school requesting her to collect him, and to ensure Joseph's safety.[30] The social worker noted that since their initial assessment, there was little evidence to suggest that Anna was or had been in a relationship with Joseph's father, and that no police reports of domestic violence had been received. They concluded that *'The fact that the parents have been able to maintain an amicable relationship for the sake of the children and present a united front is a significant strength when considering stability.'* Social care decided to close the case and to refer Joseph to TAC for support.

Months later, Kids Company's psychologist contacted Joseph's school regarding (amongst other things) their concern that an application for a statutory assessment of Joseph's SEN had not been made. Kids Company's psychologist and clinical psychologist assessed Joseph's needs, and prepared a clinical report with the aim of an urgent referral to CAMHS and subsequent NHS diagnoses. Together they concluded that *'[Joseph] has been off school for almost two years now, with only sporadic attendance followed by repeated exclusions…Furthermore, because of his ADHD and conduct disorder symptoms, he is at risk of being recruited by gangs in the area.'* A subsequent Educational Psychologist's report, to support an application for a statutory assessment stated 'It is unclear why a statement of [SEN], and a detailed evaluation of the type of education [Joseph] requires has not been undertaken long before the current (expected) application by [Joseph's school]…'

Joseph's school failed to provide sufficient information to the local authority, which resulted in Anna's application for a statutory assessment of Joseph's SEN being closed, the need for Anna to re-apply (with Kids Company's support), after many months of wasted time, and Joseph being placed at risk of future exclusions. Indeed, following a further incident, Joseph's school placed him in Kids Company's alternative education provision (AEP), with a view to keeping Joseph on its roll until his statement of SEN came through. When Joseph's final statement of SEN was issued, the maintained special schools first suggested by the local authority were considered by Anna and Kids Company to be inappropriate for Joseph's needs. It took an additional year since the statement was first issued for the local authority to agree an appropriate school. In the meantime, a friend of Joseph's was fatally stabbed near to where Joseph lived. During this time Kids Company saw Joseph lose hope in the process, and his attendance at the AEP wane. At the time the CSJ reviewed this case, Joseph's permanent schooling was still not resolved some 15 months after he had started at the AEP.

1.2.1 Early intervention

> *'… early intervention as a concept backed up by real bucks is in danger at the moment, and that is a huge disappointment.'*
>
> **Tim Loughton, MP, Former Children's Minister, in evidence to the CSJ**

30 Ibid

'The introduction of the Early Intervention Grant sent a powerful message that while no longer ring-fencing money, the Government wanted to enable local authorities to shift towards early intervention. The abolition of the grant [sic] appears to undermine the Government's own commitment to this agenda. Nevertheless, the new Early Intervention Foundation … is a welcome sign that the agenda remains alive.'[31]

The CSJ has long supported the crucial need for prevention through early intervention.[32] The importance of this in a child's early years cannot be overstated. However, the CSJ believes that it is vital for early intervention to continue throughout later years, so that it applies not just to the first three years, but up to 18 years. Early intervention should mean taking action whatever the problem is and at whatever stage it presents itself.

However, it is apparent from our research that the rhetoric and aspiration with respect to early intervention is simply not being realised on the ground in some areas. This is tragic given the evidence to support this approach – from both a human and economic cost perspective.[33] The reality of failing to take an early intervention approach is that the anxiety, distress, fear, isolation, abuse, neglect, suffering, despair, and trauma that many vulnerable children and young people will continue to endure, could have been prevented. We have repeatedly seen a failure by some social care services – amongst other statutory agencies – to take an early intervention approach to vulnerable children and young people. As discussed later, this includes children in need, and those who are at risk of or suffering street gang violence.

There are a number of factors which help to explain the barriers presented to early intervention, for example, our three to five year spending review, and electoral cycles. According to Action for Children:

'The [CA 1989] definition of children "in need" theoretically enabled local authorities to work with a broad range of children. In reality, however, traditional political and funding structures have made it almost impossible for local authorities to shift away from the provision of costly acute interventions and towards prevention, even before the current squeeze on public expenditure.[34] *This problem has created a mismatch between successive governments' ambition for early intervention and their ability to deliver it.'*[35]

31 Action for Children, *Early intervention: Where now for local authorities?*, 2013, p14 [accessed via: http://www.actionforchildren.org.uk/media/5740124/afc_early_intervention_-_final.pdf (15.01.14)]

32 Centre for Social Justice, *Breakthrough Britain: The Next Generation*, London: Centre for Social Justice, 2008; Allen G and Duncan Smith I, *Early Intervention: Good Parents, Great Kids, Better Citizens,* London: Centre for Social Justice and the Smith Institute, 2008

33 For example: Field F, *The Foundation Years: preventing poor children becoming poor adults*, London: The Stationery Office, 2010; Allen G, *Early Intervention: The Next Steps*, London: The Stationery Office, 2011; Tickell C, *The Early Years: Foundations for life, health and learning*, London: The Stationery Office, 2011; Munro E, *The Munro Review of Child Protection Part One: A systems analysis*, London: The Stationery Office, 2011; Action for Children and New Economics Foundation, *Backing the Future: why investing in children is good for us all*, London: New Economics Foundation, 2009

34 Action for Children, *As long as it takes: a new politics for children*, 2009 [accessed via: http://www.actionforchildren.org.uk/media/63568/as_long_as_it_takes_report.pdf (15.01.14)] cited in Action for Children, *Early intervention: Where now for local authorities?*, 2013, p2 [accessed via: http://www.actionforchildren.org.uk/media/5740124/afc_early_intervention_-_final.pdf (15.01.14)]

35 Action for Children, *Early intervention: Where now for local authorities?*, 2013, p2 [accessed via: http://www.actionforchildren.org.uk/media/5740124/afc_early_intervention_-_final.pdf (15.01.14)]

> *'Election cycles for local authorities vary from one year to four years. But even the longer cycle does not really encourage long-term thinking. When it comes to early help and intergeneration change we need to think about change taking place over a 12- or 16-year period. That's very challenging for any politician in the current climate.'*
>
> Senior Manager, Children's Services Department, in evidence to the CSJ

Some unitary local authorities have a third/third/third up for election every year, which can also involve shifting policy concerns. This must surely present a serious challenge to any meaningful early intervention strategy. A Senior Manager in a Children's Services Department explained:

> *'How you get sensible business done in that context, I just simply don't know. Those things are really difficult in terms of the governance of children's social care. That's tricky to get that level of consistency around early help and early intervention … You're not going to be piling massive intervention into early years to have benefits in 10 years' time if you're thinking of your next election in a year's time … But it is democracy isn't it? People forget that local authorities are democratically elected. We are a political organisation. We work within a political context and that shapes a lot of it.'*

The cross-government report, *Early action: landscape review,* examined evidence on early action's potential 'to deliver value for money and reduce public spending over the long term.' Its key findings included that:

- 'The government recognises the principle that early action is important in providing public services, but does not plan a significant shift in resources;'
- 'Deficit reduction and localism are a challenge and an opportunity for early action;' and
- 'Early action's potential to achieve positive benefits for society is unclear.'

The report also identified four key challenges which, if addressed, could help design and implement early action more effectively. These included:

- Gaining a better understanding of what works;
- Overcoming short-term bias;
- Improving coordination and accountability; and
- Increasing capacity to deliver.

With respect to overcoming short-term bias, the report stated:

> *'Electoral cycles focus the attention of politicians on short-term results. The Cabinet Office, through its work on the social investment market and "what works" centres, is showing leadership in encouraging longer-term planning. The Department of Health and the Department for Work and Pensions are placing more strategic priority on early action in some policy areas. But most departments and their officials remain cautious. Some local authorities seem more determined to use a longer-term approach, but central and local government need to do more to incentivise practitioners to exploit early action potential.'*[36]

Reductions in local authority budgets have meant that some authorities have cut early intervention services.[37] The NSPCC has highlighted that 'in England, the early intervention grant has declined substantially for each local authority between 2010/11 and 2012/13 – the average decline is 19 per cent per local authority and overall it appears that there is more 'reactive' rather than 'preventative' spending.' [38] In addition, the impact of the restrictive economic climate on the voluntary sector means that there is now a reduced resource, in some areas of the country, for local authorities to be able to refer vulnerable children and young people to or commission services from.[39]

> *'What we are seeing is that local authorities are shifting some of their money out of their early intervention services in order to attract that extra bit of money on troubled families. That is lunacy, because the troubled families formulae were worked out on the basis of numbers predicated on now. If you take the money out of early intervention, out of children's centres for instance, that is going to increase the number of troubled families. The important thing is oversight of the whole system and to anticipate the consequences of interventions in one part of the system elsewhere … You have to child proof this stuff. If you're going to redirect money away from early intervention, that is ultimately a false economy.'*
>
> **CEO, VSO, in evidence to the CSJ**[40]

We heard of the concerning impact of children being held at CAF level whose needs require social care intervention but there is a lack of children in need services on offer to them. A Senior Manager in a Children's Services Department told us:

36 The report concluded that 'A concerted shift away from reactive spending towards early action can result in better outcomes and greater value for money. The government has signalled its commitment to early action as a principle, and taken some tentative steps towards realising that ambition;' National Audit Office, Cross-government, *Early Action: landscape review*, London: The Stationery Office, 31 January 2013, pp5–7. The Centre for Social Justice has published a briefing paper which provides a framework for early intervention for professionals taking crucial commissioning and funding decisions at the local authority level; Centre for Social Justice, *Making Sense of Early Intervention: A framework for professionals*, London: Centre for Social Justice, 2011

37 See, for example, The Association of Directors of Children's Services Limited, *Safeguarding Pressures Phase 3*, p61 [accessed via: http://www.adcs.org.uk/download/news/adcs-sg-pressures-p3-report-final.pdf (21.05.14)], and Action for Children, *The Red Book 2013, Children under pressure*, November 2013, p12 [accessed via: http://www.actionforchildren.org.uk/policy-research/policy-priorities/holding-governments-to-account-the-red-book/red-book-2013 (09.05.14)]

38 Data provided by The Children's Society; adjustments into real terms using GDP deflator; NSPCC calculations; Jütte et al, *How Safe Are Our Children? 2014*, March 2014, p7 [accessed via: http://www.nspcc.org.uk/Inform/research/findings/howsafe/how-safe-2014_wda101852.html#download (21.05.14)]

39 National Council for Voluntary Organisations, *Counting the Cuts: The impact of spending cuts on the UK voluntary and community sector,* August 2011 [accessed via: http://www.ncvo.org.uk/images/documents/policy_and_research/cuts/counting_the_cuts.pdf (14.01.14)]

40 We received evidence of further concerning approaches being taken by some local authorities to the Troubled Families programme, and their impact on VSOs. These are discussed in Chapter Three

> *'You have well-meaning professionals who are trying their best but can't deal with it, so it tips over into crisis and the local authority are taking the child into care … If you had proper children in need services, you could have prevented that. If you kept the child at home and supported them properly, it would be better for the child (probably particularly for the teenage years) and the people that get early help, get better early help.'*

We heard that this approach can lead to early help and early intervention services and specialist services becoming '*swamped*,' but with nothing in between, which is more expensive and unsafe. This approach can also dilute the available support for those who do genuinely require early help or early intervention. We have heard that their needs can intensify to the point where they ultimately require statutory support, thereby placing even more pressure on social care services. We also received evidence from legal professionals regarding a concerning lack of preventative action through early intervention, to reduce the risk of children meeting the child protection threshold, or of needing to be removed from their homes.[41]

Concerns were expressed to us over the fact that some of those working in early intervention services are not appropriately skilled, trained or experienced to address the needs of the vulnerable children and young people they are left holding. Nor are they being given adequate support. We were told that this is causing considerable anxiety in many cases. This highlights another issue of concern, in that whilst a service might be labelled 'early intervention,' that may not be reflected in the reality of the work that the service is undertaking. Where workers are not skilled to meet the needs of some vulnerable children or young people, their needs are likely to become more entrenched. This runs completely contrary to an early intervention approach.

We heard about one or two early intervention services, which sit outside of the statutory framework, and are often involved in TAC processes for families. Their role is '*supposedly*' bringing other services in to support families. We were told that those who work in these services come from '*a huge range of different backgrounds*,' and that a lot of them have '*pretty generic titles*.' Our witness told us:

> *'We hear about cases, they've been open for a whole year and there's been absolutely no change. The reason it's not changed is because there's often a parent at the centre of that family with a significant mental health difficulty … the caseworker has just not been given the skills and knowledge to ask the right questions to move it on, to do the assessment of the parent or to guide the parent as to where they need to be going, or even to have any sort of therapeutic conversation which you would do if you have got therapeutic training. But they're not given access to it … It's everywhere. It has been my experience in every single place that I've ever worked … The people who are managing the most hard to reach families are often the least skilled of all.'*

41 Please see Chapter Four

Our witness went on to explain how they have gone to TAC meetings and, given their social worker training, have identified safeguarding concerns. However, this has followed numerous TAC meetings already having been held. They told us:

> *'It's almost like nobody wants to say "this is a safeguarding issue, and we need to make a referral" … maybe they lack the confidence.'*

Our witness explained that those who chair the TAC meetings come from generic teams, and vary hugely in skill:

> *'Some are very lacklustre when it comes to chairing some of these meetings, so they can become a bit ineffective. But if you do identify social care issues, you can't actually insist that people engage because it's not child in need, it's not safeguarding, and the whole thing just falls apart. For me, child protection services have become very remote, and ineffective …'*

Further issues of concern exist with respect to neglect and emotional abuse. The Education Committee found evidence that 'children have been left too long in neglectful situations.'[42] More recently, findings from Ofsted's thematic inspection showed that one third of long-term cases examined 'were characterised by drift and delay, resulting in failure to protect children from continued neglect and poor planning in respect of their needs and future care.'[43] Action for Children has revealed that many professionals feel powerless to intervene in cases of suspected child neglect. Overall, approximately half of the professionals polled felt that there are barriers which make it difficult to intervene in such cases, due to a lack of available services and lack of resources.[44] The NSPCC report *Neglect and Serious Case Reviews* highlights that 'neglect *can* be life threatening and needs to be treated with as much urgency as other categories of maltreatment.' It states that:

> *'The possibility that in a very small minority of cases neglect will be fatal, or cause grave harm, should be part of a practitioner's mindset. This is not to be alarmist, nor to suggest predicting or presuming that where neglect is found the child is at risk of death. Rather, practitioners, managers, policy makers and decision makers should be discouraged from minimizing or downgrading the harm that can come from neglect and discouraged from allowing neglect cases to drift.'*

42 House of Commons Education Committee, *Children first: the child protection system in England*, Fourth Report of Session 2012/2013, Volume 1, 7 November 2012, p3 and pp25–30 [accessed via: http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/137.pdf (13.01.14)]

43 Ofsted, *In the child's time: professional responses to neglect*, March 2014, p4 [accessed via: http://www.ofsted.gov.uk/resources/childs-time-professional-responses-neglect (12.05.14)]

44 Over one third of police officers and social workers, one in four health professionals, two fifths of primary school teachers and one in four nursery school teachers reported having felt powerless to intervene in cases of suspected child neglect. The study states that 'The poll did not ask for details about the distinction between [lack of available services and lack of resources], but it is likely that "resources" includes wider aspects such as staffing and time'. Action for Children, *The state of child neglect in the UK: An annual review by Action for Children in partnership with the University of Stirling*, January 2013, p.10 [accessed via: http://www.actionforchildren.org.uk/media/5120220/2013_neglect_fullreport_v12.pdf (15.01.14)]

The report argues that prevention and early access to help and support for children and their families is crucial, as well as help for older children who are living with the consequences of longstanding neglect.[45] Indeed, one of the key messages of the Munro Review regarding the case for preventative services was that '[they] will do more to reduce abuse and neglect than reactive services.'[46]

> *'With neglect and emotional abuse, you tend to get inter-generational behaviour, which is why it should be addressed. It's a great area of need. The irony is that if [social care] addressed the children in need, they'd be more likely, certainly in the longer term, to stem the flood of work they have to do. What tends to happen is local authorities end up operating like ineffective A&E departments. They're only dealing with the casualties that come through the front door, and they're not dealing with them terribly well so they just keep getting more and more casualties, and it's harder and harder for them to cope. Whereas if they were able to marshal their resources, which are fairly considerable, in a different way, they may actually be able to stem the flood so they're not drowned in these situations, which they leave until they are much harder to resolve.'*
>
> **An experienced Independent Social Work Consultant and Expert Witness, in evidence to the CSJ**

A witness from a VSO shared their experience of a case involving children who are being chronically neglected by their mother, who has compromised cognitive capacity and mental health problems. Social care has been involved with this family since the mother's son – now a young adult – was in primary school, and the same issues remain. Social care gives the mother instructions in terms of what she has to do, but she is not able to fulfil the targets regarding basic care, taking the children for medical and dental appointments, providing nutritious meals, ensuring the children are living in a hygienic environment, and promoting the children's safety. The VSO has seen historically that she is not able to do so. Yet the younger children are still subject to a gross level of neglect on a daily basis. They were on a child protection plan for a couple of years, and then a Public Law Outline (PLO). When social care saw that the mother had made some progress, it removed the children from the PLO. Our witness told us that at one point it downgraded them to a child in need case – '*against the advice of absolutely everyone from the professional network.*' They told us that here has been no progress with the family, that social care keeps moving the children between a child protection plan and child in need case, but with no difference being made to the lives of the children. We were told that social care did put in early intervention, which essentially involved workers teaching the mother how to clean and maintain an hygienic living environment and how to create healthier boundaries. However, she did not follow through. The outcome from the early intervention team was that the mother was not making any progress. We were told that the children are still at risk, and that their mother has not changed her parenting skills to become a functioning parent. However, because social care '*isn't seeing a "big issue," like a recent allegation of abuse, or the police haven't visited … it thinks things are fine.*' In response to our question as to the reason why social care has taken this approach to the case, our witness said '*… I think it is a sense of apathy, with social workers being*

45 University of East Anglia, commissioned by NSPCC, *Neglect and Serious Case Reviews*, January 2013, pp7–8 [accessed via: http://www.nspcc.org.uk/Inform/resourcesforprofessionals/neglect/neglect-scrs-pdf_wdf94689.pdf (14.01.14)]

46 Munro E, *The Munro Review of Child Protection: Final Report: A child-centred system*, London: Department for Education, May 2011, p69

so jaded. This is just … par for the course. This is what they see day in and day out. Personally, I don't understand why there hasn't been that real push to safeguard the children, because this has been going on for almost 20 years now. It is just apathy within social [care].'

The 2013 *WTSC* states that 'Local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families. This requires all professionals, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment. Local Safeguarding Children Boards [(LSCBs)] … should monitor and evaluate the effectiveness of training, including multi-agency training, for all professionals in the area. Training should cover how to identify and respond early to the needs of all vulnerable children …'[47]

This is essential. However, a key issue of concern raised by our research is that whilst some vulnerable children's needs are being identified – by, for example, VSOs – they are not being promptly or appropriately addressed. Gatekeeping and higher thresholds are preventing access to some social care and statutory mental health services.

Despite professionals and members of the public being increasingly aware of child neglect, 'local areas continue to struggle to effectively identify the scale of neglect in their area…'[48, 49] We heard that local authority information systems '*are geared to process*' and '*are not geared at all in terms of targeting and identifying need, and identifying demand.*' In *Child Neglect: The Scandal That Never Breaks*, Action for Children has shown that 'local areas do not collect accurate data about child neglect and so do not commission services based on the scale of local need.'[50]

> *'…quite often, public services are worried about understanding demand, because they think it will overwhelm them. They are missing out on an opportunity to manage that demand. Quite often I think people get into the system and they just bounce around it because organisations are meeting individual targets.'*
>
> **Angela Gascoigne, Management Consultant, in evidence to the CSJ**

As discussed later, accurate data is essential in order for commissioners to be able to commission sufficient services in order to meet the social care (and mental health) needs in their local area.[51] LSCBs do not commission (or deliver) frontline services; however, they have an integral part to play in the commissioning process. The *2013 WTSC* states that, in the context of the provision of early help services:

47 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, pp11–12 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (25.04.14)]

48 Action for Children, *Child Neglect: The Scandal That Never Breaks*, March 2014, p14 and pp21–22 [accessed via: http://www.actionforchildren.org.uk/media/8678791/child-neglect-the-scandal-that-never-breaks.pdf (07.05.14)]

49 Ofsted, *In the child's time: professional responses to neglect*, March 2014, pp4–5 [accessed via: http://www.ofsted.gov.uk/resources/childs-time-professional-responses-neglect (12.05.14)]

50 Action for Children, *Child Neglect: The Scandal That Never Breaks*, March 2014, p1 and p7 and pp21–22 [accessed via: http://www.actionforchildren.org.uk/media/8678791/child-neglect-the-scandal-that-never-breaks.pdf (07.05.14)]

51 We discuss the new commissioning landscape under the Health and Social Care Act 2012 in Chapter Two

'Local areas should have a range of effective, evidence-based services in place to address assessed needs early.'

It adds that:

'The early help on offer should draw upon the local assessment of need and the latest evidence of the effectiveness of early help and early intervention programmes.'[52]

However, our research has highlighted several issues of concern in each respect.

Action for Children's survey of local areas revealed that 'most areas do not routinely collect data about the children of parents who come to the attention of adult services.'[53] This is in the context of Action for Children also finding in *The Red Book 2013*, *Children under pressure*, that 'Children are "feeling crushed" under the pressure of adult problems.'[54] The importance of good parenting to children's mental health and wellbeing, throughout childhood, is universally acknowledged.[55] Entrenched intergenerational difficulties can exist in many vulnerable families, presenting often multiple risk factors to children. We heard from Dr Zoe Cameron about an analysis that she had undertaken of 20 parents' histories, together with detailed assessments of 12 adolescents entering care.[56] A 'typical toxic triangle' of domestic violence, mental illness and substance misuse featured in many of the cases, as well as criminal convictions and learning difficulties. Dr Cameron established that, in every case, the parents had unresolved problems from their childhoods with respect to trauma and loss.

A Senior Manager of a Children's Services Department also explained that the predictive tools that social care has to identify children who are the most vulnerable are not sufficiently sophisticated, and that it is very difficult to identify those who are the most vulnerable (as opposed to generally vulnerable children), and therefore to prioritise them for the most intensive services.

'… we want to identify as early as possible, the children who are in serious difficulty. I think the indicator is not just mental health…It is something more holistic. Psychosocial vulnerabilities are often there alongside "mental health" issues, so approaches that take both aspects into account are needed. It is trying to be holistic and getting a psychosocial understanding or assessment. Whatever is triggering you to look at that, then you want to look at some broader familial issues – parenting issues, if it is a child protection issue, you want to look at the mental health issues …'

Witness, in evidence to the CSJ

52 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p13 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (25.04.14)]

53 Action for Children, *The state of child neglect in the UK: Recommendations for the UK Government*, London: Action for Children, 2013,cited in Action for Children, *Child Neglect: The Scandal That Never Breaks*, March 2014, p22 [accessed via: http://www.actionforchildren.org.uk/media/867879 1/child-neglect-the-scandal-that-never-breaks.pdf (07.05.14)]

54 Action for Children, *Children are 'feeling crushed' under the pressure of adult problems*, 7 November 2013 [accessed via:http://www.actionforchildren.org.uk/news/archive/2013/november/children-are-%E2%80%98feeling-crushed-under-the-pressure-of-adult-problems (27.05.14)]; Action for Children, The Red Book 2013, Children under pressure, November 2013 [accessed via: http://www.actionforchildren.org.uk/policy-research/policy-priorities/holding-governments-to-account-the-red-book/red-book-2013 (09.05.14)]

55 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p115

56 Cameron Z, '*Lifting the Veil*,' March 2012; available at: http://www.ayph.org.uk/publications/260_Cameron%20Lifting%20the%20Veil.pdf

We recognise that the new Education, Health and Care (EHC) plans have the potential to help identify such children but it is far from certain how the new system will play out. The Munro Review emphasised the importance of the early recognition of need and of early help, which we strongly support. A new section on early help has been included in the *2013 WTSC*. Whilst we welcome the principles and intention behind this, we have a number of concerns regarding aspects of the new section.[57]

1.2.2 Referrals and thresholds

> *'Social [care] are so stretched, and the thresholds have gone up so far, that you rarely work with [them] now in anything but a complete crisis situation … Their caseloads are enormous. I've spoken to people in social [care] who are incredibly frustrated by this … it just doesn't meet the thresholds … I think it is budget dictated.'*
> **Headteacher, Special School, London, in evidence to the CSJ**

> *'It's almost like … we're trying to find incidents, trying to hope for incidents to happen, because that's the only way we can protect these children.'*
> **Social worker, in evidence to the CSJ**

A particularly concerning finding from our research relates to how referrals are being handled and processed by some social care services. We heard that a number of local authorities require a CAF to be used as a referral – for concerns over both need and risk of significant harm. There is no legal basis upon which they may make such a requirement. It can also hinder the referral process, cause unnecessary delay to the vulnerable child receiving the requisite statutory support, and place them at continuing or greater risk or harm. We were told that this practice is being used as a form of gatekeeping by the relevant local authorities.[58]

The CSJ has found many examples of social care services failing to confirm their decision on what action would be taken, following their receipt of referrals – within the requisite timeframe, or at all. We heard about referrals that have not been responded to. A number of VSOs, for example, shared their frustration over having to chase social care with repeated calls to find out what had happened to their referrals. This is concerning enough. However, it also begs the question that if they are finding it this challenging, how is a vulnerable child who perhaps contacts those social care services being treated, or a member of the public with concerns?[59]

57 These are discussed in Chapter Four
58 Please also see Chapter Four
59 We discuss the evidence we have received from VSOs in Chapter Three

CSJ review of Kids Company cases

We have also discovered harrowing cases of children:

- who were considered to be children in need, but have not been designated as such, and have been referred to other services for support – for example, a multi-agency team;
- who were at risk of or were suffering significant harm, who have been referred to other services for support, for example, TAC;
- who were at risk of or were suffering significant harm, who have been treated as children in need;
- who were at risk of or were suffering significant harm, who were treated as children in need, before their cases were then closed in circumstances where concerns had been raised over them remaining at risk of or suffering significant harm; and
- whose cases have not been brought into care proceedings to protect them from significant harm, despite clear and repeated evidence of them being at risk of or suffering significant harm; a number of those children were not even being treated as children in need.[60]

The Education Committee's report, *Children first: the child protection system in England,* refers to the inquiry, launched in July 2011, having examined thresholds for intervention by local authorities. It concluded that, nationally, 'there is great variation in how they are operated.' The Education Committee recommended that the Government commission research to understand the impact of varying thresholds in different areas, and whether thresholds for children in need and child protection interventions were too high and/or rising in some areas.[61]

'I had a call from somebody in the child protection assessment team asking me about a pupil and if I had any concerns. He's involved in quite a lot of criminal activity that is under the radar, lots of drugs, and frequently absconds. He had also recently been involved in a fairly high profile case. Obviously I said I had concerns, and that I had for some time. He's really struggling at school, and is fairly disengaged but we've negotiated a place at college for him part-time in a subject he is really interested in – in the hope that that would see him through. As I'm saying to this guy "yes I have concerns, these are some of them, and did you know of this incident of the kidnapping?" (which he didn't), he was saying "yes, but you realise he doesn't meet the threshold?" I'm thinking, I've not been talking about thresholds. You've simply asked me about my concerns, and I'm telling you my concerns. In the end I said to him, "I'm not quite sure why you're asking me because it's almost like, every time I tell you what I'm concerned about, you tell me it's not concerning enough – so I don't know why we're having this conversation."

60 Examples can be found in our report

61 In addition, the Education Committee recommended that Ofsted should monitor and report on the variation between local authorities' provision and changes over time. We note that it also discovered local authorities that were moving away from using thresholds 'in favour of a more integrated model in which all children receive appropriate help;' House of Commons Education Committee, *Children first: the child protection system in England*, Fourth Report of Session 2012/2013, Volume 1, 7 November 2012, pp5–6 [accessed via: http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/137.pdf (13.01.14)]

He got all kind of spikey and said "have you thought of doing a CAF?" I said "yes, I've contacted the CAF coordinator, but at the end of the day that's not going to make any difference". He was a bit indignant about that. It's about getting people to fill in a form, and then what? I do have concerns, but then I guess the pressure is on him, because in the great scheme of things if you have to scan, if there are lots and lots of referrals, then people have to prioritise who is more at risk than somebody else. I think that's always an issue. Some of it is geographical, some of it is cultural. In one part of the country, one part of London, some things would hit a child protection threshold that would be tolerated and absorbed somewhere else. That's a big, big issue. Even if it didn't meet the threshold of what he was saying, there was a need there.

I then had a phone call from someone else in the child protection assessment team asking me about this boy, after he had mugged someone. I told her about the previous conversation I had with her colleague before the holiday, and asked "have you liaised about the discussion?" She seemed not to know about it. This is the bit that drives me potty, we spend all this time sharing information, or you're a social worker picking up a really complex case and you don't know anything. You think, "well, did no one hand over to you?"'

Head of a special school, in evidence to the CSJ

Our research has revealed deeply concerning evidence of many referrals, where legitimate and significant concerns have been raised, not resulting in vulnerable children gaining access to the appropriate social care services.[62] We heard from numerous professionals of children who are being held at TAC and CAF level, who ought to be receiving children in need services or even, in some cases, placed on child protection plans.

'I think that the TAC process started out as a very good idea and has become hijacked by a system that is already overwhelmed. It acts now as another vessel in which to place very vulnerable children who actually require services at a higher level. But again, it's about gate keeping – "let's stick them over there where something else can be done." There's actually a perception that children receive more services under TAC. But … TAC also can get used as a stick to beat families with – almost like a threat: "If you don't engage with this TAC, then we might do something more." But actually, TAC was never originally set up for that. A TAC was supposed to be a voluntary process for families to engage in to prevent the escalation of difficulties, and to ensure children got the right services. But that is not how it is being used now … at all. They're using it to hold on to children in need. Absolutely.'

CAMHS clinician, in evidence to the CSJ

Solicitors gave evidence over the extent to which they find 'no further action' being taken by social care following referrals. We were told that this is happening on cases where they would expect not only an assessment to have been undertaken and eligible needs identified, but also support to have been put in place.[63] We received deeply troubling evidence of the types of concerns that are not meeting social care thresholds. These also serve to illustrate the extent and severity of need that some VSOs, amongst others, are left holding.

62 We discuss further evidence received in Chapter Four
63 We discuss this further in Chapter Four

'I've got a case … A teen mum … and the father of the child is young as well … cannabis users both of them. She is living in the family home with her parents but the dad is a step-dad who has been violent and aggressive. She has disengaged … with the health visitors and all of that. We've done the whole family CAF … and we have tried to refer it back up to social [care] using the fact that we think there's a possibility that she's back on the drugs, that she has disengaged with the services to protect her baby and that she's still living in the same house with the step-father … I've had an email back saying "Can you please explain to me how this is a safeguarding issue?" Now for me it's like, "how is this not a safeguarding issue? This is a month-old baby."'

'I think we are all encountering this. I come up [to VSO Head Office] and … we're all talking about our concerns about how the thresholds are changing and it's being pushed back and … back and … back. We've had these Baby P [Peter Connelly] inquiries and all sorts of things, and people still don't seem to be grasping it. I've been working with a family where the police have been involved because an under-five-year-old ran away … and was missing for an hour and a half and the police knew. I'm phoning constantly about the concerns about the family, and fact that they are refusing to engage with anybody, about the fact that I know there's a drug pusher who's going into the house, and the father when I went to speak to him one morning on the school gate had a spliff behind his back … And I'm saying to [social care] "what's going to happen? There's going to be something dreadful that's going to happen to these children." And they say "they don't meet the threshold. You've got to understand, they don't meet the threshold."'

SHS practitioners, in evidence to the CSJ

Furthermore, we received evidence from various witnesses of children who are being treated as children in need, who are at risk of significant harm.

'If [VSOs] … become involved and work closer together with local authorities, there is a fear that they will uncover all those families who are at risk, who are still being held at child in need level … it's going to raise the concerns to a higher level … to child protection. That's going to affect the budget.'

Previous middle manager, social care, in evidence to the CSJ

A social worker told us that they have lots of cases of children being held at child in need level, who they believe, given the level of risk to which they are exposed, should be on child protection plans. They explained:

'… I'm just emotionally a wreck. And I'm so stressed out … I'm thinking of these poor kids that are in this situation, and my job is to keep them safe but … I'm unable to keep them safe because of having to meet thresholds … In fact, for someone on the street, they might ask, if you're not going to do something about this, why do you call yourselves social [care]?'

Numerous witnesses to our review expressed their concern over thresholds becoming higher in some local authorities. This is in respect of both children in need and children at risk of significant harm.

Community Care Survey 2013

80 per cent of social workers said that child protection thresholds have increased in 2012 to 2013.

Social workers have reported that thresholds have risen for even the most serious forms of child abuse: nearly a third stated that thresholds for sexual abuse had risen in their local authority; 31 per cent stated the same for physical abuse and 78 per cent the same for neglect.

47 per cent of child protection workers reported having come under pressure to reclassify child protection cases as child in need cases; and 72 per cent stated that the pressure was due to senior management trying to reduce the number of child protection cases.[64]

Children first: the child protection system in England, refers to the Education Committee's inquiry having heard 'a great deal of evidence that thresholds were generally set too high …' The report reveals that arguments were made by many witnesses to the inquiry 'that the current financial pressures on local authorities were responsible for an increasing trend towards higher thresholds.' It also refers to Action for Children's finding that '80 [per cent] of social workers thought that "cuts to services will make it more difficult to intervene in cases of neglect."'[65] The *Community Care Survey* 2013 reports that 'budget cuts, rising child protection referrals and social work vacancies' were cited by respondents as the main causes of rising thresholds.[66]

We were told that thresholds are being used as a means of gatekeeping. One witness told us:

> *'There is a blatant disregard of children who are incredibly vulnerable and at a high level of risk … that is what I have seen working [here]. Social [care] just shutting the door, gate keeping, and not wanting to know.'*

Many witnesses believe that this is due to budget restrictions, and that social care services are resource- rather than need-led, adopting a crisis response because they are so stretched.

64 Community Care, *Community Care survey*, 19 November 2013 [accessed via: http://www.communitycare.co.uk/2013/11/19/community-care-survey-exposes-rising-thresholds-leaving-children-danger/#.UtGFtMh-SYK (11.01.14)]

65 House of Commons Education Committee, *Children first: the child protection system in England*, Fourth Report of Session 2012- 2013, Volume 1, 7 November 2012, pp58–60 [accessed via: http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/137.pdf (13.01.14)]. The report states that 'We have seen no hard evidence to back the assertion that thresholds are altered in the light of financial resources or targets but anecdotal accounts suggest that this may have happened covertly and there are real fears that local authorities may be forced down this path. While the range of additional services on offer may be reduced in the current climate, we do not believe that it would be acceptable to anyone, including local authorities, not to offer protection to abused children because of budget constraints. As the NSPCC argued 'Threshold levels should not be about setting targets for children entering care or receiving help, but doing what is best for each individual child."

66 Community Care, *Community Care survey*, 19 November 2013 [accessed via: http://www.communitycare.co.uk/2013/11/19/community-care-survey-exposes-rising-thresholds-leaving-children-danger/#.UtGFtMh-SYK (11.01.14)]

> *'In my view, the ethos of most of the statutory sector is they try to legislate people out of the system … The thresholds are not there to assess need; they are there to stop people accessing the service. They are barriers to the service. I think some are illegal. The spirit of the [CA 1989] is very much that the local authority should promote and safeguard the welfare of children in its area. In terms of assessing need, in theory, the spirit of the [CA 1989] is that children should be looked at individually, and resources should be need led, not resource led. But in fact, they are resource led and because there is a shortage of resources, what the local authorities do is build in systems which exclude … It is probably in contravention of the [CA 1989] and could be in contravention of parts of the Human Rights Act.'*
> An experienced Independent Social Work Consultant and Expert Witness, in evidence to the CSJ

We heard strongly expressed views over the unlawfulness of some thresholds that are being implemented by some local authorities, their lack of transparency, and of the injustice suffered by many vulnerable children who are not able to gain access to social care services. Some are suffering, for example, with the impact of serious domestic violence, severe parental substance misuse, or with unmet parental mental health needs.

There is a new requirement in the *2013 WTSC*, requiring LSCBs to publish their threshold documents, which has the potential to help address concerns over illegality and lack of transparency with respect to some of the thresholds which are being implemented. However, concerns exist over the current wording and application of the guidance, as discussed in Chapter Four.

1.2.3 Assessments

In a number of cases reviewed by the CSJ, social care failed to provide the relevant assessments within the requisite timeframe or, worse still, at all. This followed both child in need and child protection referrals.[67] In Michael's case, by the time of the third Review CPC, the core assessment had still not been undertaken – 195 days after it was actually required. It is understood by the CSJ never to have been completed. One social worker was particularly frank:

> *'… if we don't have a timescale, we're just going to leave it. I know I'm shocking with that, because say with core assessments, I'm really bad at getting those done on time. I don't respect them number one, because I don't think anyone reads them … if at crisis point they need to go to court it's great that the core assessment is done and the Judge might read it if I'm lucky. But no-one is going to read them. Me giving them to the family happens a quarter of the time – to actually read … you might have a family that can't read and write very well, so if you've written a 30-page report reading them that can take a really long time. Sharing that stuff with the family doesn't always happen, and there are things on file they don't even know about. You can't really be honest sometimes in these reports can you? … If you're being really honest, they've engaged with you, they've*

67 Examples are provided in our report. We also refer to evidence received from VSOs and legal professionals regarding assessments in Chapter Three and Chapter Four, respectively

talked to you, you've just broken down that relationship. Ultimately, if we had more time, compromising our practice methods would not be an issue; however, this is not the reality.'

'Background: a room, before redecoration, selected from [Kids Company's] "Colour a Child's Life" Programme. A [two]-year-old child slept in this bed: her family was assessed by social [care], but did not receive statutory support for [five] years;' Kids Company, *Kids Company Report for Government March 2011–2013*, London: Kids Company, 2013, pp14–15

Our evidence also revealed concerns over the quality of some assessments. In a number of cases we reviewed, core assessments contained inaccurate key details including names of family members, dates of birth, and ages. A number of core assessments failed to include information which was considered to be critical by Kids Company. This was in light of the background information and informed understanding that the VSO had of the relevant cases, and which had been shared with social care – for example, the level of violence that one child had been exposed to, and serious concerns which Kids Company had raised regarding some of Claire's family members.[68]

One social worker explained that they might have longer to do assessments now, but that is only one aspect of their job, and given the pressure they are still under in other areas – for example, court proceedings and visits – they would '*cut and paste profusely*.' They added:

> *'You get it done on time don't you? But where are you cutting and pasting it from? How old is that information? I think it's appropriate to use cut and paste if the information is within a really timely event that's happened, I think that's fine. But that doesn't always get adhered to by people. You read reports that have names of other children and all sorts of stuff, that's really common.'*

> *'Good assessment matters and is key to effective intervention and to improving outcomes for children. Significant decisions are made on the basis of social work and other professional assessments that affect outcomes for children in both the short and the long term. Yet we know from research studies, inquiries into child deaths and overviews of serious case reviews that assessment is complex and challenging. The evidence shows that on occasion, practice has fallen short of the standard required. Poor quality, incomplete or non-existent assessments have been of particular concern. Five areas have been repeatedly identified in the literature as problematic: differential thresholds, a failure to engage the child, inadequacies in information gathering, shortcomings in critical analysis, and shortcomings in inter-professional working.'*[69]

A CAMHS clinician described their experience of assessments undertaken by social workers in the child in need or duty teams:

> *'… [they] are appalling … they are shallow – it's taking three weeks to do an initial assessment … and they are not responding to emails when we ask them to explain or give us feedback after we have made a referral in.'*

We heard that the quality of assessments continues to suffer in some social care services as a result of the pressures that many social workers continue to work under. The CAMHS clinician went on to explain:

68 Claire's case summary (Case One) can be found on page 30

69 Turney D et al, *Social work assessment of children in need: what do we know? Messages from research*, Department for Education, March 2011, p1 [accessed via: https://www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research (17.01.14)]

'I think there are some very poor assessments going on. I don't know whether it's because people are not staying in the job long enough. Anecdotally, I'm being told that the social workers who are working in the children in need and safeguarding teams have only one or two years of experience of social work. The experienced social workers are presumably going into management where their job is to gate keep, and to try to put more and more cases on [to social workers]. Given the volume of referrals we are told these departments are dealing with perhaps it's only possible to do a really shallow job?'

It would seem vital, given the importance of these assessments, that they are undertaken by skilled and experienced social workers. However, another witness agreed that child in need work is delegated to unqualified or the most junior staff where, arguably, prevention requires highly skilled staff.

The APPG on *Inquiry into the State of Social Work report* also revealed issues of concern regarding assessments following child protection referrals:

'The children … involved in child protection referrals typically live in chaotic, distressing and sometimes dangerous situations, so it is crucial that the social workers charged with assessing their safety and well-being are able to make well informed decisions, in a timely manner … Too much of the evidence heard indicated that, instead, decisions are rushed and assessments less thorough than necessary for this crucial work.'[70]

We heard of instances (pre the *2013 WTSC*) where a child protection referral had not been deemed to meet a local authority's threshold, but consideration was not then given to undertaking an initial assessment to determine whether the child was a child in need. Our evidence also raises an issue of concern over the identification and recording of key information in assessments. As discussed below, some social workers are not getting to the root difficulties faced by some vulnerable parents and children, including those who are considered to be 'not engaging.' We have concerns over a potential lack of accountability on the part of some social workers, from the ground level. One told us:

'… social workers … can collect [information] in a really apathetic way or they can do it in a really effective way. How they put that up changes the entire dynamics and how people listen to it.'

A middle manager highlighted the vital importance of effective supervision in this context:

'I suppose, ideally, people don't want to see it … to recognise the harm that is going on if it's not vivid. It's a difficult area because a lot of this is discretionary – to the device of the individual worker, team, or manager that's involved in the case. We're dealing with

70 All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, The British Association of Social Workers on behalf of the All Party Parliamentary Group on Social Work, 3 December 2013, p15 [accessed via: https://www.basw.co.uk/appg/ (26.05.14)]

potentially grey areas where there is often a smell of something not going right in the family. Therefore it's pretty much left to how far you're going to dig to find something … it's difficult, because it comes back to yourself and where your perspective is coming from. That's why supervision is really needed and it's critical for workers to be held and managed. Again, that's a resource issue – time, training. People need to be able to reflect on these issues, they are such emotive issues which are linked in with how they practice. I don't think enough space is given for people to deconstruct and think about what they're actually dealing with and how that's positioning them.'

Following recommendations made by the Munro Review, changes have been made to the assessment process (although a timeframe by which the new single assessment must be completed has been retained). Legal professionals have voiced concerns in relation to some of these changes, including how the methodology for assessment (contained in the *2013 WTSC*) is to be applied. [71]

1.2.4 Bureaucracy and process

'People are often very frightened. It's a system where anxiety is obvious and necessary. It's appropriate for people to have anxiety but it has been compounded by that institutional anxiety of being found to have got some process wrong. Those are very, very difficult things to get over.'

Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, in evidence to the CSJ

Despite some positive developments in social work reform following the Munro Review, it is clear that bureaucracy and the tick-box culture is unfortunately still rife in some social care services. One social worker told us:

'They would just come up with more things for us to do … I used to think "have they read the Munro Report?" because they kept giving me more forms to fill in and the child was lost. It is just about their forms and statistics so they can look good.'

A number of social workers expressed their frustration at not being able to work creatively – including with VSOs.[72] One social worker told us:

'It's not about changing lives or making lives better for children. It is about statistics.'

Another told us:

'… everything is performance indicators and targets. We are tick boxing [sic] *a lot … I am stuck in front of the computer. A lot of the time I am doing assessment after assessment and reports. It's all important, but I think the focus has gone away from the child and that preventative side of things … Managers today don't seem interested in the child at all. All they are interested in is "is it on the system and is it in timescale?" That's all*

71 As highlighted in Chapter Four
72 Please also see Chapter Three

they are bothered about. It has gotten ridiculous and I've noticed more so in the last few years … I am in a job now where it is all about that and nothing else seems to matter.'

The frustration expressed by witnesses seems to be even more acute given the hopes they had for change following the Munro Review. We had a strong sense of how soul-destroying it can be for some social workers who feel that they are still 'chained to' their desks, over three years on from the Munro Review. They wish, as was recommended, that they could spend time with the vulnerable children and young people they are responsible for caring for, protecting and/or supporting.

1.2.4.1 IT and the Integrated Children's System (ICS)

The Munro Review commented on the problematic use of the ICS, a framework for developing electronic recording systems for social care. It highlighted conclusive findings demonstrating 'how influential and how damaging the design of the software was.'[73] It also referred to research which shows that 'the current documentation makes it difficult to "see the child"', as confirmed in evidence submitted to the Munro Review.[74] However, despite recommendations regarding the modification of electronic recording systems, challenges persist. The *Inquiry into the State of Social Work* report states that:

'Witnesses echoed the findings of the Social Work Taskforce in its 2009 report recommending solutions to the problems facing the profession. The Taskforce was clear that the [ICS] … was failing practitioners. It is therefore regrettable that four years on social workers continue to have to express serious frustration at this same system. The inquiry repeatedly heard how despite attempts to address ICS failings, long acknowledged as part of the on-going reform agenda, social workers continue to find themselves chained to their desks by this unwieldy IT system.' [75]

Different local authorities have different IT systems; we were told that '*some are good, some are not*.' Some local authorities have taken and are taking steps to modify their IT systems, to enable social workers to work more flexibly. However, it is clear that some systems continue to compound the sense of pressure on social workers, as opposed to supporting them to improve their practice. We heard that whilst practice is more easily changed now due to the *2013 WTSC*, IT systems do not necessarily support this. Various witnesses expressed their

73 Bell M et al, *The Integrated Children's System: An evaluation of the practice, process and consequences of the ICS in councils with social services responsibilities*, 2007; White S, et al, 'The descriptive tyranny of the Common Assessment Framework: technologies of categorisation and professional practice in child welfare,' *British Journal of Social Work*, 39(7), 2009, pp1197–1217; Shaw I et al, 'An exemplary scheme? An evaluation of the Integrated Children's System,' *British Journal of Social Work*, 39, 4, 2009, pp613–626 – cited in Munro E, *The Munro Review of Child Protection: Interim Report: The Child's Journey*, London: Department for Education, February 2011, p57

74 Reference is made to 'The research carried out by Professor White's team at Lancaster University and the preceding evaluation of the ICS by the Universities of York and Southampton … ;' Shaw I et al, 'An exemplary scheme? An evaluation of the Integrated Children's System,' *British Journal of Social Work*, Advance Access published 8 April 2009, 10.1093/bjsw/bcp – cited in Munro E, *The Munro Review of Child Protection: Interim Report: The Child's Journey*, London: Department for Education, February 2011, pp58–59. The Munro report states that, 'for example, there is nowhere in the current system for the child to tell their own story, or for the family's social history to be effectively summarised. Instead, there is an over-concentration on repetitive data entry and there are multiple processes and transfer points in the workflow which require the child's story to be continually retold. This encourages cutting and pasting and the process of recording to be considered a chore, rather than an integral part of the work'

75 Social Work Taskforce, *Building a safe and confident future*, 2009, cited in All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, The British Association of Social Workers on behalf of the All Party Parliamentary Group on Social Work, 3 December 2013, p13 [accessed via: https://www.basw.co.uk/appg/ (26.05.14)]

exasperation over their system's rigidity and of it being incident-, process-, and target-driven, as opposed to flexible and child-centred.

Another social worker described essentially being 'trapped in process.' They explained that '*once the process begins … it's difficult to move a step back. Because everything is guided by process and by protocol … you'd think that if we're working towards the best interests of the child, if we then realise "this isn't right … we can do something else," or "we haven't done this, then go and do that." But unfortunately we can't, because this process starts and it's like, "well … we're already following this and we have to … just go through the process."*' They provided some alarming examples of the implications of this. In one child's case, a social worker had failed to take significant and requisite action when removing them from the family. In another case, concerns surfaced regarding where a child had been placed by social care. However, we were told that process dictated that nothing could be done to reverse either situation '*until something happens, incident-driven*.'

The social worker explained that '*… we all know it's wrong but we know that we can't do much to change the process because it's happening … you can't even speak out if it's not your case and … if you do, you're not just making yourself look bad, you're making the local authority look bad … So the amount of kids who are … in situations like that who are young and vulnerable … And then you just think, "what is the point in us doing our job?" Why do we have to follow the last social worker's decision when it was wrong, and there is evidence in the back files to show that the decision was not thought out fully?*'

Undoubtedly no-one would argue against the need to free social care from its process-driven culture. However, it has been recommended that a measured approach should be taken to this. A Senior Manager in a Children's Services Department expressed their view that:

> *'I think you need enough process. I think the lessons from some of the really early child abuse scandals are about having too much wooly thinking and not having a process … there needs to be a balance between process and flexibility.'*

Our witness went on to explain how their Children's Services Department was still recovering from the '*incredibly process-driven practice*' created by the ICS, but felt that the knot was '*beginning to untangle*.' However, they fear that the Government may have swung too far in the other direction. They told us:

> *'There is a benefit to the Government loosening those strings. But I also fear that they may have loosened them too far … I'm not sure if we have kept even the basics by loosening it too much … [the 2013 WTSC] just says "work it out for yourself" … the point is … we are trying to liberate social work. I think the Munro Review was incredibly helpful in that. What we have to make sure of though is that we don't throw away the good bits of process.'*[76]

76 We discuss this and other aspects of the *2013 WTSC* in Chapter Four

'… social workers … don't have the capacity to go above and beyond what is statutory. Unfortunately, I think that is what is failing children in care, because they need what's above and beyond. I hate that phrase "they deserve a second chance" because they've never had a first chance. Let's start from the beginning here, let's give them a first chance.'

A witness, in evidence to the CSJ

1.2.4.2 Looked after children

Frustrations were also raised over bureaucracy and process in the context of looked after children. Several witnesses referred to the administrative demands on social workers, and blanket requirement for them to conduct the same amount of visits for all looked after children, regardless of their personal circumstances and needs.[77] The social workers who gave evidence in this regard clearly crave the ability to work more flexibly with the children, according to their individual circumstances and level of need. However, process appears to take precedence over their ability to do so.

'If you have someone with a high level of need, shouldn't they be seen more regularly? And if you have someone in an amazing foster care placement and they are doing incredibly well, they don't need to be seen so often. But they get seen the same as the person who's involved in gangs and has been stabbed five times … It is all tick boxing [sic]. *You wouldn't … do that in the health service … Someone who comes in with a bunion on their toe is not going to need to be seen the same as someone who needs a hip replacement … I think it's a very sad state of affairs when children who have bugger all, and have been completely failed within their family, are then failed by a system that is not set up to support them or nurture them in any way … '*

A witness, in evidence to the CSJ

One social worker told us that:

'In every case, you have to be jump ing through the same hoops … It just feels overwhelming … If anything, things are … getting worse … not … easier in terms of the demand and paperwork.'

They referred to a child who has been in the care system for over a year, who is stable and has not had a move of foster placement:

'You shouldn't be visiting them every six weeks; it should be every three months. But all local authorities have this thing now, whereby seeing the child every four to six weeks is going to protect them … All that is going to do is cover the local authority, if anything were to go wrong. Technically, you shouldn't need to do a visit every six weeks for all children. There is no flexibility there. As well as the hard core cases, you have the stable ones where you are still expected to put the same input in when a lot of the time it is not required.'

77 The Care Planning, Placement and Case Review Regulations 2010 set out the common requirements for visiting all looked after children, which are supplemented by additional visiting requirements for specific types of placement

Another social worker explained:

> *'We don't have the time … They know when you visit … how it's going to go … We get information and we record it … It is a formatted visit where you are going through the motions. You are asking the same questions. They'll say "you asked me about my health six weeks ago, it hasn't changed." I think the children, they aren't interested in that. They don't appreciate those visits but that's what we have to do. I am more interested in building relationships … I would rather do the direct, mentoring work because you feel like you're achieving more. The paperwork needs to be done, but not at the level that we're doing it. We need to get away from that, but there isn't a desire to.'*

1.2.4.3 Care leavers

Social workers also expressed their concerns over the extent of administration required, and nature of the support that they are able to give care leavers. They seem trapped in a relentless cycle of administration, formality and timescales, to the detriment of being able to spend quality time with the vulnerable children and young people. Again, process seems to take precedence over the importance of building a relationship.[78]

> *'The pathway plan forms are being amended.[79] I haven't seen them, but I doubt I will be around to see the change. Already I am hearing rumblings that they are not as slimmed down as they were proposed to be and that is always the case. You are regurgitating a lot of information and it is a cutting and pasting exercise. There is a lot of scrutiny going on, but it is about managers covering themselves from legal challenges. They could make the documents a lot simpler and they could move away from a lot of the work and make it simpler in a Munro sense but that is not feeding in. I have been hearing about Munro for [over two] years, and I have not seen any impact in making it easier. If anything, it's going the other way … We are so wrapped in this habit of having the assessment, we've got to have this and we've got to have that. Is that making a difference? It's not making a difference … I say to the young people "your pathway plan is done, do you want to see it? Do you want a copy?" "No." They are not interested.'*
>
> **Social worker, in evidence to the CSJ**

A social worker described their experience in a local authority they had recently left:

> *'I have never typed as much in my life. I felt as if I just typed. I didn't see my young people, I just typed. They only care about: "Are you in your timescales? Have you done the visits and pathway plans within timescale?" They wouldn't particularly care about what you had done, or the quality of that assessment. "Is it done?" is their main concern, so that it meets their performance indicator. If it [does] it looks good. It is all smoke and mirrors … I often used to say to people, if I was lying dead on the floor, they would step over me to see if I had completed my pathway plans.'*

78 As explained in the legal foreword, the Children Act 1989 places the local authority under a specific duty to prepare a pathway plan for care leavers, which must be completed as soon as possible after the pathway assessment. The format of that can vary and can be locally determined; however, it is one of the things that Ofsted look for and is therefore a regulated activity

79 These are locally determined

We were told that management regularly look at the number of visits and pathway plans for care leavers, and that this focus on timescales is driven by a fear of legal challenge, Ofsted and Department for Education performance tables, rather than concern over the quality of that work and progress achieved for the vulnerable children and young people. It is critical that cases are managed in a timely way, and not allowed to drift. However, the quality and efficacy of the services and support provided to care leavers is also fundamental.

> *'We're not addressing the background information, the reasons they came into care … we're not helping people to actually, I can only call it heal … For example, we've got a pathway plan, these are the things we've got to look at, education … health … and … these things are important but where's the well-being? Where's the support to help to prepare someone for adulthood? …'*
> **Social worker, in evidence to the CSJ**

> *'I do feel for some social workers. They must go through some hard stuff as well. It's not just about us at the end of the day. They must get fed up. They're trying to help young people but there's nothing. They can't do anything for that young person because they're stuck in that cycle where they can't do anything.'*
> **Young person, in evidence to the CSJ**

The reality, in some cases, is that timescales may be adhered to but with no or little positive progress actually being achieved. It appears that these requirements can in themselves present another obstacle to effective intervention with vulnerable children and young people. A social worker stated:

> *'I do the work because I want to see positive outcomes. I want to see positive change and I want to see the young people moving on with their lives. But the reality of the job doesn't allow you to be in a position to do that. It's too focussed on all the other stuff, the processes and all of the form filling.'*

1.2.5 Relationships

> *'It's not just that many social workers are not as confident in their skills as we need them to be, but that the whole system doesn't recognise that … it's about forming relationships.'*
> **Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, in evidence to the CSJ**

Relationships, where there is mutual trust and respect, are critical. The importance of relationship-based working was shown in a study of social work by Knei-Paz, who found that 'it was the quality of the therapeutic bond established between social worker and client that was the basis for what was conceived of as a positive intervention.'[80]

80 Knei-Paz C, The Central Role of the Therapeutic Bond in a Social Agency Setting: Clients' and Social Workers' Perceptions, *Journal of Social Work*, 9:2, 2009, pp178–198, cited in Munro E, *The Munro Review of Child Protection: Final Report: A Child-centred system*, London: Department for Education, May 2011, p88

Most social workers undoubtedly want to make a positive difference to the lives of the vulnerable children and young people they are responsible for caring for, protecting and/or supporting. They want to get to know, and to create and build relationships with them.

> *'I'm happy with what social care did because now my life's turned around … They've put me on the straight and narrow. I had trouble at home and the social worker talked to me and mum and tried to sort things out. It was successful. The main reason for things turning around was that I got on well with the social worker … She wasn't like "I think you should do this or that" – she would work up to it.'*
> **Child, in evidence to the CSJ**

However, many social workers are not able to do so. It is clear that insufficient importance is being placed on this vital aspect of social work by some social care services. As discussed earlier, it appears that some social care teams remain trapped in a process-driven culture. A key finding across our evidence is that greater emphasis is placed on following process in some local authorities, than on the importance of creating and building relationships with vulnerable children and young people. Some social workers are thereby failing to gain an informed knowledge and understanding of the root of their difficulties. Again, this feeds into issues of concern regarding the quality of assessments and efficacy of interventions.[81]

> *'I don't know what I would have liked them to help with but I would have liked them to help. They know something's going on but they don't know what. But they need to work it out and they didn't … Because it's family problems.'*
> **Child, in evidence to the CSJ**

> *'[My previous social worker] just stopped coming around. She didn't explain why to me.'*
> **Child, in evidence to the CSJ**

We heard of a Children's Services Department trying to 'bring back' the core of social work as relationship-based, but were told by a social worker that '*with staff turnover and retention a continuous battle, clients having trust that you won't leave the Department isn't there.*'

Some vulnerable children and young people are not being the opportunity to talk to their social worker in private. Not only can this impact on their ability to create and sustain a relationship and build trust with their social worker, it can also alienate them from the system itself, and sometimes from a young age. Michael told us that he would have spoken to social care but that a social worker never talked to him one on one:

> *'I didn't want to be in certain situations and I wanted help. I put a mask on but was crying underneath, begging for someone to give me a hug or help me. Only my dad and Camila gave me a hug. When I was 10, 11, 12, 13 – or even 14, I would have talked; it would*

81 'Studies indicate that good assessment is grounded in a thorough understanding of the child and family's situation, needs and strengths, and to gain this knowledge, practitioners need to work directly with the child and their family;' Turney D et al, *Social work assessment of children in need: what do we know? Messages from research*, Department for Education, March 2011, p9 [accessed via: https://www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research (17.01.14)]

have burst out and I would have cried. But no-one had the time to look into me, although they could have seen the pain in my eyes. After that, I hated the system.'

We heard that even where vulnerable children and young people are seen alone, there can be an issue over the amount and quality of time that their social worker is able to spend with them. We were told that some are literally physically 'seen,' and that this can be recorded as time actually spent with them. Indeed, in some of the cases we reviewed, children were recorded as having been seen, with no further details given. It was not clear how long they had been seen for, whether they had actually been spoken to and, if so, the nature of what was discussed.

'"We haven't got time to come and see you; you're going to have to see us." That is my favourite quote. Actually, it should be "you have not got time to not see that young person." You just don't know what the consequences are of not having that contact with somebody.'
A witness, in evidence to the CSJ

Again, we heard about emphasis being placed on performance and meeting targets with respect to visits, with little, if seemingly any, scrutiny paid to their content. A social worker told us that they are required to see children on child protection plans alone, in their home. However, they explained that:

'… people use it differently … There are no policies around how long you'd spend there. I don't think anybody even really reads the case notes either. When they run these stats, they look at the heading "child protection visit" … and if you tick that box, that's what's running the results. When independent and internal audits happen, they'll look at your case notes maybe then. But nobody will actually read the content unless they're actually trying to find out something specific that's gone on. But I know social workers literally go "I've physically seen the child and I'm done." And they'll pop in really briefly because it depends how they're prioritising … this family, they might not be completely high risk – spend 20 minutes with them and it's done.'

Various witnesses expressed their frustration over the timekeeping of some social workers. We understand that this can be due to the demands on social workers' time or, we were told, the result of some not prioritising it as they ideally ought to. Poor timekeeping can understandably send a negative message to any child or young person. However, where they are vulnerable, and their circumstances are often characterised by feeling let down and unvalued, it must become even more important to ensure prompt timekeeping.

'… at the moment turning up late for meetings – it's just unbelievable how much social workers are turning up late, unequipped and haven't got the knowledge of a family. And it's the practitioners who are taking that on board and saying "this is actually how the case goes."'
SHS practitioner, in evidence to the CSJ

We were also told that sometimes social workers will make appointments and will not '*turn up*,' without any explanation given in advance. '*In court*' is one that we were told '*features a lot*.'

'Social workers are the worst for being late for meetings and appointments. I've had multi-disciplinary meetings … and … some of them will be half an hour late … I have young people say to me "if she says she's coming to see me at 2pm, she's not going to be here much before 2.45pm." They shouldn't have to get used to that … You're trying to gain trust and … to build a relationship … You can't do anything therapeutic or move anybody forward without forming a relationship with them. You can't form a relationship based on flakiness. And you can't then be annoyed with them if they're late. It's got to work both ways. It does very often ring true that it's one rule for you and one rule for them. How are you ever going to get anywhere with that?'

A witness, in evidence to the CSJ

A social worker readily admitted:

'We are appalling at [timekeeping] … I know that I probably stick to half of my things on time … Timekeeping is a really big one we don't stick to … You've always got to prioritise your priorities. But there are just slack workers … You can say you went on a home visit and never went anywhere. I think at times workers feel so overwhelmed that they just need to run away and hide.'

Constraint on developing and building relationships with vulnerable children and young people, including a lack of time to undertake direct work with them, is also having an inevitable impact on the skills of some social workers.

'They used to speak to us like a six-year-old. I don't want to be spoken to like that. I want to have a normal conversation.'

Child, in evidence to the CSJ

It appears to be fuelling a loss of confidence and even a sense of fear on the part of some, who understandably feel that they are being de-skilled – including with respect to some of the basics. The same social worker (as above) explained:

'Well the direct work we don't really have the time to do. Everyone is in agreement across the board. In my team I know that people would like to have more time with kids in particular and families … But I think we're scared as well about what to do. I don't think we know how to talk to children sometimes, and we don't know how to talk to families and we don't know how to challenge them. It's scary. I spend 70 per cent of my time in front of a computer. So with that, I have to even think about how I'm going to engage a child sometimes … With that really basic stuff, we're massively de-skilled. We're on call constantly. We're doing assessment after assessment after assessment. There's so much paperwork. Any space you've got you type … We're supposed to have the time and the capacity to do it. But … you really don't have enough time to do that stuff … '

1.2.6 Approach towards vulnerable parents[82]

1.2.6.1 Engagement

> *'… statutory services almost drive people who were coping in very difficult circumstances to a point where they're not anymore.'*
>
> **Chief Executive, SHS, in evidence to the CSJ**

> *'Has she not been listening or has she not been understanding what you are trying to say?'*
>
> **Social worker, in evidence to the CSJ**

Vulnerable parents often face significant and multiple barriers to engagement with social workers (amongst others). These can include a lack of confidence, linguistic barriers, low literacy and poor communication skills, substance misuse and/or mental health problems. They may, historically, have had a negative experience of social care, have very troubled backgrounds and/or currently be facing complex difficulties. One practitioner from the national VSO, SHS, told us:

> *'When you talk about the families we're working with and who are going to be engaging with these services, they are going to be the most vulnerable in society.'*

Some face additional barriers to engagement due to their anxiety, fear, distrust and perceived stigma of social care. Numerous VSO practitioners told us that it is not seen by many vulnerable parents as a supportive service.

> *'… you mention social [care] to any family and automatically that guard will go up. There's a fear around it. Social [care] is not seen as a supportive service, it's seen as a punitive service – and "what you're going to tell me is everything I'm doing wrong, and potentially my children are going to be taken away from me." Even if it's at very early stages – Tier 1 or Tier 2, or even if it's a really minor incident – you mention anything about child protection and having to pass that on, and it strikes the fear into families. So [social care] is not seen as supportive at all.'*

> *'… I think there's also that fear where there are domestic violence and … substance misuse issues – around coming forward, and parents accessing support for themselves. And, if the children are witnessing that, are they getting the support they need? Again, as soon as you disclose domestic violence … it's automatically a social [care] issue because it's about protecting the child, and everyone … who works in these services believes that. It's how do we best do that, so that families are engaging and parents are accessing support, and the children are getting support and being protected?'*
>
> **SHS practitioners, in evidence to the CSJ**

Our evidence demonstrates that some vulnerable parents are not being listened to, and their voices are not being heard. Some social workers are not getting to know them, are not gaining

82 In its recent thematic inspection, Ofsted found that 'The practice of engaging parents in child in need and child protection work was found to be a significant challenge to professionals;' Ofsted, *In the child's time: professional responses to neglect*, March 2014, p4 [accessed via: http://www.ofsted.gov.uk/resources/childs-time-professional-responses-neglect (12.05.14)]

an understanding of the root of their difficulties or the truth of what they are experiencing. Some are not engendering their trust. All the while, the challenges faced by such parents may continue to have an adverse impact on their children, leaving them without the potentially necessary care, protection and/or support.

A feeling was expressed by one VSO that:

> *'… social care is very much done to people which means issues arise in getting families to interact with the service effectively, meaning support cannot be sufficient. Families need to be active in their case and part of the decision-making. However, a bureaucratic approach rather than person-centred leads to trust issues and therefore an inability of the service to properly support.'*

A number of VSOs told us that they try to explain to vulnerable parents that social care is there to care for and support them. Some VSOs are performing a vital role in supporting many families to engage with social care (amongst other statutory agencies).[83] We heard that where a social worker gets to know a vulnerable child and the family, the 'fear' of social care subsides. However, time constraints, other pressures and turnover rates in some social care teams can present challenges to this.

Concerns were repeatedly raised by VSO practitioners about the approach taken by some social workers towards some vulnerable parents. Views were expressed about an uncaring or insensitive approach being taken towards them, and a lack of understanding about the history of and/or difficulties often faced by vulnerable parents. The critical importance of a positive style of communicating, compassion and relationship, was powerfully reinforced by a number of profoundly distressing accounts that were shared with us of what some parents have suffered.

A SHS practitioner referred to a family that one of her practitioners is currently working with. The mother was tortured herself as a child and is having extreme difficulties raising her daughter.

> *'One of the ways social [care] seemed to see fit to approach it is to be quite accusatory to her about what she's doing, and what she's not doing. And in a meeting with lots of other professionals, they disclosed a very intimate piece of information about the kind of torture that she had endured. I know you have to put things in context sometimes for other professionals but there really was no need to go to that level … My practitioner … felt absolutely terrible … like the intention was almost to humiliate this person and strip her of all dignity. We couldn't see a clear motivation for doing that. And she said the way that mum then was in that meeting … how on earth are you going to engage?'*

83 This is discussed further in Chapter Three

We also heard several examples of vulnerable mothers not being believed by social workers, where VSO practitioners were convinced of the validity of their accounts. In one such case, a mother had mental health problems, had lost both of her parents when she was a teenager, and had been in '*really violent relationships*.' The SHS practitioner explained:

> *'… when I started making phone calls to make referrals for that family, they were very well known to social [care], and the response was "okay, yeah, we know that family and half of the things that she says we don't believe …" I'm supporting the family, I've been aware of the situation for the last three years and every time I hear the story it sounds exactly the same to me. I do not hear anything different. And I'm sitting with mum, and she's literally shaking – because she's going into a panic attack because she feels that she's not being believed.'*

One social worker said to us that:

> *'… social workers are not trained to empathise with clients. They're not trained to put themselves in the person's position. They're not trained to understand … I think it's about being therapeutically trained … that would change … the way they work with the people, the way they perceive people, the way they look at someone and think "actually, why is this happening? Where's this coming from?" Because we might look at it from the child … But we should be doing that from the parent as well …'*

A different social worker referred to the amount of social workers that they have worked with on child protection cases (amongst others), where child protection plans have been in place for over a year, and where they start to work with a vulnerable child and their parent(s) and discover information about their traumatic history. They explained:

> *'And I think to myself … does anyone know what this woman has been through and how that's impacted? In fact, do we even know if we've been setting things too high for her? Do we even know what we're actually doing here? … There's this whole focus on … incident-driven stuff … We're not trying to understand the world from the parent's perspective … to … help the parent so that they can help the child. We're trying to tell the parent what to do and how to do it … dismissing whether or not they understand or need much more support to be successful … and we're losing the child in the whole process … all that gets put down is that … the parents have shown no insight … – [i.e.] they don't acknowledge the concerns.'*

They explained the difference it could make if, in reality, a social worker actually sat down and talked to the mother. They said that, perhaps, if the time and training was available, they could uncover the untold story. They might discover that she had suffered, for example, domestic violence and had to leave her country of birth with her children:

'then maybe we'd say, it's not that she doesn't show insight, she's a damaged lady. She's had no input from services, she's experienced extreme loss, and maybe what we need to be doing is coming from a different angle here?'[84]

As they want on to explain, this failure to engage can have tragic consequences for vulnerable parents and their children:

'… the amount of parents who have got learning disabilities … and have ended up losing their kids because no-one has ever taken the time to know or to investigate anything, and things have been set too high for them all the time. It's like you're setting them up to fail …'

1.2.6.2 Failure to investigate and address parental difficulties

'… kids are getting big problems because no-one is dealing with their parents. Unless we can get to a point where we can support the parents to support their kids, we're just building up more and more problems.'

Chief Executive, SHS, in evidence to the CSJ.

'A number of studies showed that problems with substance misuse … are a feature of a significant proportion of cases dealt with by children's social care services.[84] *However, social workers are not always well equipped to deal with these issues. A clear message from the studies was that children's social workers needed appropriate training in how to assess and work with parents who misuse substances … Other studies pointed to the need to develop an understanding of the impact of domestic violence on children …'*[85]

Another key finding from our evidence is that some social workers are failing to investigate and address parental substance misuse and domestic violence promptly, effectively, or at all.

'"Don't go looking and don't name it" is the approach that is being taken. We are condemning children to "Netherland" and pretending they do not exist – but we know that they do.'

Camila Batmanghelidjh, CEO, Kids Company, in evidence to the CSJ

84 In the context of relationships formed between social workers and parents during assessments: ' … the research does not identify clearly the extent to which parental involvement and co-operation is affected by the knowledge and skills of the social worker compared with other contributory influences, most importantly the attitudes and behaviour of the parents and also the organisational or managerial systems within which practitioners work. As a general point, the relationship between parental engagement and outcomes for children remains under-researched;' Turney D et al, *Social work assessment of children in need: what do we know? Messages from research*, Department for Education, March 2011, p10 [accessed via: https://www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research (17.01.14)]. Furthermore, we understand that there is an absence of large scale studies in the UK that explore the link between quality of social work (or multi professional input) and outcomes

85 Cleaver H et al, *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*, London: Jessica Kingsley Publishers, 2007; Forrester D, Harwin J, Parental substance misuse and child welfare: outcomes for children two years after referral, *British Journal of Social Work*, 38, 2008, pp1518–1535; Harwin J, Ryan M, The role of the court in cases concerning parental substance misuse and children at risk of harm, *Journal of Social Welfare and Family Law*, 29(3-4), 2007, pp277–292, cited in Turney D et al, *Social work assessment of children in need: what do we know? Messages from research*, Department for Education, March 2011, p11 [accessed via: https://www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research (17.01.14)]

86 Turney D et al, *Social work assessment of children in need: what do we know? Messages from research*, Department for Education, March 2011, p11 [accessed via: https://www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research (17.01.14)]

In several cases that we reviewed, social care had been made aware of concerns, some raised by Kids Company, of parental substance misuse, or of both parental substance misuse and domestic violence, and its impact on the children. However, it failed to take prompt or robust action to investigate or address these issues, leaving the children to suffer the consequences. This is also despite pleas having been made, in some of these cases, by Kids Company or other VSOs, and other agencies, to share information and discuss their concerns. Social care simply failed to engage with their concerns.

In a number of cases, where concern had been raised about a parent's suspected Class A drug addiction, social care teams seemingly did not want to look for or find evidence. They did not, for example, take a hair sample, to establish the position for themselves. In response, a social worker told us: '*It's expensive, they'll never do that.*' They explained that they would prefer to have a case in court, to be managed that way – *'because it's structured, timetabled and it's overseen by someone who is not us.*' They also explained that if the case was in court, if social care was alleging that the mother was addicted to drugs, her lawyer would then pay for that test, and that it can cost thousands of pounds.

> *'Social [care] made me grow up an angry kid because of what they made me see. I had to force myself to forgive my family – not to hate my mum and family and to keep the peace. I didn't want to form an army against my mum. But that didn't help me. It just made me bottle stuff up even more – bottle my emotions. The only thing my mum taught me to do was to put a mask on myself and hide. I could be really hurting inside but I would put a smile on my face to hide it. It made me angry inside. I still feel angry.'*
> **Michael, in evidence to the CSJ**

We also discovered vulnerable parents who have failed to receive timely and appropriate support for their mental health problems. In a number of cases, they were understood by Kids Company to have fallen through the net of professional care. While the vulnerable parents' needs remain unmet, this can have devastating consequences on the welfare, emotional well-being, behaviour and mental health of their children.

A witness told us that some social workers:

> *'… don't really listen or take the steps that … legally they should in order to protect the kids. They may see the risks, but they don't recognise them formally.'*

Tragically, this was borne out in our evidence. We found numerous cases where serious concerns were expressed to social care over highly vulnerable children being at risk of or suffering from significant harm, and social care failed to take prompt and/or requisite action to address those risks (for example, by undertaking a child protection investigation, holding a child protection conference, or bringing the case into care proceedings).[87] Staggeringly, severe domestic violence and parental substance misuse remained relatively untouched as issues of concern. In one case,

87 Examples are provided in the report

despite the gravity of Kids Company's concerns regarding a mother's Class A drug addiction and extreme violence in the home, most of her children remained in her care – exposed to continuing chaos, danger, neglect, emotional abuse and trauma – for years.

> *'Throughout my whole childhood, [my mum] couldn't look after me. I had to look after myself but at the same time I was looking after myself, I was the one supporting her and not social [care]. I made plans myself for how I could help my mum. I tried a sympathetic plan, I tried an aggressive plan, and I tried a run away plan – for example, when I was 15 and went to [stay with a relative]. That was one of my plans – to run away and tell her I'd never see her again – and for her to be clean for a year at least before I would see her again. Another plan was to give my mum the choice: me or the drugs. I said that to my mum. As heartbreaking as it was at the time, she chose the drugs. She didn't say it but her actions told me that. I can understand it's an addiction but an addiction can be broken with the right support.'*
>
> **David, in evidence to the CSJ**

In various cases social workers failed to recognise the false compliance of parents. We discovered parents who were manipulative towards their children and/or the agencies involved, and succeeded in masking the truth from social care. Michael described his mother as having '*blinded*' social care.[88] David felt that his mother tried to hide her '*drug issues*' by diverting the blame on to him, claiming that he had '*so-called behaviour issues*,' which led to him being placed in a special school which itself recognised was not appropriate for David.[89] Even more concerning, is that this invariably happened in circumstances where Kids Company had been raising the alarm for years, and had not been listened to.

Our evidence also revealed the apparent collusion of a number of social workers with parents and/or adoption on their part of a blame mentality towards the child. One witness told us:

'*The focus for change is often put on the child as opposed to the parent(s). And that is where ultimately the responsibility lies.*'

According to our Kids Company case reviews, some social workers failed to objectively question or challenge the version of events given by some parents, and failed to speak to or meet with the child to discern what they were experiencing. The CEO of Kids Company told us about one parent who was presented as having made every effort to set appropriate boundaries for their child, with which they had failed to comply. The CEO believed that the adults around the child were presented as 'victims' or 'push-overs,' and that an aspect of blame was attributed to the child for their emotional disturbances. However, this was considered by the CEO to be a legacy of the relentless abuse and deprivation that the child had suffered. We found examples of blame also being placed on Kids Company, whereby it became even less about the child and detracted even more from concerns about the parents.

88 Michael's case summary (Case Three) can be found on page 34, and a longer version in Appendix 4
89 David's case summary (Case Four) can be found on page 37, and a longer version in Appendix 5

In evidence to our review, Dr Karen Broadhurst referred to a case of a young mother who was using heroin. She said:

> *'The services didn't appear to pick it up. They had an inkling but they weren't really getting to the root issue. For me reading the case file, it was obvious … because every time the worker dropped in she was asleep on the settee, and the baby asleep in a pram naked with a blanket thrown over him. Mum was not with it and was comatose … This mum had been caring for her baby for ten months.'*

Dr Broadhurst understood that social care had delegated monitoring the mother to supported housing. She told us that a housing worker '*was going in and calling on this woman once or twice a day*,' and that a health visitor was also '*dropping in*.' Dr Broadhurst added:

> *'This was a highly vulnerable young woman from looking at her history, with a new baby. The [social] worker was extremely busy. That is the problem with social workers (they are in court with ten cases), so they can't do the intensive relationship based work that's needed with young mothers like this. They would do a health and welfare assessment when the other agencies would say "help, there is something terribly wrong here". So she did an assessment. She was perhaps dropping in once every six weeks … It was hinted at and it was suspected but there was no drug testing … it is easy looking back on a case with hindsight but I think one of the things that is really problematic in social work is the fact that when you have a case that is designated child in need – that child was not on a child protection plan which is in itself gob smacking – that is pushed out and is delegated to other services … you've got this person who is known to six services, but is absolutely not known to any of them properly. Nobody has properly built a relationship with this individual. Nobody is really properly visiting …'*

1.2.7 Approach towards vulnerable children and young people

1.2.7.1 The voice of the vulnerable child and young person

> *'I think the voice of the child often isn't in assessments and the real experience of the child doesn't come through … When you look at procedures, law, and guidance, it all stresses including the voice of the child – their wishes and feelings – in the work of social [care]. That is great, but in reality that is not what happens.'*
>
> **Witness, in evidence to the CSJ**

Vulnerable children and young people can face multiple barriers to engaging with social workers and other professionals. Many have dysfunctional families and chaotic lives, some also have substance misuse difficulties and/or mental health problems. We have witnessed vulnerable children and young people battle one crisis after another. Some have succeeded, against all the odds, to regain a degree of stability in their lives, before being dealt with a severe blow and sent reeling – often by a parent who is also struggling with their own immense difficulties.

Vulnerable children and young people often face enormous challenges to function in the way that many of us in society are able to do by, for example, returning calls – whether promptly or at all – attending meetings and appointments, and reading, processing and acting on correspondence. Many struggle with a debilitating lack of confidence, anxiety, and fear with respect to attending meetings. Many have poor literacy and communication skills. They often have no credit on their phones to return calls, or listen to messages, due to lack of money. By

virtue of their adverse early life experiences, some suffer with attachment problems, making it very hard for them to develop trust in others. In addition, some find it difficult to cope with and adjust to change in their lives.

'A focussed review of recent evidence summarises the key characteristics that children and young people look for in a social worker.[89] These are:

- *willingness to listen and show empathy, reliability, taking action, respecting confidences, and viewing the child or young person as a whole person and not overly identifying a child with a particular problem;[90] and*
- *ability to communicate with children of varying abilities and address the emotional needs of children at key points in their lives.'[91]*

A recurring theme across our evidence is that the voice of many vulnerable children and young people is not being heard. They are often not being listened to by their social workers, sometimes at critical points; nor are their wishes and feelings being taken into account. It must be emphasised that the voice of the child is always an important consideration that needs to be properly respected. It is not just included in the CA 1989, but is regarded as one of a handful of fundamental principles in the UNCRC (Article 12), which underpins all other rights.

> *'They could have given me a hug and asked me why I was crying afterwards. It's simple. I'm a child. I don't know nothin'. I only know what my mum and dad have told me, and what the streets have taught me. Social [care] could have easily sat me down. Kids aren't dumb, they're smart. They know what's goin' down and I had my assumptions. But I blacked it out and when I got older I realised I couldn't run away from it. It's inside and waiting to break out.'*
>
> **Michael, in evidence to the CSJ**

If services fail to hear the voice or real experience of the vulnerable child or young person, the quality of assessments and efficacy of interventions is likely to be negatively affected.

'Keeping the child or young person "in view" is fundamental to good assessment, and failure to do so can have severe consequences, as analyses of serious case reviews have consistently demonstrated. Good practice with children and young people includes taking time to build relationships, listening to and respecting them, giving information, providing support for them to understand assessment reports, and offering them real choices

90 *Children's views and experiences of contact with social workers report*, July 2010 – cited in Munro E, *The Munro Review of Child Protection: Interim Report: The Child's Journey*, London: Department for Education, February 2011, p42

91 Cited in Munro E, *The Munro Review of Child Protection: Interim Report: The Child's Journey*, London: Department for Education, February 2011, p42

92 Munro E, *The Munro Review of Child Protection: Interim Report: The Child's Journey*, London: Department for Education, February 2011, p42

when possible.[92] *However, research continues to indicate that there are difficulties for many workers in making and sustaining relationships with children and with representing the child's voice in assessments. A number of personal and practical factors have been identified that affect the relationship between the practitioner and the child or young person. These include time constraints, insufficient skill or confidence in conducting direct work or undertaking child observations, and insufficient emotional support to ensure that workers do not become overwhelmed by such engagement.'*[93]

We heard how many vulnerable children and young people do not have confidence in social work. One child told the CSJ that she had kept silent about something for '*about five or six years*,' prior to finally telling someone recently at the VSO she attends. She told us that she would have welcomed having someone to talk to about it but, from what she had heard, she did not personally want social care to be involved. She explained:

> *'I know they're trying to do their job but sometimes they can get it wrong. Like sometimes they assess the situation in the wrong way … I wouldn't be able to trust. I wouldn't be able to talk to them … sometimes they misread the signals … instead of talking just to the parents about it … they could speak to the child or children … because they'll get an understanding of how the child's feeling and that …'*

The child explained that she felt someone from social care could '*maybe*' have helped her at the time something happened – '*Like, just for someone to talk to and that … and [be] understood*.' Her message for social care was:

> *'Just listen to them, and they might actually tell you what's properly going on, instead of just getting half the story.'*

A number of VSOs referred to the distrust of social care on the part of some vulnerable children, their fear of the unknown and that they will be in trouble or removed from their home. However, some VSOs are facilitating in this area and acting as a bridge between services – effectively supporting the vulnerable children to engage with social care, amongst other statutory agencies.[95]

Some vulnerable children and young people have had to fight for social care's support and, if it was provided, it was provided later than it should have been. One VSO stated:

93 Bell M, Promoting children's rights through the use of relationship, *Child and Family Social Work*, 7, 2002, pp 1–11; Cleaver H et al, *Assessing Children's Needs and Circumstances: The Impact of the Assessment Framework*, London: Jessica Kingsley Publishers, 2004 – cited in Turney D et al, *Social work assessment of children in need: what do we know? Messages from research*, Department for Education, March 2011, p10 [accessed via: https://www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research (17.01.14)]

94 Turney D et al, *Social work assessment of children in need: what do we know? Messages from research*, Department for Education, March 2011, p10 [accessed via: https://www.gov.uk/government/publications/social-work-assessment-of-children-in-need-what-do-we-know-messages-from-research (17.01.14)]

95 This is discussed further in Chapter Three

'… they often feel put upon or that the right decision isn't made because of budget constraints. They feel they are in a fight with Children's Services, having to fight to get their rights and needs met.'

A solicitor told us about one story of a young woman who could no longer face such a struggle:

'I had a very sad email from a client recently saying "can you close my case, I've moved back in with my ex-boyfriend, he's beating me, I can't fight social [care] anymore, thank you for your help, tell social [care] I'm just another statistic." It was horrible to read. She has fortunately managed to get away and [into] some housing … and is keeping in touch with me. Again, this is somebody who, despite the case being closed, she tells me how she is getting on. This is not somebody who is trying to be difficult and trying to fail to cooperate and engage. This is someone who wants the help but is coming up against it.'
Solicitor, in evidence to the CSJ

Other vulnerable children and young people can develop a lack of faith, trust and confidence in the system, and a sense of having been historically failed by it. This can be a fundamental reason why, in some cases, a vulnerable child or young person does not attend meetings, or seem to be interested in engaging with the relevant documentation. Some hold little, if any, belief or hope that anything will change by virtue of engaging with social care, based on their previous experiences. Some have 'zero faith' in the system.

Michael developed a lack of faith and trust in a system which he saw let him down repeatedly from an early age. He refers to the social worker never talking to him one-to-one. It is revealing that Michael gave an indication as to how he was desperate for someone within the system to give him a hug and the opportunity to talk. He said he only received this from the CEO of Kids Company, and the man he regarded as his father.[96] He believes if that had happened when he was between 10 and 14 he would have opened up, but after that he hated the system. This re-affirms the point that for children who are let down by the system, it is very difficult for them to put their trust in it. This always creates a very difficult position for the child who may be regarded as uncooperative, as discussed below. However, it is important to understand that a young child who is let down by adults in authority is far less likely to be able to rationalise this in a dispassionate way. This expects a level of maturity that many people may not have, whether child or adult. Yet, it is often the child who will be criticised.

The CEO of Kids Company also told us about one young person who had been left homeless, destitute and without an educational placement by a local authority at various points during their childhood. Unfortunately, the local authority made it much more difficult for them to engage with their allocated social worker and personal adviser by assigning them to the young person years later than it should have done. It also made it much more difficult for the young person's workers. The young person potentially could have drawn so much more from the support that they offered. However, having been historically failed by social care over many years, they felt that their situation had not changed, and could not see the point in completing their pathway plan.

96 This statement from Michael is contained earlier on page 113

Having made a further concerning disclosure which triggered additional child protection concerns on Kids Company's part, Claire informed social workers, who arrived to interview her, that she did not want to speak to them. However, she later explained to Kids Company that social care had allowed her to stay with her mother, in spite of the physical and emotional abuse she had received, and that they did not protect her when she was sexually abused. She reasoned that because social care did not help her then, it would not help her now, and expressed a great deal of anger towards social care for not protecting her.

This seems to have resulted in her lack of trust and confidence with social care. It is understandable that the sense of betrayal in such a situation is even stronger when (whether perceived or actual) it comes at early formative years. Similarly, the feeling that social care is ineffective, and/or will not provide support, may have had a significant impact on Claire's view of social care's ability to help. It also begs the question of what potentially could have been understood by the social workers, from their interview, about what Claire was experiencing, had she felt able to talk to them. Claire also stated in another meeting that social care had never listened to her, had done nothing for her and that she did not see the point of it. The social worker responded that she was '*doing a 35-day assessment and that was all…and social workers would come in and out of [her] life*.'[97]

The barriers which prevent some social workers from developing a relationship with vulnerable children and young people can, in turn, impact on their willingness and/or ability to engage with social workers. Some vulnerable children and young people do not feel that their social workers or social care actually care about them. Some voiced strong emotions to us about this.

> *'I didn't see love or care from social workers. They get in and out and don't intervene. Social [care] needs to work more with the children. I hate them. They let me down and betrayed me.'*
> **Michael, in evidence to the CSJ**

> *'The reason why I told [my new social worker about the sexual abuse I had suffered] is that she understood me. If the previous social worker had listened [five years before], I would have told her. It was about her body language and I didn't feel she cared … I felt [my new social worker] cared.'*
> **Child, in evidence to the CSJ**

We would hope that all social workers are empathic towards vulnerable children and young people, and take a supportive and respectful approach towards them. However, regrettably, we found a lack of understanding, empathy and compassion on the part of a number of social workers, and a disrespectful or negative style of communicating with or about various vulnerable children and young people. This featured across a number of cases we reviewed. For example, Daniel, a homeless 15-year-old, with a history of domestic violence and alcohol addiction in his family, was placed in B&B accommodation by social care which was wholly unsuitable. When Daniel's key worker raised concerns about this, in light of Daniel's traumatic history and high level of vulnerability, he was told by the social worker that Daniel had not had a bad upbringing,

97 Claire's case summary (Case One) can be found on page 30

and that '*addicts and alcoholics*' were everywhere, so Daniel needed to '*get used to it*.' The social worker and their line manager displayed a particularly critical attitude towards Daniel. The former stated that the situation was Daniel's fault. The latter placed the onus of change upon him, in circumstances where he was traumatised, by asking '*what is [Daniel] doing to show he is changing*?'[98]

Following a meeting at CAMHS, Claire told her key worker from Kids Company, that she thought her social worker had spoken about her as if she was dead. She added that when the social worker talked about things that happened when Claire was first involved with social care in detail, '*it really hurt*' her knowing the ins and outs of it all.[99]

1.2.7.2 Did not cooperate/did not engage

> *'If a vulnerable and traumatised child or young person does not turn up for appointments – what then? Social care may argue that it has complied with procedure but what about the child or young person's emotional state and challenges they face?'*
>
> **Camila Batmanghelidjh, CEO, Kids Company, in evidence to the CSJ**

As explained above, barriers to engagement can impact on the extent to which vulnerable children and young people feel able and willing to share the reality of what they are experiencing, and enduring within their home and/or local environment. In the case of *R (J) v Caerphilly CBC*, the Judge made reference to the 'uncooperative child' in his decision.[100] While commiserating with the local authority about the difficulties that this may cause, he stated that an uncooperative child should not prevent the local authority trying to complete its statutory obligations (e.g. assessment) as best it can. However, in some local authorities, a child or young person 'did not co-operate' or 'did not engage' is still used to justify no further action or involvement on the part of a social worker, and for their case to be closed.[101]

> *'… we constantly have this with young people – they don't want to engage. But why … is it their problem? … And it's never about us … when I think the problem is us really … our approach … our limitations … our lack of creativity … our lack of understanding and putting ourselves in the person's position. I think we're just driven by a set of questions that we need answers to.'*
>
> **Social worker, in evidence to the CSJ**

This issue featured heavily across our evidence. It raises various issues of serious concern. One is that 'did not engage' can be referred to as if that is an answer to the situation in itself – demonstrating an inflexibility of the system and/or mindset. We heard that some vulnerable children and young people may not be given appropriate or genuine opportunities to engage, and that some can effectively be encouraged not to engage.

98 Daniel's case summary (Case Two) can be found on page 32

99 Claire's case summary (Case One) can be found on page 30

100 R (J) v Caerphilly CBC [2005] EWHC 586

101 We were told by a solicitor that, in their experience, non engagement on the part of some vulnerable children and young people can be confused with not accepting. Another explained that there is a significant difference between not engaging and not cooperating. In their view, lack of cooperation is also often perceived as lack of engagement, and that again is a different thing to not accepting or disagreeing

'It all stems from the child. If we want to ignore the child, we can effectively ignore the case and then close it. It's easily done. If the child doesn't talk to us or we don't have the opportunity to talk to them, it all stems from them. If we don't get any information from them, it doesn't go out across the board. We can't feed it back to the parents if we need to, we can't feed it back to the school, we can't get other services involved. If we don't get them involved we can just close it all off can't we?'

Social worker, in evidence to the CSJ

'Not engaging', where genuine best efforts have not been made by social workers to engage vulnerable children and young people, is not good enough.

'I encounter all the time issues in terms of them saying "we can't get hold of your client, your client is unavailable, we can't continue to deal with this when we can never get hold of the"… You'll speak to your client and they'll say they haven't had any calls. Sometimes there are disingenuous accounts of attempts having been made to try and contact when we have no difficulty contacting the child or young person.'

Solicitor, in evidence to the CSJ

One social worker told us:

'… a lot of social workers who don't want to do specific bits of work, will put it down to the child or young person doesn't want to engage, even if they haven't tried to engage with them … That is a social worker's get out clause for anything – non-engagement … no-one ever questions it … Non-engagement is like our magic term for … "I tried my hardest," but in fact [it] is our magic term for "no-one can do it" … a huge culture in social [care] is that you can close a case just with … non-engagement. End of.'

The social worker recalled having sat in CPCs for children who have been on child protection plans for a number of years and, for example, witnessed domestic violence over a sustained period. Their social workers were not able to say what the children's experience of the domestic violence was and how, according to the children, it had impacted on them. Our witness discovered, upon asking, that the social workers did not know, because they had not spoken to the children about it – because they said that the children would not engage. As another witness explained:

'It's all very well saying they don't engage. We need to try and engage them. In order to do that we need to find out why they're not engaging, and ask them why they find it difficult to talk to us … I had no way of getting in touch with [one girl]. She wasn't answering her phone so I wrote her a letter … She phoned me as soon as she picked the letter up because I held her in my mind. She knew that she was in my mind, and that meant something to her …'

We also heard about management not wanting cases '*where they're making stats look really bad*' because, for example, social workers are not visiting, or having the meetings they are supposed to.

'… if we're not engaging the family, they're not going to work with us if we don't have that partnership from the start. We shouldn't have to hound families sometimes, but if we don't give them that attention, and we're not reliable, we're not turning up on time and we're not making new appointments, they're not going to engage with us. Why would you bother? … We'll go "well, you didn't engage", and close [them] off. And when they want help eventually, we'll say "you didn't engage last time, what's different now?" You look really good because you've closed the case and you've moved on haven't you. You can have another one. There's always a big pressure to close cases if we're not active with them.'

Social worker, in evidence to the CSJ

However, it is important to note that we also heard remarkable accounts of some social workers' motivation and determination to engage successfully with vulnerable children and young people, and to dig beneath the surface of their apparent unwillingness to cooperate. Some push hard on cases where they face a genuine struggle to break through to meaningful engagement.

1.2.8 Children in need

'There's a sector of the population … that is being overlooked – children in need … because [social care] have to deal with all those cases that are significant risk, they are at the bottom of the pile. They are left there swimming around until something happens for them to raise it to … that level … If it's a child in need case, it's at the bottom of the list. Sad to say … This is why I keep saying we need to have more working together … because [social care] have an influx of high risk cases that they have to deal with …'

Previous middle manager, social care, in evidence to the CSJ

Another key finding from our evidence is that some social care services are not working preventatively. Many children in need are being overlooked – they and their families are not receiving the support that they need. This can prolong and increase the extent of the child's suffering and risk of harm. It can also lead to further pressure ultimately being placed on social workers and the system, and local authorities incurring greater financial cost.

It appears that many children with unmet needs are languishing at the child in need level in some social care services. We heard that some social workers are experiencing untold anxiety and stress as they desperately try, unsuccessfully, to secure the appropriate support for them.

'… the problem … is … that if you don't address need, you're more likely further down the line to end up with harm … If you deny an individual access to general health care, so they become increasingly unwell, rundown and unhealthy, they're much more likely to be susceptible to more serious illness, which means you have to intervene medically in a much more intensive, and ironically expensive way. Exactly that happens within families, and not only does it happen but it's much harder to ameliorate. So it's likely to recur and exactly that happens with harm.'

An experienced Independent Social Work Consultant and Expert Witness, in evidence to the CSJ

Some cases are being allowed to drift until they hit the child protection threshold; some can end up in care proceedings.[102] Again, this runs completely contrary to an early intervention approach.

> *'… from what I hear and from my experience, it's really common for care proceedings to come out of a scenario where, potentially, if social [care] had provided appropriate support under S.17 to the family at an earlier stage, those care proceedings might not have become necessary.'*
>
> **Solicitor, in evidence to the CSJ**

Some vulnerable children's needs are being overlooked when they are removed from a child protection plan. Their cases are closed and consideration is not given to how their continuing needs might still require support from social care. An experienced Independent Social Work Consultant and Expert Witness referred to research which indicates, post the CA 1989, that:

> *'… when it is decided that children are no longer at risk of significant harm, the services cease. But because they're no longer at risk of significant harm doesn't mean they're no longer children in need …'*[103]

A solicitor commented that some children may not be children in need but that social care should keep their cases open and review them. In addition, we heard that some vulnerable children who have succeeded in gaining access to social care services, are being 'stepped down' to TAC, or other support which may exist. We question how many of these ought to have continued to receive children in need services, and how many are subsequently referred back to social care for its intervention – whether at the child in need or child protection level.

> *'Personally I don't like having child in need cases. I find them frustrating because … with child protection, it's … monitored by the [Independent Reviewing Officer]. And it's very structured. And out of all the cases in terms of child in need, child protection and looked after children, I think more focus is around child protection because we go "risk, risk, risk". But child in need cases, again they're very slippery because you can … have these families that … need a lot of resources and on-going support … They are cases which are generally very difficult to manage because we're supposed to step cases down to TAC … but again they've got their own thresholds as well …'*
>
> **Social worker, in evidence to the CSJ**

One potential explanation given to us for an increase in the number of children being taken into care in some local authorities, is the fact that some social workers may be pursuing this route as a means of dealing with children in need cases. We understand that these cases can require a lot of support and resources, over a significant period of time, be challenging to manage and lack the structure afforded to social workers by child protection plans. A middle manager also explained that '*With children in need, because it's left with the family on a*

102 Further evidence, from legal professionals, is contained in Chapter Four

103 See, for example, Davies C, Ward H, *Safeguarding Children Across Services, Messages from Research*, 2012, p82 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/183231/DFE-RR164.pdf (27.05.14)]

voluntary basis, it gets a bit grey,' as opposed to a child protection case where '*they are placed in a more forced position*.' This feeds into our concerns over the approach taken by some social workers towards engaging vulnerable parents, as discussed above. Furthermore, we are mindful of vulnerable children who are considered to be 'not engaging,' in circumstances where they perhaps have not been given genuine opportunities to do so, or have effectively been encouraged not to engage. In such cases, some vulnerable parents and children are not receiving the necessary and effective support that may otherwise help to address the children's needs while their cases remain open; some are not receiving any support by virtue of their cases having been closed.

> *'If it's child protection, you're going to get more attention … other professionals can rattle the cage a bit more. If it's child in need … it's a lot easier to sweep away.'*
> **Social worker, in evidence to the CSJ**

Concerns have been expressed to us that social care services in some local authorities are not equipped to carry out direct work with children in need. A previous middle manager in social care told us that:

> *'Children in need are being overlooked because social workers are not experienced enough to do that kind of work.'*

Another witness agreed that child in need work is delegated to unqualified or most junior staff where, arguably, prevention requires highly skilled staff. They explained that one of the key issues is that:

> *'A lot of social work tasks in terms of direct work tend to be commissioned out to other agencies which leaves the qualified social worker in the local authority managing the case, and the work of others, rather than directly working with children …'*

The Munro Review sought to address this. However, over three years on, it appears to remain an issue in some areas. Our witness added that there is '*quite a lot of fragmentation because many individuals or services seem involved but not necessarily closely*'. The Munro Review was not supportive of referring direct work out. This is work that social workers quite rightly regard as one of the most important and rewarding aspects of their role, and which they would like to be performing. In light of evidence to our Review, we believe that it is imperative for local authorities to draw on the support of, and work in partnership with, effective VSOs. This is even more important where the demographic necessitates it, and where there are higher levels of need and demand for social care services.[104]

104 We discuss this in more detail in Chapter Three

1.2.9 Children at risk of or suffering street gang violence

'If it is not frightening enough thinking of 13- and 14-year-olds being encouraged into criminal behaviour, it now seems there is a growing trend for "Tinies" to join gangs – children as young as seven and eight. Because of their age they are less likely to be stopped by the police, so they can run drugs money for the gang, earning cash for themselves in the process. There are rumours now of even younger children getting involved in gangs. They are known as "Babies". Police officers tell me that they know of gangs whose eldest members and leaders are 14-year-old boys. They all carry knives and their after-school activities tend to revolve around robberies. One North London police officer said, "we see 13- and 14-year-old boys who have been stabbed four or five times. The blades go millimetres from their arteries, threatening their lives, but it doesn't shake them up. Instead they think they are invincible."'[105]

- The shooting of Kyle McDonald in September 2013 was reported to have been the 123rd teenage murder in London alone since January 2007.[106]

- At a forum convened by Kids Company, as part of the London Evening Standard's Frontline London campaign, children and young people reported that they 'had lost so many friends to stabbings and shootings that they no longer bothered to attend funerals'. The devastating reality is that 'for them the murder of their contemporaries had become "the norm"'.'[107]

Some vulnerable children growing up in dysfunctional families face serious challenges within their home environment, which often has a profound impact on their behaviour. However, when they live in deprived areas where social breakdown is rife, they can also face considerable threat and danger within their local community, predominantly it seems from street gangs – the presence of which appears to be becoming more common.

The CSJ report, *Dying to Belong* (2009), provided a landmark review of street gangs in the UK. It highlighted, amongst other concerns, a disconnect between statutory agencies, which were failing to intervene early. It reported that vulnerable children were 'falling through the net' of statutory agencies regardless of a clear escalation in behavioural problems and offending.[108] The CSJ has made various policy recommendations with respect to street gang activity, including the critical

105 Regan P, Hoeksma L, *Fighting Chance: Tackling Britain's Gang Culture*, London: Hodder and Stoughton, 2010, pp32–33

106 London Evening Standard, *The Gangs of London*, 25 September 2013 [accessed via: http://www.standard.co.uk/news/london/frontline-london-day-1-the-gangs-of-london-8838696.html (20.01.14)]

107 London Evening Standard, *Frontline London: These young gangsters have lost so many friends they've stopped going to their funerals*, 25 September 2013 [accessed via: http://www.standard.co.uk/news/london/frontline-london-these-young-gangsters-have-lost-so-many-friends-theyve-stopped-going-to-their-funerals-8838684.html (20.01.14)]. The London Evening Standard's campaign, in partnership with Kids Company, is providing support for ex-gang members 'to establish and grow viable social enterprises as a means of escaping the criminal and gang-related cycle'

108 Centre for Social Justice, *Dying to Belong: An in-depth review of street gangs in Britain*, London: Centre for Social Justice, 2009, pp121–124. *No Excuses* also revealed that the impact and influence of street gang activity is pouring into some of our schools and PRUs, presenting them with serious difficulties in terms of managing the associated behaviour, as well as the pupils' disengagement from education; Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, September 2011, pp65–70 and pp87–99

need for a preventative approach, through early intervention.[109] As *Dying to Belong* argued, the only way to tackle gang culture in the long-term is by preventing children from becoming involved in the first place. After the 2011 riots, the Coalition Government recognised that more had to be done to address the issue of gangs. It published *Ending Gang and Youth Violence*, which took on board many of the CSJ's recommendations.[110] Regrettably, our findings in *Time to Wake Up: Tackling gangs one year after the riots*, did not demonstrate encouraging progress:[111]

> *'Worryingly, many [witnesses] have drawn us a picture of little or no progress, despite the publication of a positive political strategy. Some have even suggested that the problem is becoming worse with increased violence amongst younger gang members and growing numbers of girls joining gangs. There is also deep concern that the Government is not serious about making a long-term commitment to tackling gang culture and its roots.'*[112]

Indeed, more recently, Nick Hurd, the Minister for Civil Society, with responsibility for youth policy, reportedly admitted that *'mistakes were made'* with respect to tackling gangs and youth violence. He acknowledged that '*The issues are still there, the children are still here*,' and that '*As a country we cannot afford to let children grow up thinking that violence is normal* …'.[113] The Rt Hon Iain Duncan Smith MP has also reportedly stated that London had been '*hopelessly dysfunctional about gangs*' in comparison to Liverpool and Strathclyde.[114] That said, encouraging signs have emerged more recently from the Government's Ending Gang and Youth Violence programme. The Home Office has reported that youth violence is continuing to decrease in the areas which are being targeted.[115]

During our Review, we discovered cases of vulnerable children who were known to be at risk of or suffering violence from street gangs – some from a young age. They presented with emotional and behavioural difficulties, which their parent(s) and school found increasingly challenging to manage. A number of the children had more serious mental health problems.

However, we have seen a repeated failure on the part of some social care services, amongst other statutory agencies (including schools), to take an early intervention approach to the involvement of children in street gangs, and to them being at risk of or suffering street gang violence. A number of the cases also demonstrated a lack of cooperation between statutory services, with no-one taking the lead in coordinating services. This resulted in escalating

109 Centre for Social Justice, *Dying to Belong: An in-depth review of street gangs in Britain*, London: Centre for Social Justice, 2009; Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, 2011

110 Home Office, *Ending Gang and Youth Violence: a Cross-Government Report*, 2011 [accessed via: https://www.gov.uk/government/publications/ending-gang-and-youth-violence-cross-government-report (20.01.14)]

111 Centre for Social Justice, *Time to Wake Up: Tackling gangs one year after the riots*, London: Centre for Social Justice, 2012

112 Ibid, p1

113 London Evening Standard, *Youth minister admits 'mistakes have been made' on gangs as he praises our campaign*, 21 October 2013 [accessed via: http://www.standard.co.uk/news/london/youth-minister-admits-mistakes-have-been-made-on-gangs-as-he-praises-our-campaign-8893953.html (20.01.14)]. 'A new Government blueprint' for tackling gangs has since been launched; London Evening Standard, *Frontline London: Wounded gang members will be offered path to a better life*, 13 December 2013 [accessed via: http://www.standard.co.uk/news/london/frontline-london-wounded-gang-members-will-be-offered-path-to-a-better-life-9003063.html (20.01.14)]

114 London Evening Standard, *Interview: 'Gangs can't be beaten by police alone. They are a sickness in our city,' says IDS*, 25 October 2013 [accessed via:http://www.standard.co.uk/news/crime/interview-gangs-cant-be-beaten-by-police-alone-they-are-a-sickness-in-our-city-says-ids-8904187.html (20.01.14)]

115 HM Government, *Ending Gang and Youth Violence: Annual Report 2013*, December 2013 [accessed via: http://www.official-documents.gov.uk/document/cm87/8746/8746.pdf (20.01.14)]. The Government's Ending Gang and Youth Violence programme is being prioritised in 33 local authorities across England and Wales with the highest levels of gang and youth violence

difficulties and more entrenched needs on the part of the children, requiring more intense and expensive intervention. It also exacerbated their risk, harm and suffering.

We discovered alarming evidence of children who were at risk of or suffering significant harm from street gang violence, but were not treated as child protection cases. A number were not even designated as children in need. Concerns were raised by Kids Company, in several cases, over the significant and immediate risks that it felt needed to be addressed by social care urgently. The level of risk to which the children were exposed increased over time – as did the extent of their harm. For example, Daniel received death threats and suffered an attack; his friend survived an attack in which he was repeatedly stabbed.

Adam was on the receiving end of an attempted stabbing – he and Joseph each lost a friend who was fatally stabbed.[116] Child X's case provides a further deeply distressing example of a child who has been brutally failed by the system in this regard.[117] The missed opportunities in their, as well as other cases across our evidence, are unfathomable.

A social worker informed us that they are not able to gain access to services or training that would enable them to support some vulnerable children better. They explained:

> *'There's nothing at all to work with these young people … And then again it goes back to the thresholds. The people who can help them are once they get into the criminal justice system … "Oh, now we've got a YOT Referral Order from court because they've committed an offence – YOT can maybe do some work with this young person around gangs." But I think to myself "what about us? And all of the other kids that we're also working with? What about them? And then also, why have we waited? We've known he's been involved in gangs for the last year and a half. Why have we waited for an incident to happen that now leaves him at a disadvantage due to now having obtained a criminal record and all that comes with that record?"'*

1.2.10 Older children (i.e. 14- to 17-year-olds)

> *'Usually what the concerns are when they're 14 or 15 is that they're engaged in anti-social behaviour, substance misuse … there is a reluctance to put them on a child protection planbecause they're 14 or 15 – they're going to do what they want to do anyway. Concern over them being at significant risk or over there being a fatality, death … is minimised, compared to if it was a younger child. So once again families with children who are a lot younger, they're at the top of the totem pole – they are the ones we're going to be dealing with. Because God forbid if anything happened to them, it's going to be big news in the media. A 14-or 15-year-old – who is going to really be paying much attention to 14-and 15-year-olds?'*
>
> **Previous middle manager, social care, in evidence to the CSJ**

116 Adam was on a child protection plan – under the category of physical abuse and neglect. Kids Company has informed us that Adam's increasing gang involvement was discussed in child protection conferences

117 Further details of which can be found in Chapter Four

"'Crack Den," from Kids Company Exhibition "Shrinking Childhood" at Tate Modern, 2004. This work was produced by ten children illustrating the impact of parental substance misuse on the home;' Kids Company, *Kids Company Report for Government March 2011–2013*, London: Kids Company, 2013, p82

From our research it seems that older children are getting the worst deal in terms of care, protection and/or support than any other age group. This is consistent with the Education Committee's 2012 report *Children first: the child protection system in England* which concluded that:

> *'Our inquiry has revealed a worrying picture with regard to the protection and support of this group [i.e. those aged 14 to 18]. This is characterised by a lack of services for adolescents, a failure to look beyond behavioural problems, a lack of recognition of the*

signs of neglect and abuse in teenagers, and a lack of understanding about the long-term impact on them. It is clear that the system as a whole is still failing this particular group in key ways.'[118]

The *Community Care Survey 2013* also highlighted the particular plight faced by older children. It revealed that professionals had reported that:

'… unofficial, even unlawful, policies are developing in some areas, denying support and care to [those] aged 14 and above.'

One respondent is quoted as stating:

'We were told [those] aged 14-16 can't have child protection plans.'[119]

A Senior Manager in a Children's Services Department told us that:

'… one of the reasons I think that … child protection is not sufficiently well recognised for [older children]… is that the focus is on young children and babies. That is right in many ways but arguably, the clear focus on young children, means we are not focussed on older children.'

We asked a social worker why they thought social care had not taken robust action to support David after he had the courage to tell his social worker about his mother's substance misuse, dealers frequently visiting the home, and reportedly having shown his mother's crack pipe to social care. Their response was:

'It's because he's 15 though, what are we going to do? It's too late then isn't it?'[120]

A recurring theme across our evidence is the problem experienced by older children with respect to obtaining accommodation and support under S.20. We were informed that for 14- to 15-year-olds, *'this is a major thing with local authorities where the game playing'* comes in. They explained that this is on the basis that when they turn 16, it no longer becomes an issue for social care. A previous middle manager in social care told us:

'It's a stalling mechanism. Even with the Southwark Judgment ruling that … local authorities have responsibilities for a [child] up until they turn 18 … a lot of local authorities do not use it, and then because families aren't aware of it, they don't know … They still have a responsibility, but still we have to get a solicitor involved.'

118 House of Commons Education Committee, *Children first: the child protection system in England*, Fourth Report of Session 2012/2013, Volume 1, 7 November 2012, pp3–4 [accessed via: http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/137.pdf (13.01.14)]

119 Community Care, *Community Care survey*, 19 November 2013 [accessed via: http://www.communitycare.co.uk/2013/11/19/community-care-survey-exposes-rising-thresholds-leaving-children-danger/#.UtGFtMh-SYK (11.01.14)]

120 David's case summary (Case Four) can be found on page 37, and a longer version in Appendix 5

As one child told us:

> *'[At] 15, I went into [social care] and said "I got kicked out [of home]" … And they said "go to housing", and housing sent me back to them and didn't do nowt. So I got to find my own place … Just nothing happened. They wanted me to wait. And then I waited. But nothing happened … They said they would ring me and they never did … I gave them my number. They said "have you got any place to stay for a couple of days till you sort yourself out?" I said "yeah … [my friend's mum's house]". And they never got back to me … I just gave up. Can't be arsed with it. I don't like being messed about … I was quite upset, I was really angry. Yeah, really pissed off.'*

A middle manager referred to the position regarding children over 14 being taken into care. In their view, there is a real difficulty maintaining the balance between statistics and trying to maintain numbers, against best practices and how that is held, and how decisions are made. It worries them at times, in their experience, that rather than importance being given to the child concerned, weight is given to the likelihood of further disruption to their sense of stability, and conclusions are then drawn based on demographics such as their age, and the lack of resources. Our witness explained the mindset of teams within their social care department, when they are presented with a child who is within the 14 to 16 age bracket:

> *'Often they don't know what to do, because the child is off the radar for being accommodated. It's not ideal. They've made it this far without having to go there, which again is another question to ask: "what's gone on there?" Just because they've slipped through the net doesn't mean it didn't need looking in to … That is an immediate area of struggle that the service is finding it difficult to engage with. I'm finding my team are often presented with referrals from this pool of children, and actually whilst in some cases it might be a suitable referral, in others it's not because the family is full of crisis. Actually, what I feel is needed and would be a helpful way forward, would be a Crisis Intervention Team. There is a serious gap because you've got social workers on these teams who are highly pressured with case loads, lengthy hours, and short intervention space. They're not really getting the time to make that in-depth assessment, it's a snap shot. The family's unstable and they need someone going in to just hold it.'*

The middle manager told us that concentration is being placed on keeping numbers low of children coming into local authority foster care homes – '*which is a bad thing*.' They said that obviously if there is a concern, that needs to be upheld and prioritised, and that some people struggle with making those decisions. They explained:

> *'… I think it's multi-layered, the whole topic … there are aspects of keeping numbers low … of people's own position that they are holding, and [it being] discretionary as to how far a social worker will dig due to their own feelings, their own training, the supervision they're receiving, team pressures which can be subject to low staffing, high turnovers, high case loads … there are a multiple of issues that come in at all angles.'*

Our witness added that it is not always down to budget, and that there are certain targets that teams have got to achieve.

Another issue of serious concern is that of some local authorities housing older children in B&Bs.[121] Dr Karen Broadhurst told us:

> *'Even when our teens get slightly older … and possibly more receptive at that point to services, we don't have the infrastructure to house them in safe areas. We have hostels and B&Bs in the worst parts of towns. They are surrounded by gangs, violence and drugs. How are they going to get out of that lifestyle? Social workers are acutely aware of shortfalls in services and this frustration drives workers out of social work.'*

One social worker told us:

> *'I think putting children in B&Bs probably still goes on, but I think it has reduced quite a lot. I think it was in response to what are you going to do with a teenager who is beyond parental control and will not engage with what you're doing? It is very difficult. I don't necessarily think that was the right response, but with resources as they may be, it may be either that or they are on the street. In that respect, I can see possibly, when there is no other option, it is better than absolutely nothing, but that doesn't mean it is in any way acceptable.'*

Placing older children in B&Bs may have reduced in that particular social worker's experience, as it has hopefully done in the experience of many others. However, the practice featured repeatedly across our evidence, including that provided by various legal professionals.[122]

We heard that some local authorities are adhering to the *Southwark Judgment*. One social worker told us that, in their experience, '*resistance*' to undertaking child protection assessments for 16- and 17-year olds, or placing them on child protection plans, '*is decreasing quite a lot*.' However, they added:

> *'There seems to be a lot more acceptance that children at 16 and 17 need social [care] intervention, rather than being offloaded onto housing … I don't think it has changed it completely. There are still cases where the default reaction is to re-house them somewhere … it has still got a way to go.'*

Our evidence demonstrates that practice certainly continues to vary across different local authorities. Indeed the same social worker had heard from previous colleagues now working in other local authorities that '*there the practices are not as positive as I have just described my experience being*.'

We heard examples of some innovative approaches being taken to support this age group. This included the provision of a 'gate way service' by Children's Services in one local authority and a VSO. A Senior Manager of a Children's Services Department told us:

121 See, for example, evidence obtained by Newsnight, as referred to in Chapter Four

122 We discuss the difficulties faced by some older children with respect to obtaining appropriate accommodation and support under S.20, as well as the legal implications of that, further in Chapter Four

'Basically it is the first point of access and advice for [children] to see what their housing need is – "Is it something we can do? Does it need to go through Children's Services? Do they need an assessment?" It is a filter, but it properly supports [children]. We fulfill the Southwark Judgment. We carry out assessments on [children] and provide housing if we need to. There is a route back in. If it is purely a housing need, and there are some [cases like that], it can go back to those district councils and we have protocols about how that is done … The other problem is that district councils' funding is under massive pressure. Their protocol comes under more and more strain and the definitions become more fought over.'

We also heard about improvements being made, for example, by creating a team comprising social workers and housing officers, overseen by a manager from each respective department. We were told of the cost efficiency of this, as well as improvements in identifying child protection issues, making appropriate referrals and children being returned home who did not need to be housed. Our witness told us:

'I think it was the people that were there as well, but it was the structure of having that joint working between two very different departments, who were concerned with the same issue, and it had a number of knock-on effects that made the working and the results for the children who were facing difficulties an immense amount better. I can see when departments don't work together; they are all lost in the middle.'

Andrew Webb, President of ADCS, referred to the high proportion of older children who enter the care system:

'The biggest group doesn't enter care until their teens. The adolescent entrant to the care system is going to be the least successful user of the care system … if a kid comes into care at 14, we don't fix them very well. Some we do … But for that group who have probably been vulnerable for most of their lives, it is not effective as an intervention.'[123]

We were also told by a Senior Manager of a Children's Services Department that the peak age now for children in care in their area is 16. They said that when children come into care at 14 or 15:

'It is very difficult to make a change in their lives at that stage. The pathway feels like it is set at that point. It is very difficult to reset it … It is a big task. It is much easier when we get them younger.'

For reasons highlighted throughout our report, this again raises the critical importance of early intervention. As demonstrated by many cases across our evidence, we wonder how many opportunities were previously missed to intervene and help resolve older children's difficulties. We question how many could have been supported, with their families, to avoid ultimately entering the care system, at a significant financial cost, and with increasingly limited resources on the part of local authorities.[124]

123 At the time of publication, Andrew Webb is no longer the President of ADCS
124 Further concerning evidence was provided by legal professionals in this regard, as discussed in Chapter Four

Dr Karen Broadhurst referred to a piece of research that she has undertaken around care proceedings, which gave her access to a significant amount of information regarding the 75 cases in the study.[123] In particular, there were a lot of vulnerable young women who were having their babies removed. Dr Broadhurst had a look at some of the histories of these young women before they became pregnant between the ages of 15 to 18. She found some key themes. These included sexual abuse or assault by a peer group, homelessness, violence and poverty. Dr Broadhurst also found examples of problems which were enduring and were not resolved. These included, at the more extreme end, the case of one young woman who presented with a psychotic episode and, at the lesser end, cases involving lots of problems with adolescent acting out behaviour – including self-harm, drug and alcohol abuse very early on (i.e. at 12 and 13 years old). She told us: '*I think that is the issue. These problems were enduring and they weren't resolved.*' The other pattern that emerged clearly in those cases was that '*parents could not cope or the foster carers couldn't care, so they were in and out of placements, or homeless and sofa surfing.*' Dr Broadhurst added:

> *'They didn't have any stability or secure base at that critical 15-to 16-year-old age. They ended up in temporary accommodation and ended up pregnant … They were exhibiting clear relationship issues stemming from these … traumatic childhoods. For whatever reason, the standard casework model that the local authority was able to offer, and the referral to CAMHS, didn't seem to sort it. I guess the question for me is "what kind of intervention do we need?"'*

We share Dr Broadhurst's concern over the effectiveness of current statutory interventions with respect to vulnerable older children. Careful consideration needs to be given as to how to improve the position and better engage with them.[124]

As highlighted below, our evidence also paints a very bleak picture of a lack of support and services provided to some care leavers within (and outside) of this age bracket.

1.2.11 Care leavers

> *'… I'm 21 now, I'm an adult. I'm meant to be an adult. I am an adult at 18, I was at 16. But you know, when do you stop needing support if you haven't got a family?'*
> **Young person, in evidence to the CSJ**

> *'They go from having quite a high level of support, to leaving care teams who carry much bigger case loads, because there are less leaving care social workers, and they just don't get the support. I find this extraordinary … the support seems to decrease, when actually the need is increasing because they are becoming independent and they need help with housing and all the rest of it. Particularly without the support services like Connexions, which seems to have disappeared. I just don't know how they are expected to cope. You*

125 Broadhurst K et al, *The Coventry and Warwickshire Pre-Proceedings Project: Final Report*, [Cafcass. eScholarID:200864, 2013; Holt KE et al, *The Liverpool Pre-Proceedings Pilot: Interim Report*, London: Cafcass. eScholarID:200865, 2013. Please note that the key themes identified in the data by Dr Broadhurst were not the focus of the research but incidental to it

126 We also discuss Dr Broadhurst's research in Chapter Two

are not ready to be out in the world at 18, even if you have a massively supportive family around you.'[127]

A witness, in evidence to the CSJ

'Accommodation selected for [Kids Company's] "Colour a Child's Life Programme;"' Kids Company, *Kids Company Report for Government March 2011–2013*, London: Kids Company, 2013, p63

We came across examples of care leavers without appropriate or, in some cases, any leaving care support, who were struggling to budget and stay on top of their bills, and with the administration involved with benefits. Some had got into arrears which led to eviction from their homes, resulting in them facing severe difficulties in finding alternative housing. Had they

127 The Centre for Social Justice called for the Government to improve the outcomes of care leavers by extending the care leaving age, so that they are able to remain in a supportive environment, in accordance with the experiences of their peers. This would include the right for them to remain with a former foster carer until 21, remain in a former residential home until 21, obtain another type of supported placement until 21, and a guaranteed return to foster care or residential care for those who leave care before 18; Centre for Social Justice, *'I never left care, care left me': ensuring good corporate parenting into adulthood; A briefing paper for peers on proposed amendments to the Children and Families Bill 2013*, London: Centre for Social Justice, October 2013. The Government has since confirmed its decision that 'All children in care will be able to stay with their foster families after they turn 18 following a £40 million funding boost and a new legal duty on councils to provide [financial] support…for every young person who wants to stay with their foster parents until their 21st birthday…'; GOV.UK, Press Release, *Children to stay with foster families until 21*, 4 December 2013 [accessed via: https://www.gov.uk/government/news/children-to-stay-with-foster-families-until-21 (27.05.14)]

received the support, advice and guidance that they were statutorily entitled to, the risk of them falling on even harder times may well have been mitigated. Yet non-engagement on their part was repeatedly cited as an explanation for why the support was lacking. A number of these children were in accommodation at some distance from the local authority responsible for them, presenting them with further challenges in terms of engaging with social care.

We highlighted, above, frustrations voiced by witnesses over the procedural requirements that they feel hinder social workers from being able to work in more of a relational way with care leavers. We were also told about the pressure being applied on some social workers to move looked after children out of their foster placements and into a council flat:

> *'The pressure is to get them into the flat, and when they are in there but they can't keep the tenancy because they weren't ready, the pressure is on you again: "Get them out and keep them in."] If you can't keep them in, then that is your fault. But they were never ready in the first place … I have literally felt bullied into not advocating for the best interests of my clients, but for the best interests of the local authority. It isn't right, and it is not what I am trained to do … How could this ever work? How could you ever feel valued in that position?'*

We were told that the reason for the local authority applying this pressure is to save money on the foster placements.

The impact of appropriate support not being given to some care leavers was heartbreakingly apparent, in relation to the risk that they became exposed to, and with respect to their practical and emotional needs. Again, the importance of relationship was revealed to be paramount, and its absence devastating for vulnerable children and young people, who can understandably be left feeling alone and helpless.

1.3 Other challenges to frontline practice

> *'The child is what keeps everyone in business, because if they weren't in crisis none of us would be employed. And they just get left at the bottom.'*
> **Social worker, in evidence to the CSJ**

1.3.1 Leadership, internal relationships, communication and decision making

As one witness emphasised, within institutions that are tasked with delivering services which are very sensitive and very difficult to deliver – and to vulnerable people whose needs are very complex, some of whom do not necessarily want the service or value the service – relationship is absolutely key. However, we received some extremely concerning evidence regarding the negative impact that poor leadership and conflict at the top level is having on various departments within some local authorities, including social care teams.

> *'What I see more and more of is that … there is very little, if any, time, thought, resources or creativity given to relationship building. There is nothing there. From the very top you*

have boards [including those of local authorities] or gangs of councillors, and the way that they speak … to each other and relate to each other is shocking … I've heard all sorts of things. I have heard board members say "if there has to be bloodletting, there has to be bloodletting". I have seen bullying in boards. I have seen people treating each other with complete disrespect and contempt … When you look at the way the board is relating to its executive directors and its executive teams, it is absolutely appalling. And then when you look at the executive teams, they are completely failing to engage with the teams that they are paid vast amounts of monies to lead. There is no leadership. It is just not there.'
Witness, in evidence to the CSJ

Ofsted's first stand-alone *Social Care Annual Report* revealed a lack of strong and stable leadership in a number of Children's Services Departments.[128] Sir Michael Wilshaw stated that:

'Incompetent and ineffective leadership must be addressed quickly. But where those in leadership positions have capacity and potential, this must be recognised and nurtured … Too much leadership volatility in social care is counter-productive … One in three local authorities has had a change in their Director of Children's Services last year alone. The combination of unstable communities and political and managerial instability in our social care services is a dangerous mix.'[129]

We heard concerning accounts of a bullying culture, in a number of local authorities, which is being transmitted down to those on 'the frontline.' One social worker told us '*I don't think that people feel they have a voice*.' Another explained:

'… managers, something happens to them … they lose track of what it is on the ground level … I suppose they are under certain pressures, but there seems to be a lack of understanding. I've had really good managers as well. It makes a huge difference if it comes down from the top. The philosophy of the place can be really good, even under trying circumstances in terms of workload. But when you have a bullying culture, it is really awful … It is at the management level where the problem is. They are bullying and there is a lack of respect. It is the way they treat each other. Because they are treated in a particular way, they pass that down.'

The negative impact of such environments on working relationships can in turn have an adverse impact on our vulnerable children and young people.

'This is a toxic relationship that's going on right here … you'll see it between agencies and us, and it's not ok. And internally, it's just the worst. I think it's worse than what we do with external people. We're just horrible to each other. If we don't even like the people we work with … how does the client have a chance? We've got our own battle going

128 Ofsted, *Social Care Annual Report 2012/2013*, 15 October 2013 [accessed via: http://www.ofsted.gov.uk/resources/social-care-annual-report-201213 (16.01.14)]

129 Figures reveal that of the 17 local authorities judged 'inadequate' in the previous year, a new Director of Children's Services had recently been appointed in 11, while 'a major change in senior leadership of one sort or another' had occurred in the period prior to inspection in 12; Ofsted, *Press Release: First Social Care Report puts spotlight on leadership*, 15 October 2013 [accessed via: http://www.ofsted.gov.uk/news/first-social-care-report-puts-spotlight-leadership?news=21735 (16.01.14)]

on with each other … Then say you've got a family that doesn't like you, doesn't want to engage with you, it's just a bad relationship across the board … and we haven't even mentioned the kid … And they're lost again because there are so many layers of complex relationships to try and work through before putting systems in place to start working towards the needs of the kid.'

Social worker, in evidence to the CSJ

A culture of working in partnership must start from within an organisation. However, we heard about a lack of cohesion, departmental in-fighting, and '*power struggles*' between teams in some Children's Services Departments, with a culture of '*passing the buck as much as possible*' to each other. If these teams are not working together, there appears to be little hope for them to be able to work in effective partnership with external agencies, or indeed with vulnerable children and young people.

However, what was encouraging was hearing, for example, of the benefits of co-locating members of different departments – for example, social workers and housing officers to address the needs of older children in the context of the *Southwark Judgment*. We were told by a social worker:

'I think probably the best practice always come from not just having joint working protocols, because pieces of paper don't make all that much of a difference, but having actual members of different teams sitting in the same offices day to day with each other. It is only when you see how somebody works day to day that you actually understand what they are going on about. If they're in a different office and you only hear what they're going on about over the phone, it doesn't work.'

Our evidence also reveals a concerning picture with respect to how decisions are being made in some local authorities, with an apparent disconnect between senior management, middle management and frontline social workers. We understand that this can lead to a lack of awareness, on the part of senior management, of the realities faced by social workers and, in turn, of the vulnerable children and young people that they are responsible for supporting.

'Everything is discussed at senior management level. Those who are on the floor are left out. That is the easiest or the best way to get all the information that you need about blockage. On a senior management level what they're looking at is finance. On the ground level they have a tug of war going on. That's why we see that social workers always get the blame. They see what's happening on a day to day basis but because they don't have the purse strings … they're in a difficult and awkward situation.'

Previous middle manager, social care, in evidence to the CSJ

We heard of the need for senior management in some local authorities to have more discussions with middle management, and those on the ground, to discuss how they can best use all of their resources in order to serve their vulnerable families, children and young people.

We were told that poor communication and a lack of awareness can run right up to the top. One social worker said:

'The Director doesn't even know half the things that happen … if service heads want to make themselves and the department look good, [they're] not going to hear the ins and outs … The Director doesn't know what we get up to down on the bottom. He trusts that all the different managers are doing that.'

Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, expressed the view that:

'The creation of Children's Services Departments, while in theory you can see the argument, I think it's diluted expertise in social work in the leadership of those organisations.'

Tim Loughton, MP, informed us that when he was Children's Minister, he would always challenge the leader of the Council, Director of Children's Services and often the Chief Executive of the local authority. One of his first questions would be when they had last gone out with their social workers. He said:

'Invariably they would come back and say "oh yes, I have a monthly management meeting with all of my senior social workers." "No, no, the question was when did you last go out with your social workers on a case seeing real people?" With one exception … they had never done it. Where you have got a Director of Children's Services who came from an education background, with no real knowledge of social work, let alone councillors with absolutely no knowledge of social work and child protection, it's quite important that you go and find out how it works, and whether there is another Baby P [case] potentially about to blow up on one of the estates in your Council area.'

1.3.2 Quality of social workers

'I do think that there is a fundamental issue about the workforce and that too often reforms are designed with either ideal workforces in mind as opposed to real workforces, or they are not thought about at all. And there isn't a question about "have we got the people to be able to do these things?" … We still have a lot of people in the field who are not what I would want for the social work workforce. People are looking at shortcuts and quick fixes for training … I'm sure that there are ways in which we can do it in less time but shortcutting on the investment in the workforce is a mistake …'

Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, in evidence to the CSJ

We were told that where blockages exist, this is not necessarily as a department or organisation, but due to individuals in key positions. There are many high calibre social workers; however, we heard that there are others whose standards of performance are poor. One social worker told us:

'From what I'm seeing, there are some social workers who are absolutely amazing and … doing some great work with children and families … However, they're at the point of a nervous breakdown … But there are also social workers I see … who just have really poor practice. Or they have poor practice because they have bad management oversight. Or they're newly qualified and no-one's got the time of day for them, because we're all busy

and running around, and the people that do give them the time of day are social workers who are not the best practice role models, however they've got plenty of time to give them. They're happy to jade them and fill them with all sorts of nonsense about what our job is.'

Concerns were raised by various witnesses over some social workers lacking the most basic skills, in not being able to spell, or write reports.

> *'I can't tell you how many reports would come my way … where I had to rewrite the entire thing. They couldn't write in proper sentences, the grammar was absolutely atrocious. Quite frankly, the writing was the equivalent to that of a child. It was so poor. Reports had to be read by a manager first, and how it got past a manager to me just continually astounded me. It was just such poor quality. You have people who can't adequately express themselves or communicate doing frontline work with children and we have the expectation that they do understand risk and what that means, and what that might look like and how it manifests. To me, it just did not make sense. How can we be putting people in such an important position if they don't have very basic skills?'*
> A witness, in evidence to the CSJ

We heard accounts of the long and intense working hours, and high volume and complex cases of many social workers, and of their passion and commitment for helping vulnerable children and young people – in spite of the serious challenges highlighted here. However, a number of witnesses also expressed concerns over '*a sense of lethargy*' on the part of some social workers, who '*can get away with doing the bare minimum*.'

It appears that the ability of some vulnerable children and young people to gain support from social care services can depend on how motivated their social worker is to push and fight for it. It seems it can be something of a lottery in terms of the service they receive, depending on who their case is allocated to – the social worker's experience, motivation, personality, resilience, extent to which they are willing and able to make their voice heard, and the frequency and quality of supervision they are given by their manager.

We were told that significant numbers of newly qualified social workers are being taken on by some local authorities. Concerns were raised by a number of witnesses regarding their ability to challenge managers, where necessary. In addition, senior social workers commented that some newly qualified social workers will not challenge managers where a more experienced social worker could or would. Views were expressed that experienced social workers should be in child protection, not newly qualified; alternatively, it was felt that newly qualified social workers need to be supported very closely and '*not just left to get on with stuff*.'

1.3.3 Lack of confidence, fear and inured to maltreatment and risk

Within their often highly pressured and intense work, social workers can face extremely emotive issues, requiring a certain degree of confidence and resilience. However, we have found an extremely concerning lack of confidence and even fear on the part of some social workers in addressing some of the issues faced by vulnerable children and young people.

'What you have got to have confidence in the most, as a social worker, is in saying "I don't know how to do everything, and actually I don't know everything and maybe I might be wrong," and to get somebody else's opinion. I think that is a very difficult thing for anybody, but it is a very difficult thing to build into your practice – to say "this is probably what is going on, but I might be wrong," or "this is what needs to be done, but I don't know how to do it." To be able to practice like that, it takes quite a lot of confidence.'

Social worker, in evidence to the CSJ

In response to our concerns over examples of the lack of appropriate action having been taken in cases we reviewed, one social worker explained:

'It's down to the social worker, it might be scary. They might not have done that before – [for example] remove a child. I picked up a case where the kids were looked after and were in care … The social worker admitted they didn't know what they were doing. I don't know what I'm doing sometimes. And if you don't have good management and good oversight, you're making decisions you don't know how to answer.'

Another social worker shared their experience of being instructed by their manager to interview a young child who had alleged that she had been hit by one of her parents. Having never done this work before and, in the absence of any guidance from their manager, the social worker told us:

'I felt very disempowered … I actually went on Google to see how to do it. That is how out of my depth I felt.'

'Upward delegation' featured repeatedly across our evidence – "*I have to talk to my manager.*" One witness explained that:

'It becomes a standard defence against engaging, which comes from a fear of getting it wrong, and not being confident or feeling supported.'

In one of the Kids Company cases that we reviewed, the social worker repeatedly informed the child's key worker that they needed to ask their manager what to do about various aspects of the case. The key worker felt that the social worker could not decide anything. The social worker was clearly unsure about a number of issues and needed guidance. However, it was concerning and frustrating for the key worker, who was trying to secure protection and a safe outcome for the child as a matter of urgency.

A social worker told us that they had been instructed to support a child who was presenting with 'concerning' behaviour. They explained:

'I don't know how to work with that type of behaviour … no training, no experience. I have a lack of confidence. I feel like I could do more damage. I have a lack of guidance. I have a lack of supervision from management.'

They also informed us that there are no specialist services within their borough that work with teenagers who present with that type of behaviour. In those circumstances, we were told:

> *'… what usually happens in situations like that, believe it or not, is that it doesn't get addressed … because people are scared … So these things go under the carpet … No one actually goes in to do the piece of work … because we're not trained, we don't feel confident … Because we're driven by the one incident … and we're driven by a referral system.'*

They also told us that:

> *'A lot of people do say … "I was unable to address this." But then … someone at a later date should look into this and … work should be done around helping [the child]. But it never gets picked up, it never gets done … And then as new concerns come in, with a lot of these children, something else will happen, then we're driven by that incident and we forget about what happened before … I think to myself … "we're sitting here today because of this, but look at all the stuff that's happened before, that hasn't actually been dealt with".'*

Concern has been raised by a number of witnesses over the potential for social workers, and others, to become inured to the evidence of maltreatment, due to how much they see of it.

> *'I think a lot of frontline social workers are quite jaded. Maybe they do care, but I think a lot of them have got to the point where they have detached themselves. The child doesn't really get put at the forefront of the work that they do.'*
> **Witness, in evidence to the CSJ**

Camila Batmanghelidjh, the CEO of Kids Company, has voiced her concerns over social workers becoming immune to risk:

> *'Some will go as far as beginning to grade levels of abuse. I know of child protection departments where sexual abuse of children involving penetration will be acted on, but those involving exposure to inappropriate behaviour or sexual touching will not. When we start grading child abuse we become institutionally savage.'*[130]

As referred to below, we believe that social workers should be given therapeutic support, to help them to cope with and process the distressing and traumatic circumstances that are faced by many of the vulnerable children and young people that they are responsible for caring for, protecting and/or supporting.

> *'… it's like we are now in a situation where you've got a child lying on the floor about to be run over by a ten-ton truck, and [social care] would say "no, we don't think they're in danger, and anyway we don't have anyone to pick them up or move them to somewhere safer." It really does feel like that. I've heard of colleagues going out to houses with social workers where there's no bedding on the child's bed and they're not concerned – "oh yes, well we see families*

130 Daily Mail, *Social workers are so immune to abuse that they turn into robots who cannot protect our childr*en, 24 November 2013 [accessed via: http://www.dailymail.co.uk/debate/article-2512426/Social-workers-immune-abuse-turn-robots-protect-children.html (13.01.14)]

like that all the time" … If you think about it … in a system where, as a professional, you are constantly raising concerns and they're not taken notice of – that, in the end, has an effect. That is where the danger is that everyone becomes increasingly inured to risk, and even less likely to make referrals than they were before. At some point, your survival mechanism will kick in, and it will just begin to protect you by numbing you to risk because it can't do anything else. You will no longer be able to tolerate that anxiety if other professionals are not reacting.'

CAMHS clinician, in evidence to the CSJ

1.3.4 Pressure, caseloads and morale

'I know from my direct contact with social workers across the country that they are often writing their case conference and court reports late at night, getting up very early in the morning to do them and regularly working at weekends. Exhausted, having to cut corners, sometimes in tears, and knowing that if a child dies they may be on the front page of a tabloid. This is crazy. It is unsustainable.'

Ray Jones, Social Work Professor and Former Director of Children's Services[131]

Community Care Survey 2012

'Social work caseloads are increasing in number and complexity and many practitioners are buckling under the strain … When asked for the reasons behind [this increase], many social workers reported shrinking teams, high sickness absence rates and rising referral rates. However, some also simply stated that they qualified last year and were now facing a heavier caseload as a result.'

Some key statistics:

- Half of all social workers have seen at least one colleague leave their team over the past year due to high caseloads;
- Caseloads have increased for the majority (58 per cent) of social workers over the past 12 months;
- The average number of cases held across the UK is 25 … 'however, there were wild variations in the number of cases held by individuals';
- Approximately one third of social workers (35 per cent) reported that their caseload had increased in complexity over the past year.[130]

Many witnesses expressed their concerns over the high case loads being carried by some social workers – a high proportion of which can be in court, some involving numerous children, with each child requiring individual reports to the court and within timescales. We heard examples of some social workers carrying alarmingly high case loads, which were described as '*horrendous*,' '*crazy and dangerous*.' However, it is not just about the volume of cases. It is also about their complexity, as well as the complexity and severity of the needs of the vulnerable children and young people.

131 Reported in Community Care, '*England's child protection system is at the point of breakdown*,' 18 November 2013 [accessed via: http://www.communitycare.co.uk/2013/11/18/englands-child-protection-system-point-breakdown/#.UtF_rMh-SYJ (11.01.14)]

132 Community Care's online survey was carried out in June 2012 of 925 students and social workers across the UK [accessed via: http://www.communitycare.co.uk/2012/07/17/half-of-social-workers-have-seen-colleague-quit-over-caseloads (18.01.14)]. The majority of respondents (70 per cent) said that they usually defined a case as one individual, as opposed to grouping families or siblings together. The Centre for Social Justice has been informed that the Association of Directors of Children's Services Limited does not currently hold statistics on the caseloads of social workers in England, or of their sickness absence rates

'If you have a poor manager, you're not given any support, you're told "here are your cases, get on with it" and people don't stay. I have watched hugely experienced people just leave where I have come from, because of huge case loads.'

Social worker, in evidence to the CSJ

We were told that due to the needs and crises of some vulnerable children and young people demanding a larger amount of work and its intensity, '*other children can get lost*' or '*forgotten*.'

'Social workers told the inquiry that rising referrals has led to increased caseloads, stretching the capacity of each practitioner to unsafe levels. The evidence reinforced BASW's findings in May 2012, when 77 per cent of respondents … said caseloads were unmanageable.'

APPG on Social Work, *Inquiry into the State of Social Work* report (2013)[133]

We also heard directly from the frontline about the pressure being placed on social workers by their managers to close cases. A SHS practitioner told us:

'We're finding … that social workers are wanting to close the cases far too quickly. They're actually saying themselves, they've got pressure from their managers. They don't believe they should be closed. We haven't had enough time to gauge if the parents are doing what they should be doing – it's not enough time. The timescales are too short but they're like "we're coming today, we're coming to this TAC meeting because we want to close the case".'

We raised our concerns with several social workers over cases in which Kids Company had tried to raise the alarm without it having been acted upon. In response, one social worker explained:

'It's scary if we do what you want us to do. Because we might find there's lots of work to do as well … I can't read this email today because I know what this is going to tell me. I don't have the capacity to deal with this; I'm going to blow up. I need to breathe today. I'm going to do it tomorrow … you want to be a good social worker and do well for your kids; however, by taking up a priority such as a S.47 means that the crisis you are dealing with at that time in the day for another child becomes less important and then, by default, you're letting another child down. In the office we are supportive of one another to help in these situations. However, sometimes there is just no-one spare to help.'

We were told about the practice being used of 'naming and shaming' social workers who do not adhere to targets regarding, for example, conducting home visits and 'seeing' vulnerable children and young people. In addition, we also heard about the pressures faced by some agency social workers, and the negative impact that these can have on the vulnerable children and young people they are trying to support.

133 All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, The British Association of Social Workers on behalf of the All Party Parliamentary Group on Social Work, 3 December 2013, p15 [accessed via: https://www.basw.co.uk/appg/ (26.05.14)]

'Where I was before … I felt like I was achieving more. I did feel like I was making a difference, and I was able to build those relationships with the young people. You had more time and caseloads weren't as complex. You were able to do your job within the time. I could probably do 20 cases there, because you just didn't have crisis management, which is what I am doing now. I am just running from fire to fire and trying to put a little bit of water on them … They will give you all the high profile cases rather than spread them out through the team … Because they think locums are getting paid loads of money, they will give you all the crap and the stuff they don't want the permanent staff to have. That creates instability and movement in terms of social work change for the young people. Certainly for the young people I speak to, they see social workers come and go. There is no consistency there … If the cases were balanced and shared out across the board, and we all had two or three high profile cases, but I have about 10 high profile cases out of 19. I just feel like I can't do the work.'

Social worker, in evidence to the CSJ

A number of agency social workers stated that they feel they are just told '*to get on with it*,' and lack professional support, which leads them to not want to stay. This can cause further disruption to the relevant social care services. It can also be another blow to the children and young people who miss out, once again, on being able to build or maintain a relationship with their social worker. As acknowledged by one:

'They're the ones that suffer all the time. They have to keep meeting one million and one workers.'

Our evidence has highlighted concerning practice, in some local authorities, regarding the handover of cases or case loads to existing or new social workers. We heard accounts of the poor quality of handovers. In some cases, these were social workers with pre-existing high and complex case loads. This seems to depend, in large part, on the quality of the particular manager.

'We have "this team" and "that team." Even a transfer from a LAC team … is not transparent, and the allocation process is not that transparent … you're just allocated cases all of a sudden … there's a brief hand over meeting where you get a case summary, and you have a brief discussion with the manager and the social worker, and you're expected to run with that straight away. This thing is about building relationships and I need more time. I can't just have something land in my lap, but that's what they expect …'

Social worker, in evidence to the CSJ

We were told about the handover of one case where a baby was in care. The previous social worker had written that the baby was with a relative. However, it transpired that the baby was in fact in foster care. Our research also revealed that the difficulties caused by internal transfers of cases within some social care services can compound the challenges faced by the relevant vulnerable families, as well as children and young people.

'The other problem is families' cases are often lost through transition periods where case transfers take place and the communication difficulty within that time … I feel that is a dangerous spot … A referral comes to us, but then it's almost been left and frozen for a

month where a case is transferring from one team to another. I just think we need to look at that quite closely, and quite differently. Why can't there be some joint working going on … so the family isn't lost or put to a frozen status, so that it continues because often that is the most intense time? … It's the crucial point.'

Middle manager, in evidence to the CSJ

' … I'm glad I'm doing [this job], I love it to bits but I need to quit soon because I'm falling apart doing it. But it's an amazing job; it's such a critical job.'

Social worker, in evidence to the CSJ

From the anecdotal accounts we have heard, and aforementioned surveys and reports, it appears that significant numbers of social workers are continuing to suffer with extremely low morale.[134] One social worker explained:

'There is a lot of good work being done by a lot of good people. The sad thing is that these people feel unvalued … under pressure and ultimately are leaving the profession.'

Another told us:

'I am quite cheesed off with social work because it seems so far away from what I trained for, and what my views of it are – about helping families and children. I've only been in the profession for about 12 years, but in that time I have seen it get gradually worse …'

Others referred to the '*tremendous turnover of staff*' and fact that '*hugely experienced*' staff were leaving, with '*a huge loss to the team – all that knowledge and … history with the young people*.'[135]

'It's not what any of us want to do anymore. The pressure we have been under and not being able to do the work that we want to do. All of us want to leave.'

Social worker, in evidence to the CSJ

1.3.5 Supervision

As emphasised in the Munro Review, a social worker's supervision is critically important. Supervision is traditionally conducted by a social worker's direct line manager or supervisor, and ought to focus on case management and reflection. We heard examples of new approaches being taken by some social care services. For example, the distinction being made between case management and reflection, and supervision being conducted by experienced practitioners (but who are not direct line managers) amongst other approaches. This is with a

134 All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, The British Association of Social Workers on behalf of the All Party Parliamentary Group on Social Work, 3 December 2013 [accessed via: https://www.basw.co.uk/appg/ (26.05.14)]; Community Care online survey, June 2012 [accessed via: http://www.communitycare.co.uk/2012/07/17/half-of-social-workers-have-seen-colleague-quit-over-caseloads (18.01.14)]; The British Association of Social Workers and Social Workers Union, *The State of Social Work 2012*, May 2012 [accessed via: http://cdn.basw.co.uk/upload/basw_23651-3.pdf (11.01.14)]

135 The CSJ has been informed that the Association of Directors of Children's Services Limited does not currently hold statistics for the turnover of staff in social care teams in England

view to enhancing the social workers' support whilst, at the same time, giving their managers extra capacity. We were told that whilst such an approach costs money, it has generated positive feedback. It is considered to be very important by the leadership, and has the benefit of building up the confidence and resilience of newly qualified social workers.

However, there is clearly room for considerable improvement on the part of other local authorities. Witnesses informed us that the frequency, length and quality of supervision varies across local authorities. We were told that it can be strictly adhered to in some, but that it '*doesn't happen for months on end*' in others. It appears that some social care services are not using supervision as a means of providing genuine support to their social workers, who instead feel that it is more about those in senior management protecting themselves. We heard how supervision can feel like just another tick-box exercise for some. One social worker explained:

> *'… if you're dealing with [high profile] cases, it is more like crisis management and you're just letting your managers know what's going on. It is all about arse covering and they are protecting themselves … In supervision, they will record stuff and make decisions and actions. You've got action upon action. God forbid you don't remember an action and something does happen. But they are covered; they will say "he had supervision, and he was instructed to do this" … they are the controllers that monitor the system, to monitor what you have or haven't done. It is like Big Brother watching you … You're playing catch up all the time.'*

Another social worker said:

> *'I have never really had good supervision. The only person who ever gave me proper supervision was my very first practice teacher in 1997. Nobody has ever matched it. I wouldn't call it supervision; I would call it "have you done …?" because that is all it is: "Have you done this? Why not? You need to do this," or you're for the chop.'*

In addition to this, we heard accounts of social workers feeling unsupported, overwhelmed and that they are expected to 'get on with it' and 'cope' with the work. They do not feel they are able to express that they are struggling in supervision, or that it is a safe place in which they can speak honestly. A middle manager told us:

> *'It's difficult because there is this culture of … "Don't moan and get on with it." There's a horrible stigma with social workers holding and managing everything and, if they can't manage, that's because they are not performing as a social worker should …'*

One social worker told us: '*There is an element of, if you dare say how you feel, you'll get fired.*' Another explained:

> *'You have to be careful about what you say, because things could be used against you. In being able to express your inner most thoughts and feelings and emotions, I think you do need to be careful because I have heard stories. It is about trust and you need to be in a*

trusting relationship. For me to let rip about the cases and work load, if I start expressing those to certain people they will think "get rid, [they are] not up to it".'

Concern was also expressed regarding the personal qualities and resilience required to survive the environment, by some of the managers who supervise social workers. A CAMHS clinician told us:

'… this is where we may be looking at the effects of vicarious traumatisation on senior staff. Once they get to become senior staff, they are numbed I feel to the emotional impact of the work. If they stay in the work for a length of time, they become shut down.'

We question the extent to which supervision in such cases can be effective and genuinely supportive to social workers, and its impact on the vulnerable children and young people they support. It appears that the welfare, emotional well-being and mental health of many social workers is being overlooked. We believe that their supervision should comprise a therapeutic component, and that this should be conducted by someone other than a social worker's line manager – for example, a therapeutic worker within a social care team, a social worker who has done post-qualifying training, or a NHS clinician. It is crucial that social workers are provided with a safe place in which to discuss their own emotional well-being and mental health, and without the fear of being judged.

1.3.6 Lack of legal knowledge and poorly applied practice[136]

Our evidence gives us serious concern about the apparent lack of relevant legal knowledge on the part of some social workers and, even more worryingly, of some of those within middle and senior management.

'… they don't know the law. I have done a lot of training … [asking] very straightforward questions … It's rare that you get a group of managers within a local authority getting more than 25 per cent of the answers right. It is basic legal stuff. I asked them what S.7 is and they don't know … what a mandatory piece of guidance is and what isn't[137] *… These are the people who are actually supervising basic grade workers. If they don't actually understand the law, and how it operates and how it works, and the spirit of the law, how can they implement it? How can they argue against other managers who impose things that may not be legal or may not be within the spirit of the law?'*

An experienced Independent Social Work Consultant and Expert Witness, in evidence to the CSJ

One social worker told us:

'I work with a lot of people who aren't from Britain, so knowing the law is really really difficult as well … Knowing the law is just down at bottom isn't it? You hope someone around you is going to tell you.'

136 This is discussed further in Chapter Four
137 Local Authorities Social Services Act 1970, Section 7

Some social workers also struggle to apply the relevant law to practice. One explained the challenges that they can face:

> *'It can be lack of experience, but I think more of what it is, is a lack of knowledge of how legislation actually works, and a lack of discussion of that kind of thing at a practice level. It tends to be that the policy, and the knowledge of the law, is monopolised a little bit at a managerial or a senior level … access to the legislation is on the internet, anybody can look at it, but the ability to discuss … how it applies in practice doesn't happen at a practice level very easily. You have got to do it yourself. It is not necessarily structural; it is more to do with the fact that when you are doing a team meeting or supervision, the primary concern is the cases you have got, and the concerns coming out of that … things are constantly coming back in crisis, you don't have the capacity to be able to familiarise yourself with legislation, long documents, research and guidance. It is very difficult to have that time in a work context to do that.'*

Dr Karen Broadhurst illustrated the pressure on social workers in relation to the extent to which they can study law as part of their initial education (discussed in further detail below), and the demands on them in practice. She said:

> *'The problem is that you can do two or three years of qualification, but it is not long enough. The complexities of the law are even more now, and the case law. If you're in child protection, you have got to keep apace of social change, and they don't have the chance to do that. They get thrown in at the deep end. Many of the young social workers I interviewed were all wanting to leave – local authority legal advisors, in my experience, are often highly skilled and knowledgeable, but there doesn't seem to be the time to effectively share that expertise, or the turnover in social workers is so demoralising for the local authority solicitors that they are perhaps less inclined to do that coaching for fear of their input being wasted.'*

1.3.7 Resource

> *'Those who work on ground level, they're smart. They know what the issues are. Those in middle management, have a tug of war. They see what's happening on the ground level but then they've got someone from senior management saying "no, no, no". The amount of heated discussions that I had to have to try to get what I needed – the battle, because you've got senior management telling you "no, we haven't got the money to be able to do this", and then you've got the people on the ground saying "but we need this, we need that".'*
>
> **Previous middle manager, social care, in evidence to the CSJ**

Local authorities are under immense pressure in light of the significant budget cuts. We were told that some small unitary local authorities are particularly struggling. A number of internal services which would otherwise have been available to help social workers to meet the needs of vulnerable children and young people have disappeared and others are under threat.

Frustration was also expressed in relation to the lack of external services in some local authorities. We heard about apparent gaps in available specialist services to help address certain issues which can present from a multi-cultural demographic. We heard that some social workers and those in more senior positions, are not aware of effective VSOs in their area, which also raises an issue of communication between social care and some VSOs.[138] A middle manager told us that, regarding the 14 to 16 age bracket, there is a need in their local authority for more accessible targeted support services. They explained that the one service that is currently available for social care to refer this age group to is provided by a charity:

> *'We're often being given the message that they are overwhelmed with caseloads and all they can do is offer one appointment or two at the most. If they're missed, then the case is closed.'*

We asked what happens to the children in these circumstances. Our witness explained that it is really difficult to move forward, and there is nothing holding the family. They added:

> *'The only other place they can go is youth offending but that's if they've got criminal links or status, but for the rest … where do they go? There really needs to be an association with a live problem for them to be picked up or cared for. Otherwise there isn't much really going on by way of community support services for parents or children within that bracket. You either need to be a teenage girl who's pregnant or somebody that's committed an offence to be provided with a service. If you're quiet and there's abuse going on, nobody wants to know. That's what it feels like is going on in our society.'*

However, whilst facing intense pressure from tight budgets and increasing demands, it seems that what money does exist is not necessarily being used as efficiently or effectively as it ought to be in some social care teams. A previous middle manager in social care recalled their experience of having worked on projects which had been set up for children in need cases:

> *'… I have seen how money has been mismanaged and not been put in the correct places … It's gone on for years and years. I'm sitting there looking at this thinking "my goodness, who is managing this? Who is overseeing this?" They completely failed in their responsibilities. Who is monitoring the people who manage those projects, and ensuring that those projects are working to the best of their ability and producing the outcomes? It's not being done. So we're wasting money …'*

1.3.8 Social worker selection, education and training

> *'Social work is a very difficult job and that's why it's very important we are careful about who we select to train to do it – and that they have both the ability to empathise and "to stand back from".'*
>
> **Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, in evidence to the CSJ**

138 As discussed in Chapter Three

Intellectual ability, analytical skills and resilience, are essential for those in the social work profession. However, a capacity for empathy, compassion and an ability to listen, are fundamentally important personal qualities for a social worker to possess. Vulnerable children and young people repeatedly told us that they want someone they can talk to, someone who will listen to them and who they feel cares. For all of the complexities that can be involved, they are crying out for some of their basic human needs to be met; yet, tragically, these are often overlooked.

> *'You can't be a social worker if you don't care … I don't know if social [care] employ people by their qualifications only, or if they have interview processes where they find out if they really do care about other people's well-being. It seems to me some of their employees only do it because it's their job. They should have an interview process where they find out if the people truly do care about young people's well-being. If they fail that process, then they are not the right person for that job. With [my previous social worker], I felt like he might have been qualified for the job but I didn't see an ounce of care in his eyes …'*
>
> **David, in evidence to the CSJ**

1.3.8.1 Impact of adverse life experiences on vulnerable children and young people

'A child's first three years are critical in terms of the brain's social, emotional and physical development. The quality of a child's primary caregiver's support and nurture profoundly influences these very early formative years.[139] *We know that the brain is acutely vulnerable during these years to trauma, the impact of which can be shocking. Indeed, "the stress hormones, such as cortisol, that are elevated during trauma, flood the brain like acid",' which can lead to the development of fewer synaptic connections. Neuroscientists viewing scans of key emotional areas in the brains of abused or neglected children have likened the experience to looking into a black hole.*[140]

Despite the alarm bells being sounded by a growing body of neuroscience about the severe consequences of adverse early life experiences on children, and how trauma affects brain development, we are concerned that insufficient importance is placed on this within social workers' initial and continued learning.[141] One social worker told us that they had very little teaching on brain development at university, had had one training session on it at work in a year, and that they were desperate for more. They said:

> *'… we're taught the basics … And again, that's why we … miss out on a lot of this stuff because … we're not trained in it. So we can't see it. As long as he's in a clean nappy and*

139 Centre for Social Justice, *Breakthrough Britain: The Next Generation*, London: Centre for Social Justice, 2008; and Centre for Social Justice and Smith Institute, *Early Intervention: Good Parents, Great Kids, Better Citizens,* London: Centre for Social Justice and Smith Institute, 2009, cited in Centre for Social Justice, *No Excuses: A Review of Educational Exclusion*, London: Centre for Social Justice, September 2011, p57

140 Centre for Social Justice and Smith Institute, *Early Intervention: Good Parents, Great Kids, Better Citizens*, London: Centre for Social Justice and Smith Institute, 2009, pp62–63, cited in Centre for Social Justice, *No Excuses: A Review of Educational Exclusion*, London: Centre for Social Justice, September 2011, p57

141 As in any other area of science the implications of these neuroscientific findings are debated and the existence of direct causal links is contested, but professional training should at the very least be informed by and about such debates

he's playing with his mum, we think "he seems alright, there's no concerns." So I don't think we have the appropriate training … the amount of social workers that are going out and seeing babies every day and haven't got a bloody clue, it's just ridiculous.'

Another social worker told us, with respect to brain development, '*I've never heard anyone talk about it. Ever.*'

Evidence indicates that domestic violence increases the risk that children, in particular boys, will have behavioural problems, such as aggressive behaviour.[142] This was borne out across many cases across our evidence. Over and over again, boys who had witnessed and/or experienced domestic violence, presented with challenging behaviour. However, there was very little evidence in these cases of efforts having being made to address the trauma that these boys were undoubtedly suffering. Some cases involved extreme violence and were shocking for an adult to read or hear about, let alone for a child to experience. One case involved children getting spattered in blood trying to stop the fighting in their home, only to be found cowering in a shed at Kids Company after they had taken shelter there.

The CSJ was informed by various witnesses, during its research for *No Excuses,* that attachment and relationship problems lie at the root of many excluded and self-excluded pupils' difficulties.[143] Again, educational exclusion has featured heavily across the evidence to our Review. Furthermore, gangs provide belonging, loyalty and the 'unconditional love' that many children and young people lack at home.[144] Indeed, in its *Ending Gang and Youth Violence: Annual Report 2013*, the Home Office refers to anecdotal evidence (for example, from VSOs) that 'gang-associated young people often have attachment issues.'[145]

'My view is that relationships are at the heart of these young people's issues … It is compounded by peer group and environment … I would say an attachment approach is very useful in informing how we work with young people, however, we also need to understand the broader socio-economic context of young people's lives and impact thereof.'

Dr Karen Broadhurst, in evidence to the CSJ

However, it strikes us that more must be done to support social workers to understand these difficulties, and to help inform their approach in response to them. One social worker told us that they received '*a little bit*' of teaching on attachment at university, and that they and fellow students were sent off to read about it –'*the truth is most people don't do the reading up on it.*' They added:

142 Yates TM, et al, Exposure to partner violence and child behavior [sic] problems: A prospective study controlling for child physical abuse and neglect, child cognitive ability, socioeconomic status and life stress, *Development and Psychopathology*, 15, 2003, pp199–218; Sternberg KJ, et al, Type of violence, age and gender differences in the effects of family violence on children's behavior [sic] problems: A mega-analysis, *Developmental Review*, 26, 2006, pp89–112, cited in Centre for Social Justice, *No Excuses: A review of educational exclusion,* London: Centre for Social Justice, September 2011, p57

143 Centre for Social Justice, *No Excuses: A review of educational exclusion,* London: Centre for Social Justice, September 2011, p58

144 Centre for Social Justice, *Dying to Belong: An in-depth review of street gangs in Britain*, London: Centre for Social Justice, February 2009, p94

145 HM Government, *Ending Gang and Youth Violence: Annual Report 2013*, December 2013, p22 [accessed via: http://www.official-documents.gov.uk/document/cm87/8746/8746.pdf (20.01.14)]

'Most people in social work can tell you what attachment is, but only from one perspective. And they look at attachments through observations and through behaviours … I think we just look at the surface – "oh look, he runs to mum, oh look, he's crying and she gave him a cuddle – they've got a good attachment." So I don't think we really look at it, and we're not trained to.'

Another social worker told us: '… *attachment … people don't know what it means half the time. It's just … one of these loose terms that gets banded around.*'

'If we were therapeutically trained as social workers, we'd be able to say "… before I work with this child, what's actually happened to this child?" Then also let me speak to the child – "what's happened to you?"… The degree is straight social work theory, legislation … there's no therapeutic aspects to the social work training in this country which to me makes it rubbish. Because we don't want to know what's happened in the generations of this family. We're not interested. With a lot of the problems, possibly you can see the patterns, you can see themes.'

Social worker, in evidence to the CSJ

There is also the issue of training. Dr Karen Broadhurst explained:

'It is taught and it is covered, but I guess there's a difference in going from that to a local authority setting and having any scope to implement any of what has been learned in a University setting. I think social work training is quite foundational really. When you're doing social work education, my view is that you need to read, and think, and develop your critical and analytical skills. In addition, social workers should be highly skilled at psycho-social intervention, but we have lost that.'

We heard about one university which has excellent input to its Masters programme from its psychology and psychiatry colleagues leading the field in attachment therapies, but we understand that this is unusual. We were informed about a number of universities where there is strong therapeutic input at degree level but that this is not consistent. We were also told that there are significant differences between degree programmes, but that following the quality enhancements, many programmes will be giving greater weight to direct engagement and skills to promote change in families.[146] We hope that such provision will become consistent in degree programmes across all universities, to ensure that initial social work education equips social workers with high quality therapeutic learning. We also hope that opportunities are made available for, and priority is given, to high quality continuing professional development (CPD) in this area.

146 The quality enhancements followed messages from the Social Work Reform Board, and are now endorsed by the College of Social Work. They give far greater weight to skills training and linking theory and practice

In the meantime, we note Sir Martin Narey's reference to the Education Select Committee's (then the Children Schools and Families Committee) recommendation, in 2009, that:

> *'Current requirements for the social work degree should be rationalised, combined and, where appropriate, set out in greater detail to form a basic common curriculum. We particularly wish to see consensus on the content of training on child protection, child development and communication with children.'*[147]

Sir Martin has observed that this rationalisation has not happened, he has suggested that the list of aspects that a newly qualified children's social worker needs to understand at graduation should include (amongst others):

> *'… a comprehensive grasp of the basics of: child development; attachment theory; the longer term impact of neglect and maltreatment on children; [and] communicating with children…;'*[148]

More recently, Ofsted has recommended that the Government:

> *'… review the social work reform programme and ensure that training, both before and after qualification, includes mandatory material on neglect, focussing on its identification and assessment, as well as comprehensive training on child development, attachment theory and child observation.'*[149]

We also received evidence that some social workers are seen as being out of touch by children, young people and colleagues – particularly regarding problems associated with street gangs, and sexual exploitation. A fundamental concern, on the basis of our findings, centres on how social workers can best be equipped to understand and address the emotional needs of vulnerable children and young people, and complexity and severity of issues that they can face in today's society.

1.3.8.2 Legal training

We were told that the teaching of law in some social work degrees can be '*very limited*' and that it is '*often not very good,*' because it focuses on the theory of the law as opposed to its applied practice. Concerns were also raised in Sir Martin Narey's recent report.[150] This is extremely worrying, given its complexity and the extent to which law underpins social work practice. Our concerns were compounded by the challenges that some social workers face in keeping up to date with developments in the law as part of their continuous training, and the opportunities available to them to discuss and learn about its application with managers

147 Narey M (Sir), *Making the education of social workers consistently effective, Report of Sir Martin Narey's independent review of the education of children's social workers*, February 2014, p5 [accessed via: https://www.gov.uk/government/publications/making-the-education-of-social-workers-consistently-effective (27.05.14)]

148 Ibid, p10

149 Ofsted, *In the child's time: professional responses to neglect*, March 2014, p6 [accessed via: http://www.ofsted.gov.uk/resources/childs-time-professional-responses-neglect (12.05.14)]

150 Narey M (Sir), *Making the education of social workers consistently effective, Report of Sir Martin Narey's independent review of the education of children's social workers*, February 2014, p9 [accessed via: https://www.gov.uk/government/publications/making-the-education-of-social-workers-consistently-effective (27.05.14)].

in practice. This must undoubtedly stunt their professional development and impact on their confidence. This fits with accounts we have heard from various witnesses of being repeatedly told by social workers that they need to speak to their managers. There also appears to be an issue over the ability of some managers to gain the requisite training.

1.3.8.3 CPD

As the Munro Review emphasised, it is essential that social workers are supported to enhance their knowledge base and skill set, through CPD. However, despite the proposed reforms, our evidence demonstrates that challenges exist with respect to some social care teams developing and building a learning culture. Some social workers are struggling with the extent to which they are able to continue their learning. We have been told that obstacles to developing a learning culture stem from the fact that safeguarding activity in many frontline Children's Services teams has increased in the past two years.[151] This means that it is difficult for team managers to sanction the release of staff. The other issue, we were informed, is that local authority training budgets were the first to be hit as a consequence of public sector cuts, and that the provision of CPD has been undermined. In addition, we heard that although local authorities are working creatively with their higher education institution (HEI) partners to explore options for no-cost knowledge exchange, local authorities widely report that they are unable to plan or commit to a CPD framework as envisaged by Munro, and set out in the performance capability framework.

One social worker explained that they had a supportive manager, and were allowed the freedom to learn:

> *'… but I don't think that a lot of people necessarily are. It is a thing that depends on personality really … because if you have got a manager who is quite confident in their staff, they will allow the freedom to do that. If you have got a manager who is over-worked, not confident or has quite a micromanagement style, you're not going to be able to get it … If you are in a nurturing structure … it can work very easily. It is getting the right environment. It is not just the right structure; it is the right people in it as well. I think that is absolutely essential. If you have got a structure where a lot of people clash or their working model doesn't fit, it just won't work. You have got to have people who have confidence in their staff, and the people who can enable people to learn and do better.'*

We also heard about the challenges presented to both local authorities and HEIs, where the former are unable to guarantee their funding for CPD, and that the latter cannot invest in developing CPD provision if a market is not guaranteed. We were told that this is particularly so for the higher profile research intensive universities, because this group of universities may well deem that investing energy in research and innovation is more worthwhile than delivering an increasingly 'thin' CPD curriculum. This can also impact on the quality of training provided, particularly where local authorities ask what training can be provided without charge, as we are told that some are doing. Dr Karen Broadhurst told us:

151 The Association of Directors of Children's Services Limited, *Safeguarding Pressures Phase 3* [accessed via: http://www.adcs.org.uk/download/news/adcs-sg-pressures-p3-report-final.pdf (07.01.14)]

'Social work is one of the few professions that has never effectively established [CPD]. The situation is so much better for health professionals, for example nurses and midwives. Health professionals benefit from sustained funding via regional health bodies supported at a national level. This enables universities and health providers to plan and deliver high quality provision. For social work, agencies appear unable to plan for any sustained periods because national support from government appears insufficient/ambivalent. In my opinion, it's not that there is a shortage of high calibre candidates either entering the profession or graduating, rather that when qualified workers go into practice, that they don't receive the kind of [CPD] that would nourish them in their roles, and enable them to further develop their capabilities. Lack of support once qualified, I believe, is at the heart of retention issues in social work. Universities struggle to plan and deliver high quality [CPD] for social workers for the same reasons.'

We were told that some social workers self-fund their learning, and do courses during their annual leave. We understand that there is a requirement that social workers meet annual CPD requirements, but heard that there appears to be wide discretion in terms of what counts and what is deemed to be of sufficient quality. This begs the question as to whether the CPD that is undertaken is as valuable and focussed as it could be to help enhance the relevant social workers' skills, knowledge and experience. We were told that this is a leadership issue, and that managers ought to stipulate what is a priority and introduce some mandatory training. It has been suggested to us that managers should direct social workers regarding what CPD they ought to do, and that this should be monitored in their supervision. However, we have also been told that this is a budget issue primarily.

1.4 Reforms

'… child protection is now being fragmented. The Minister now in charge of child sexual exploitation and everything around that … is now Damian Green in the Home Office[152] *… It is not a policing matter. We need to do a lot better on catching and persecuting the perpetrators but it is above all an intervention and prevention measure, and that comes from the Department for Education. And it comes from working particularly closely with schools and Children's Services Departments, which are regulated by Ofsted and are financed by the Department for Education. Obviously youth policy has now been hived off to the Cabinet Office, so that effectively the Minister for Children has become Minister for Adoption and SEN. I think that is a huge retrograde step … Munro will now find the job of implementation that much harder because [child protection] is fragmented across different departments.'*

Tim Loughton, MP, Former Children's Minister, in evidence to the CSJ

Our vulnerable children and young people crave consistency from a cohesive child protection system. Separating out responsibility for child protection within government runs the risk of adding further complexity to it, and creating additional gaps through which vulnerable children and young people are likely to fall.

152 Responsibility for child sexual exploitation has since moved from Damian Green to Norman Baker in the Home Office

' … the inquiry heard evidence to support fears that the solutions of 2010 and 2011 are already old news, with witnesses indicating that the pace of implementing Munro's recommendations is painfully slow and that the bulk of her recommendations for revitalising child protection work are being sidelined.'

APPG on Social Work, *Inquiry into the State of Social Work report (2013)*[153]

Concerns have been raised by a number of witnesses in relation to the pace of change in reform to the child protection system following the Munro Review.

> *'A lack of confidence in social workers themselves compounded by a process model is a vicious circle that is quite difficult to get out of … If there was more effort and confidence on the design of improvement, and there was a bit more resource going into it, we would be making faster progress. I think things on the professional side are getting better but I don't think we are retaining people in jobs, and the speed of change in relation to the child protection system following [the Munro] Review is just too slow.'*
>
> **Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, in evidence to the CSJ**

We are aware that a number of local authorities have re-designed, or are in the process of re-designing, their social care services following the Munro Review. It will obviously continue to take time for any positive outcomes achieved by these changes to work their way through. Concern was expressed to us over how local authorities refocus their social care services in this new context.

> *'Just to look at the Munro Review and say "we're going to refocus [our services] in line with it" actually is very worrying. Because what that is not saying is "we're analysing how best the Munro Review can be used to provide services to the community who after all we're supposed to be representing." What we should be doing is looking at the Munro Review and saying "how best can we use this to assist us in changing and being more effective?"'*
>
> **An experienced Independent Social Work Consultant and Expert Witness, in evidence to the CSJ**

What is clear is that there is not a 'one size fits all' solution in terms of reform to the child protection system. The Reclaiming Social Work 'Hackney model' is an example of a new approach being taken. This was profiled in the Munro Review and a recent evaluation has demonstrated positive findings.[154] Many witnesses to our Review expressed their admiration for the Hackney model. However, some were also careful to point out that what might work in Hackney, given its particular demographic, may not be suited to another local authority. It was felt that this is not necessarily the only model to bring about the desired change in terms of creating a profession which is '*self-confident, creative and to a much greater extent*

153 All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, 3 December 2013, p8 [accessed via: https://www.basw.co.uk/appg/(26.05.14)]

154 Forrester D et al, *Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's* Services: *Final report of a comparative study of practice and the factors shaping it in three local authorities*, University of Bedfordshire and Tilda Goldberg Centre for Social Work and Social Care, June 2013 [accessed via: http://www.beds.ac.uk/__data/assets/pdf_file/0011/258491/Final-Report-RSWv3-19072013.pdf (15.01.14)]

self-regulating than it has ever been in the past.' Concern has also been voiced about some local authorities 'cherry picking' aspects of the model, rather than adopting it as a wholesale re-design.[155] This runs contrary to what its founders intended.

> *'What we concluded from that research was that there is such a lot of work going into back covering and documenting and auditing what you do, that you don't have enough time to do anything.*[156] *The Munro Review tried to tackle that. I don't see that it has made that much difference. Again, I think local authority senior managers struggle to get away from that model.'*
>
> **Dr Karen Broadhurst, in evidence to the CSJ**

We heard from a number of witnesses that some local authorities are resisting reform, and are sticking to the old process-driven model. We were told that when you combine this with a lack of confidence in the social work profession, and loss of leadership at senior social work level, '*people think it's safer to stick with something*.' However, several witnesses expressed the hope that the new Ofsted inspection regime will make a difference to this, with its focus on quality of practice and experience of children, young people and their families. We believe that it is critical that Children's Services are sufficiently supported to understand what constitutes good and outstanding quality of practice and experience under the new regime, and how to best achieve it.[157]

We were told that the National Social Work Reform programme is also pushing to relieve the focus on process in social work. Andrew Webb, President of ADCS, told us:

> *'It is making some progress, but not enough and not fast enough. I say that as the former Deputy Chair of the Government's Social Work Task Force.'*

Mr Webb went on to emphasise the need for an absolute commitment to be made to the professional development of the social work profession. He stated:

> *'There needs to be that institutional adoption of professional excellence. In other disciplines, such as the NHS, you see that. We have moved too far away from that with some local authorities. With the spending cuts, I worry that we won't get there. We need to work with professionals who are much more prepared to take responsibility for their own learning, as part of the deal of being treated better and valued. This has to be a co-ownership of re-claiming, or maybe just claiming, social work. There has to be a commitment on all sides. An absence of tolerance for the stuff that is not good enough, and things that aren't trying to move us forward – that's what we need in the profession. Instead of defensive practice, we will see creative practice.'*

155 Community Care, *Stress-busting Hackney model under threat from cherry picking councils*, 17 July 2013 [accessed via: http://www.communitycare.co.uk/2013/07/16/stress-busting-hackney-model-under-threat-from-cherry-picking-councils/#.UtZvYsh-SY1 (15.01.14)]

156 Dr Broadhurst added that audit and back covering is largely driven by the Ofsted inspection regime, which remains onerous; Broadhurst K et al, Performing 'Initial Assessment': Identifying the Latent Conditions for Error at the Front-Door of Local Authority Children's Services, *British Journal of Social Work*, 40(2), 2010, pp352–370. eScholarID:197222 | DOI:10.1093/bjsw/bcn162; Wastell D et al, Children's services in the iron cage of performance management: street level bureaucracy and the spectre of Švejkism, *International Journal of Social Welfare*, 19(3), 2010, pp310–320. eScholarID:197962 | DOI:10.1111/j.1468-2397.2009.00716.x

157 We discuss these and other issues regarding Ofsted in Chapter Four

1.5 Conclusion

> *'[The system] is not doing its job anymore. For some reason, something has gone terribly wrong. The whole system is failing.'*
> **Social worker, in evidence to the CSJ**

Our evidence demonstrates that child protection systems in some local authorities are far from child centred. Some social care teams are considered to be resource- rather than need-led, operating a crisis response. It seems that a range of factors are crippling the potential for effective frontline child protection practice in some areas, with budget restrictions presenting additional difficulties. The current challenges also exist in the context of us appearing to have a bigger child protection problem than official figures indicate. For example, our report has identified children who ought to be designated as children in need are not, and children who ought to be placed on CPPs are not. There are also those who are not even known to social care services.[158]

Insufficient emphasis is being placed on the importance and potential of early intervention in some local authorities. A lack of preventative work is being undertaken – including by some social care teams towards certain cohorts of children.[159] It is appalling that social workers (amongst other professionals) are feeling powerless to intervene in cases of suspected child neglect. We know how devastating the consequences of neglect can be, and the impact of delayed intervention. Our concerns about early help and early intervention are intensified by the consequences of the '*haemorrhaging*' of '*cases down to the next level*,' and some aspects of the *2013 WTSC*.[160]

The gatekeeping operated by some local authorities is fundamentally concerning, as are rising thresholds – some of which appear to be unlawful.[161] We have been shocked at the complexity and severity of need of some children who have been unable to gain access to the relevant social care services. Equally, shortcomings in many assessments, and extent of 'no further action' being found by solicitors who gave evidence to us is of extreme concern. Some of those who do gain access to social care services are not receiving the appropriate support to meet their needs. One witness told us that '*enacting a lower threshold and timely response is largely beyond the capacity of the local authority*,' due to caseloads being '*too high*,' and therefore the local authority being '*consistently on the backfoot*.'

Some social care teams are struggling to break away from a process-driven culture. Where bureaucracy and prescription continue to win over the importance of relationship, everyone loses. Tragically, timescales and targets still often seem to carry more weight than the quality of work undertaken with some vulnerable children and young people, and the progress achieved for them. A rigid, formal and structured approach, as opposed to flexible and child/young person-centred, continues to have an adverse impact on the quality of practice that many social workers are able to offer. One social worker asked '*What is the point in us doing our job*?' This is compounded by a lack of time to undertake direct work. In turn, the

158 Harker L et al, *How safe are our children?* London: NSPCC, 2013[accessed via: www.nspcc.org.uk/howsafe (14.01.14)]
159 For example, children in need and those who are at risk of or suffering street gang violence
160 The latter point is discussed in Chapter Four
161 As discussed further in Chapter Four

experience of vulnerable parents, children and young people continues to suffer. Ofsted has now shifted towards a focus on the child's journey. However, we heard that there has been:

> *'no let up in the need to audit practice to an excessive degree. The extent to which inspection and regulation continue to drive this micro-auditing of practice is not entirely clear, or whether local authorities are simply struggling to effect change.'*

The approach of some social workers towards vulnerable parents, children and young people, can exacerbate their pre-existing barriers to engagement. Some social workers are not uncovering the truth of their experiences, or developing an informed understanding of their circumstances and needs. This can have an adverse impact on the quality of their assessments and efficacy of their support and interventions. There was a palpable sense of drift and chaos in numerous cases across the CSJ's evidence, with no-one gaining a firm grip on the key issues of concern – for example, parental substance misuse and domestic violence. We repeatedly heard that children are not at the forefront of some social work practice and are getting '*lost*' or '*left at the bottom*.'

A lack of confidence and fear can exist on the part of some social workers towards vulnerable parents, children and young people, and vice-versa. This can present additional barriers to engendering trust – a critical component for effective practice. We were stunned at the ease with which vulnerable voices can be silenced by, for example, being recorded as 'has shown no insight,' or 'did not engage.' This is in circumstances where such statements may not provide a fair or accurate reflection of the situation. We question how many are losing out on support as a result. We understand that, in truth, these statements can sometimes mask a lack of confidence, skills, training, experience and support of social workers. The vital importance of vulnerable parents, children and young people feeling that they can have faith, trust and confidence in the child protection system, and be heard, is often being overlooked.

There appears to be a big issue in relation to children in need – the services for whom, in some local authorities, are not sufficiently resourced. Where the children's needs and risk of harm escalate, requiring more intensive intervention, further pressure is placed on child protection systems – at a time when we can least afford it.

> *'A lot of harm that local authorities deal with could have been dealt with in a much less intense way earlier and would cost them a great deal less in resources, including their staff time. It's not just in terms of staff hours, but staff pressure. Because if the staff are constantly having to deal with this flood, they get worn down … you get huge turnovers and … more and more problems. That is exactly what you see … they need to … re-think how they're offering their services … the opportunity they have now in times of scarce resources is to actually refocus, and to say we can't constantly be doing that because it's expensive, what we ought to be doing is stopping the cost at the beginning of the process. And … so when we have to intervene more intensively, it's far less frequently and we can use our more experienced and expert workers to do that stuff. But that's exactly what they don't do.'*
>
> An experienced Independent Social Work Consultant and Expert Witness, in evidence to the CSJ

Furthermore, a problem exists with respect to how some local authorities are marshalling their resources. Some are not utilising them as they should be, and are not securing the most positive outcomes for vulnerable children and young people. Angela Gascoigne, Management Consultant, referred to a best practice approach in terms of supporting and enabling a more sophisticated approach to service delivery and service planning, whilst highlighting the difficulties faced by some local authorities in this regard:

> *'The best organisations are reducing the costs of the waste and improving the outcomes. They are doing that by forensically looking at what they are spending their money on, and looking at what works and what doesn't work. Local authorities are really struggling with this. Their information systems are geared to process. They are not geared at all in terms of targeting and identifying need, and identifying demand …'*

Children who are at risk of or suffering street gang violence, older children and care leavers, are also being particularly let down by some social care services. We were told that:

> *'… because demand exceeds supply, the local authority has to find a way to reduce demand and it does this by filtering, tending to filter out cases of older children.'*

Our witness said that this is not '*an intentional neglect – but that's the result.*' They added that:

> *'… many social workers feel deeply uncomfortable about not being able to provide an adequate service – indeed, this drives workers out of social work – but essentially, social [care] services are not adequately resourced to respond to an increasingly complex presentation of social problems and need – given austerity and complex new social issues.'*

Strong and stable leadership is of paramount importance. However, there seems to be serious cause for concern over a lack of this in some Children's Services Departments, with the negative impact that this can have on the workforce beneath.[162]

> *'I don't actually know what you [would] need to do to get fired … Because you do see such poor practice … You see lots of bad things happening and managers know.'*
> **Social worker, in evidence to the CSJ**

We do not question the high calibre, professionalism and unrelenting dedication of the vast majority of social workers who are battling day in, day out, to care for, protect and/or support our vulnerable children and young people – all too often against the odds. Most social workers are desperate to do a good job. However, our evidence has highlighted the poor performance of what we would hope are a very small minority. It cannot be acceptable for any of us to tolerate poor practice in child protection social work. In addition to the likely adverse consequences on vulnerable children, it can impact on the morale of all of those who are performing to higher standards.

162 Ofsted, *Social Care Annual Report* 2012/2013, 15 October 2013 [accessed via: http://www.ofsted.gov.uk/resources/social-care-annual-report-201213 [05.02.14)]

'We have spent 20 years infantilising the profession of social work. You cannot underestimate the culture change that is required to get us into a better place …'

Andrew Webb, President of ADCS, in evidence to the CSJ

Significant positive change is clearly still required in the culture and practice of some local authorities. It appears that many social workers are feeling demoralised. Many vulnerable children and young people, as well as parents, feel that they are not being listened to, heard or supported, However, some social workers are voicing the same frustrations. They need to feel safe and supported in their role, particularly given the chaotic, distressing and sometimes dangerous circumstances in which they work. We need to support and retain good and experienced social workers, and their expertise and knowledge within the system.

'You need time to spend with the young people. It's not about filling in forms. You can still be accountable for what you've done; you don't need to repeatedly fill in the same information. You need good, well informed, well trained managers with basic humanity. You need a safe space to feel you can be creative. You need to feel that if you do want to advocate on behalf of the person, that you won't get the sack, you won't get into trouble or make yourself out to be a troublemaker. You need to feel valued. You need to feel positive about your practice as well. It shouldn't all be about "have you done?" and "why haven't you done?"'

Social worker, in evidence to the CSJ

It is not just a matter of increasing the number of social workers. The careful selection of those who wish to train to become social workers is also extremely important. One witness said:

'One problem that I see … with social work training, is that the Government is putting money into new schemes, partly to just speed up the training, partly through criticisms that are strongly contested. One of the issues was "Are we getting the right calibre of people? Are we attracting high quality students?" It depends what you mean by high quality in terms of social work. It doesn't necessarily mean getting a first, it could be someone who has got a particular profile of academic capability but capacity to be resilient and face the difficult situations that social work is about. That tends to come from life experience, maturity.'

Many vulnerable children and young people are facing deeply complex and severe challenges, which some social workers are not being equipped with sufficient education, training and support to identify, understand and properly address. For example, attachment problems were a common thread in the cases that we reviewed. Yet they demonstrated that there is no uniformity of practice when it comes to responding to vulnerable children and young people with attachment problems.

'We don't heal children at the moment, unfortunately. Child protection protects children but we don't heal children.'

Senior Manager, Children's Services Department, in evidence to the CSJ

Of further concern are the obstacles preventing some social care teams from developing a learning culture. We believe that some social workers (amongst others) can also be hindered by a lack of relevant legal knowledge, and difficulties in applying the law to practice.

All these issues suggest that many social workers still find themselves struggling to help many vulnerable and complex families who desperately need support. It is essential that we engage in a national discussion about how their needs can be best met – by social workers and others – and, in doing so, debate exactly what it is that society wants social workers to do.

chapter two
Statutory mental health provision

2.1 Introduction

'We have inherited a 115-year-old psychiatric classificatory model which does little to aid our understanding as people don't fit neatly into diagnostic boxes and little account is taken of social and environmental risk markers. The importance of developmental influences such as early attachment on resilience is often alien to a lot of our services and we continue to focus existing resources on extreme and enduring problems – almost nothing on prevention. Consistency of approach is not there, and children and young people are falling through the gaps.'

Public Health Manager, Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT), in evidence to the CSJ[1]

'We're sitting on a ticking time bomb in this country; I honestly believe that in many areas we have turned our backs on children and parents experiencing hopelessness and despair … These children are the parents of tomorrow.'

CAMHS clinician, in evidence to the CSJ

2.1.1 Prevalence and cost of mental health problems[2]

There is a high prevalence of childhood mental health disorder in the UK. One in 10 children aged between five and 16 has a diagnosable mental health problem.[3] These include (but are not limited to):

1 It should be noted that the views expressed by the Public Health Manager, BSMHFT, throughout this report, are their individual views and may not represent those of BSMHFT

2 A 'rough guide' to mental health in the UK – including categories, and causes and effects of mental ill-health – can be found in Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, pp27–31

3 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, pxxi. YoungMinds has estimated that this amounts to almost 850,000 children; YoungMinds Mental Health Statistics [accessed via: http://www.youngminds.org.uk/training_services/policy/mental_health_statistics (07.02.14)]

- Between one in every 12 and one in 15 deliberately self-harm;
- Approximately 290,000 have an anxiety disorder;
- Almost 80,000 suffer from severe depression;
- Just over 510,000 have a conduct disorder; and
- Just over 132,000 have severe attention deficit and hyperactivity disorder (ADHD).[4,5]

The most common mental health problem in boys aged between 11 to 16 years old is conduct disorder; and in girls within the same age bracket it is emotional problems. However, both are also common in the opposite gender.[6]

It should be noted that the above data has been drawn from the last national survey undertaken by the Office for National Statistics – in 2004 (*2004 ONS survey*).[7] A follow-up survey was undertaken in 2007; however, it was a longitudinal survey and followed the same children.[8] There is no comparable national data on children below the age of five in England.[9] The last Adult Psychiatric Morbidity Survey was conducted in 2007 (*2007 APMS*) and published in 2009.[10] The lack of up-to-date information on the prevalence of mental health problems in children and young people is a source of great concern, particularly in light of the potential impact that the recession may have had on the mental health of this age group.[11] Indeed, back in 2010, Professor Sir Ian Kennedy had expressed his view that there was 'a barely detected epidemic of mental health problems in young people.'[12]

4 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, cited in YoungMinds Mental Health Statistics [accessed via: http://www.youngminds.org.uk/training_services/policy/mental_health_statistics (07.02.14)]. '"Conduct disorder" is the official, psychiatric term for serious antisocial behaviour' – for example, in American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV*, Arlington, Virginia: American Psychiatric Association, 1994, cited in Hagell A et al, *Key Data on Adolescence 2013*, London: Association for Young People's Health, 2013, p84

5 More recently, it has been established that the majority of those who self-harm are aged between 11 and 25 years old; Mental Health Foundation, *The truth about self-harm: for young people and their friends and families*, London: Mental Health Foundation, 2006; and Association for Young People's Health, *Adolescent self-harm*, London: Association for Young People's Health, 2013 – both are cited in Hagell A et al, *Key Data on Adolescence 2013*, London: Association for Young People's Health, 2013, p82. However, it is noted in *Key Data on Adolescence 2013*, that in light of self-harm being 'a very private behaviour and a very sensitive topic … there is a shortage of reliable information about young people who do not make use of [A&E] or other services'

6 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, cited in Hagell A et al, *Key Data on Adolescence 2013*, London: Association for Young People's Health, 2013, p78

7 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005. This report describes the prevalence of mental health problems among five-to 16-year-olds in 2004

8 The survey focussed on the persistence and onset of mental disorders among the children since the *2004 ONS survey*. It states that 'While the follow-up survey did not set out to examine prevalence of mental disorder, compared to the 2004 baseline there is little change in the number of children and young people at 2007 diagnosed with a disorder.' The children have not been followed-up on again since; Parry-Langdon N (ed), *Three years on: Survey of the development and emotional well-being of children and young people,* London: Office for National Statistics, 2008, p8

9 The follow-up survey of 2007 stated that 'Children under five were excluded in 2004 primarily because the assessment instruments for these children are different and not so well developed as those for older children;' ibid, p4

10 This report provides data on the prevalence of treated and untreated psychiatric disorder in those aged 16 and over in England. 13 per cent of males aged 16 to 24, and 22.2 per cent of females within the same age bracket, were found to have met the diagnostic criteria for at least one common mental disorder in the week prior to interview; National Centre for Social Research and University of Leicester, *Adult psychiatric morbidity in England, 2007: Results of a household survey*, The NHS Health and Social Care Information Centre, 2009, p40 [accessed via: http://www.hscic.gov.uk/pubs/psychiatricmorbidity07 (24.02.14)]

11 Hagell A et al, *Key Data on Adolescence 2013*, London: Association for Young People's Health, 2013, p78; and Oliva L and Lavis P, *Overlooked and forgotten: A review of how well children and young people's mental health is being prioritised in the current commissioning landscap*e, Children & Young People's Mental Health Coalition, December 2013, p14 [accessed via: http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/ (11.02.14)]. We discuss this further later in the chapter, in the context of commissioning

12 Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs,* September 2010, p72 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (21/02/14)]

Concern has also been raised over 'much' of the mental health data on those aged 16 to 25 being presented in wide age bands (within adult data), making it harder to understand information about this cohort. Where data is available in more narrow age bands, for example, in the *APMS*, 'each age band has a relatively small sample size, making it more difficult to generalise from this data and estimate local need.'[13]

Half of all lifetime mental health problems first emerge by the age of 14, and three-quarters by the mid-20s.[14, 15] Although more than half of all adults with mental health problems were diagnosed in childhood, less than half of them were treated appropriately at the time.[16] We know that those with the poorest mental and physical health and well-being live in our most deprived communities.[17] Children (and adults) from the lowest quintile (20 per cent) of household income are three times more likely than those in the richest quintile to have common mental health problems.[18] They are also nine times as likely to have psychotic disorders.[19] Approximately 40 per cent of children and young people in contact with the youth justice system have a mental health problem, and more than 90 per cent of those in custody.[20, 21] The prevalence of mental health problems is considerably higher in looked-after children and those adopted from care, than those who have not been in care.[22] In *Completing*

13 Oliva L and Lavis P, *Overlooked and forgotten: A review of how well children and young people's mental health is being prioritised in the current commissioning landscape*, Children & Young People's Mental Health Coalition, December 2013, p14 [accessed via: http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/ (11.02.14)]. We discuss this further later in the chapter, in the context of commissioning

14 Kim-Cohen J et al, Prior juvenile diagnoses in adults with mental disorder, *Archives of General Psychiatry,* 60, 2003, pp709–717; and Kessler R et al, Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, *Archives of General Psychiatry,* 62, 2005, pp593–602 – both cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p8 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

15 Kessler R and Wang P, The descriptive epidemiology of commonly occurring mental disorders in the United States, *Annual Review of Public Health,* 29, 2007, pp115–129, cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p8 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

16 Kim-Cohen J et al, Prior juvenile diagnoses in adults with mental disorder, *Archives of General Psychiatry,* 60, 2003, pp709–717, cited in YoungMinds Mental Health Statistics [accessed via: http://www.youngminds.org.uk/training_services/policy/mental_health_statistics (07.02.14)]

17 McManus S et al, *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*, NHS Information Centre for Health and Social Care, 2009, cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p9 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

18 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, cited in Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p93

19 Marmot M et al, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010*, The Marmot Review, London, 2010, cited in Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p93

20 Healthcare Commission, *A Review Of Healthcare In The Community For Young People Who Offend*, London: Commission for Healthcare Audit and Inspection, 2006, cited in *CAMHS Review – Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families and Department of Health, November 2008, p21 [accessed via http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399 (18.02.14)]

21 Department of Health, *Promoting Mental Health for Children in Secure Settings: A framework for commissioning services*, London: Department of Health, 2007, cited in *CAMHS Review – Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families and Department of Health, November 2008, p21 [accessed via http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399 (18.02.14)]

22 NICE states that 'About 42 [per cent] of children aged [five to 10] years who have been in care develop mental health problems compared with [eight per cent] who have not been in care; the figures for 11- to 15-year-olds are 49 [per cent] and 11 [per cent] respectively; NICE, *Children's attachment: final scope,* p5 [accessed via: http://www.nice.org.uk/nicemedia/live/14174/66022/66022.pdf (18.02.14)]

the Revolution: Transforming mental health and tackling poverty, the CSJ described the risk factors for poor mental health in children and young people.[23]

> The enormous cost of mental health problems to the economy in England has been estimated at £105 billion, and treatment costs are expected to double in the next 20 years.[24, 25, 26]

2.1.2 A brief overview of key developments since 2008

The final report of the national CAMHS Review (*2008 CAMHS Review*) found that since 2004, following Every Child Matters and the *National Service Framework*, there had been 'significant progress within all services contributing to mental health and psychological well-being.' However, it found that 'children and young people are still often receiving fragmented and inconsistent support,' and that 'support is still sometimes provided too late in a crisis, and information is not easy to come by.' It was recognised that what children, young people and their families/carers want is 'often quite simple … consistent relationships with people who can help and to be treated with dignity and respect.'[27]

Professor Sir Ian Kennedy reported, in 2010, on the cultural barriers in the NHS to children and young people's needs being met, and made a series of recommendations to address them. These included a call for urgent action to be taken 'to respond to the mental health needs of children and young people.' He stated that 'Mental health services must be available and accessible, including through self-referral, and be integrated with other services, particularly through schools.'[28]

The Department of Health subsequently set out its vision, in *Achieving equity and excellence for children,* in 2010, of how the NHS reforms could improve health services for children

23 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, pp95–105

24 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p2 and p10 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

25 This figure includes '£21.3 billion in health and social care costs, £30.3 billion in lost economic output and £53.6 billion in human suffering;' Centre for Mental Health, *The economic and social costs of mental health problems in 2009/10*, Centre for Mental Health, October 2010, cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p2 and p10 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

26 McCrone P et al, *Paying the Price: The cost of mental health care in England*, London: King's Fund, 2008, pp 220-226, cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p2 and p10 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

27 *CAMHS Review – Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families and Department of Health, November 2008, p5 and p8 [accessed via http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399 (18.02.14)]. Please see the mental health section of the legal foreword in this report for further information on the *National Service Framework*

28 Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, September 2010, p72 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (21/02/14)]

and young people.[29] It recognised that '… there is some way to go before services are truly child-centred,' and sought to address key issues identified with the services, including those raised by Professor Sir Ian Kennedy.[30, 31] In 2011, the Department of Health published '*You're Welcome*' – a ten point criteria for making health services children and young people friendly.[32]

The cross-government mental health strategy, *No health without mental health*, also published in 2011, claims to be 'both a public mental health strategy and a strategy for social justice.'[33] It contains the following six shared, cross-government and multi-agency mental health objectives, to improve mental health outcomes for all:

1. '***More people will have good mental health**: More people of all ages and backgrounds will have better well-being and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.*

2. ***More people with mental health problems will recover**: More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates, and a suitable and stable place to live.*

3. ***More people with mental health problems will have good physical health**: Fewer people with mental health problems will die prematurely and more people with physical ill health will have better mental health.*

4. ***More people will have a positive experience of care and support**: Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.*

5. ***Fewer people will suffer avoidable harm**: People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.*

6. ***Fewer people will experience stigma and discrimination**: Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.'*[34]

29 Department of Health, *Achieving equity and excellence for children, How liberating the NHS will help us meet the needs of children and young people*, September 2010 [accessed via: https://www.gov.uk/government/publications/achieving-equity-and-excellence-for-children (07.02.14)]

30 Ibid, p7

31 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p39 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

32 The criteria are based on examples of effective local practice working with those under the age of 20; Department of Health, *You're Welcome – Quality criteria for young people friendly health services*, May 2011 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf (14.02.14)]

33 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, pp2–3 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

34 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p6 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

Talking therapies constitute a critical priority area of *No health without mental health.*[35] In 2008, the Improving Access to Psychological Therapies (IAPT) programme was launched to provide psychological support within NHS-commissioned services in England, for those of working age with depression or anxiety. The Government has committed to spend an additional £400 million over four years to 2014/2015 on talking therapies which have been approved by the National Institute for Health and Clinical Excellence (NICE).[36] It aims to complete the roll-out of IAPT services across England for adults of all ages who have depression or anxiety disorders by March 2015.[37] In 2011, a stand-alone programme was initiated to extend access to psychological therapies to children and young people – the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT). The Government has invested up to £54 million in this programme.[38]

Progress has unquestionably been made in various respects with improving mental health services for children and young people in this country. We have discovered examples of good practice in a number of areas. However, as demonstrated by our Kids Company case review, and across our wider evidence, many vulnerable children and young people with mental health problems continue to face significant barriers in accessing, engaging with and obtaining appropriate care and support from primary and secondary care services. Tragically, some statutory mental health services are far from child/young person-centred, with many vulnerable children and young people suffering a huge injustice with respect to their well-being and mental health.

2.2 CSJ review of Kids Company cases

Our review of Kids Company's cases revealed that the vulnerable children and young people with mental health problems broadly had two different types of experience when it came to the provision of statutory support. They essentially either (a) failed to gain the care and support that they needed (and in circumstances where they were receiving social care intervention), or (b) were given some care and support but it was short lived and/or sporadic, and appears to have failed to address their needs. Examples of the former group include:

35 Ibid, p39; 'Psychological therapies, or talking therapies, refer to a range of interventions which are intended to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functionality;' Centre for Social Justice, *Completing the Revolution, Commissioning effective talking therapies*, London: Centre for Social Justice, April 2012, p9

36 In its report *Completing the Revolution: Transforming mental health and tackling poverty*, the CSJ emphasised the need for more accessible mental health services and early intervention to prevent problems from becoming entrenched. Although the CSJ welcomed the advent of the IAPT programme, it was clear that it needed developing and improving, particularly in terms of choice and accessibility, if people's needs were to be met. The CSJ has since published a follow-up report in which it reviewed the barriers to delivering cost-effective talking therapy nationwide using the full capacity of the existing national talking therapy workforce; Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p36; Centre for Social Justice, *Completing the Revolution, Commissioning effective talking therapies*, London: Centre for Social Justice, April 2012

37 Department of Health, *Talking therapies: A four-year plan of action*. A supporting document to *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, London: Department of Health, February 2011, p3 [accessed via: https://www.gov.uk/government/publications/talking-therapies-a-4-year-plan-of-action (13.03.14)]

38 IAPT, *New Resources for the Children and Young People's IAPT project announced* [accessed via: http://www.iapt.nhs.uk/news/new-resources-for-the-children-and-young-peoples-iapt-project-announced-today----/ (14.02.14)]. We discuss CYP IAPT further later in the chapter

- In one child's case, their social worker had made a referral to Kids Company and stated that counselling services might prove to be very useful to the child and their future outlook, should they wish to access them. However, there is no record of the social worker having made a referral to CAMHS;

- In Michael's case, social care had made a referral to CAMHS but there appeared to have been no follow-up. When the social worker finally discussed the matter with Michael, he decided he did not want support from CAMHS – a missed opportunity given that this therapeutic input may have been very beneficial for Michael, in light of his background;

- One young person had been referred to CAMHS but no therapeutic support was offered on the basis that they were considered not to have engaged when they attended their assessment;

- There appears to have been no CAMHS involvement in David's case;

- In another case, involving a child who suffered from depression, self-harm, and anger management difficulties, social care had considered making a referral to CAMHS but failed to ultimately do so;

- In one child's case, they had self-harmed, details of which Kids Company had provided in its subsequent referral to social care. However, there is no record of social care having made a referral for the child to CAMHS;

- In another child's case, they had made a suicide attempt, details of which Kids Company had provided in its subsequent referral to social care. However, there is no record of social care having made a referral for the child to CAMHS.

Examples of the latter group include:

- The support that Claire received from CAMHS after her case was reopened, following a referral to social care, was sporadic – largely it seems due to her engagement difficulties;

- Daniel succeeded in gaining four months of support from CAMHS, which we understand resulted from a referral by YOT. Kids Company felt that this did not meet his needs. His key worker told our researcher that:

  'Until [Daniel's] mental health concerns are addressed and he is in consistent, supported accommodation, there is every likelihood that he will commit further crimes.'

- Callie had not received support from CAMHS or AMHS; however, she did receive hospital treatment on a number of occasions and support from a Community Mental Health Team (CMHT). There was a key missed opportunity in Callie's case arising from a failure to explore her mental health problems in spite of a referral by Kids Company to social care;

- Following a CAMHS assessment, Joseph attended a number of CAMHS appointments and was prescribed medication. He took the medication at first, but suffered rare but known side effects and physically attacked his mother, Anna – the only time he did so. He stopped taking the medication after this. Following this incident, Anna and Joseph reportedly requested cognitive behavioural therapy (CBT) instead of medication, which was refused by CAMHS, before they then closed the case.[39] However, the CSJ notes that correspondence from CAMHS states that having attempted to contact the family without response, and confirming that Joseph had refused medication, CAMHS planned to close the case;

- In one child's case, they were not provided with individual therapy by CAMHS; instead CAMHS asked if Kids Company could provide this. CAMHS provided the child and their primary carer with family therapy for a period, before then closing the case;

- In Adam's case, social care had made an urgent referral to CAMHS, which agreed to produce a report for the SEN Tribunal. A year and two months after the referral was made, Kids Company recorded that CAMHS had confirmed that they would close Adam's case, that he did not meet their threshold, and that they did not recognise a mental health problem in him from a medical point of view;

- In another child's case, a referral was finally made to CAMHS by their PRU, despite social care having been involved in their case for a significant period of time. However, CAMHS ultimately closed the case due to the child's and their primary carer's disengagement.

In numerous cases that we reviewed, the children and young people have received support from Kids Company – by accessing direct therapy at their school and/or the charity's in-house mental health provision.[40] Those who have not received direct therapy have received therapeutic support from Kids Company key workers who are therapeutically trained.

The initial key questions that emerged from our review of the cases, in the context of this chapter, were firstly, why were some of the vulnerable children and young people not gaining access to statutory mental health provision and, secondly, why were the needs of those who did gain access to such provision apparently not met? In this chapter we explore the potential answers to those questions. Our witness evidence and literature review helped us to better understand the difficulties that can be experienced by vulnerable children and young people, as highlighted by our Kids Company case review. It opened up a number of key serious issues of concern, including:

- The ambition with respect to early intervention failing to materialise on the ground in some parts of the country;

- The barriers faced by some vulnerable children and young people with mental health problems in accessing, engaging with and obtaining appropriate care and support from primary care and secondary care services;

39 This information was disclosed by Anna
40 We discuss this further in Chapter Three

- The extent and impact of cuts to some CAMHS budgets and reduced resources – including, for example, higher thresholds being applied by some CAMHS services;
- Diagnosis and intervention issues;
- A lack of timely and/or appropriate care and support being afforded to some vulnerable children and young people – including, in particular, children with conduct disorder, children and young people who are exposed to street gang violence, and those with dual diagnosis; and more of a focus being placed on CBT in some areas as opposed to tailoring treatment to the individual needs of vulnerable children or young people;[41]
- Other constraints on effective and efficient use of resources;
- The long-standing issue of transition from CAMHS to AMHS; and
- Commissioning.

Another issue of grave concern is that some vulnerable children and young people with both social care needs and mental health problems, are not gaining access to timely and/or appropriate care, protection and/or support from social care or statutory mental health services. We discuss the lack of cooperation and coordination between some statutory services, which featured in numerous cases across our evidence, in Chapter Four.

2.3 Early intervention

> *'I understand that CAMHS are busy with very disturbed children, but … there's a lot of evidence that if you can support [them] in the early stages of their mental health problem, you can head it off at the pass, or at least prevent it from being so severe. But services are not geared to that because they have to be geared to those who actually have severe mental health illness because there isn't enough money or it's the way it's organised. I think we were … and are missing enormous opportunities to create massive difference in our CAMHS.'*
>
> **GP, in evidence to the CSJ**

No health without mental health emphasises the importance of promoting good mental health and of early intervention – 'particularly in the crucial childhood and teenage years,' thereby preventing mental illness from developing.[42] The CSJ reinforced the need for prevention through early intervention by including it as a key principle for mental health policy solutions for children and young people in *Completing the Revolution: Transforming mental health and*

41 Those with dual diagnosis are considered to have 'co-existing mental health and drug and alcohol problems,' HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p41 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

42 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p2 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

tackling poverty.[43] A powerful economic case also exists for mental health promotion, mental illness prevention and early intervention.[44]

However, in parallel with frontline child protection practice, our research has revealed that the ambition with respect to early intervention, in the context of mental health services for children and young people, is failing to translate to the ground in some parts of the country. Again, we have discovered a stark contrast between the aspiration and reality. In failing to intervene early with vulnerable children and young people with mental health needs, their problems may become more entrenched and enduring. They may also ultimately hit the statutory threshold, placing yet more pressure on some services that are already struggling to cope.

We have found repeated evidence of a lack of early intervention approach towards some vulnerable children and young people, including some of those exposed to street gang violence who may, for example, be suffering from potential unidentified PTSD. Instead, more of a crisis response is being taken in some areas towards those with severe mental health problems. We have also discovered deeply distressing evidence of some vulnerable children and young people with complex, severe and enduring mental health problems failing to obtain the necessary statutory support to meet their needs.

There are a number of factors which help to explain the barriers facing early intervention. Financial considerations appear to weigh heavily. We heard of the battle that can be faced to persuade commissioners, and sometimes senior NHS Trust executives, of the need to take an early intervention approach. A Public Health Manager, BSMHFT, explained that they are understandably nervous in the current climate but contested that:

> *'[it requires a] … top-down message giving senior executive groups permission to … do what needs to be done to … invest in prevention approaches … in partnership working … within our field in public and mental health, building resilience, creating that at the earlier stages, giving children and young people tools, giving teachers toolkits and methods to adopt more of this resilience work – to at least help reduce the lower level issues at that stage when they are becoming a problem … over time that will inevitably have an impact on reduction of chronic cases … '*

Our witness referred, in this context, to the fact that whilst we know that mental ill health accounts for 23 per cent of the total burden of disease in the UK, it only receives 13 per

43 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, pp105–106 and pp109–110. See also, Centre for Social Justice, *Breakthrough Britain: The Next Generation*, London: Centre for Social Justice, 2008; Allen G and Duncan Smith I, *Early Intervention: Good Parents, Great Kids, Better Citizens, London*: Centre for Social Justice and the Smith Institute, 2008; and Centre for Social Justice, *Making Sense of Early Intervention: A framework for professionals*, London: Centre for Social Justice, 2011

44 Knapp M, McDaid D and Parsonage M (editors), *Mental Health Promotion and Mental Illness Prevention: The Economic Case*, Personal Social Services Research Unit, London School of Economics and Political Science, January 2011

cent of NHS health expenditure.[45, 46] They added '*So there's a mis-match between the basic resource being offered to mental health and the amount of burden of care we know it accounts for within services.*'

> *' … within statutory services, funding tends to be very much targeted on providing therapeutic input for people who are quite unwell and generally not at all on the lower level mental health issues, which we know is the starting place for more severe problems over time … So that is a problem in that our remit isn't traditionally to start with children and young people as the problems are emerging, when issues could be "nipped in the bud" but to focus on the crises when people are … at a more severe stage in their mental health or mental disorder history … It's … like constantly fighting fires without investing in safe environments and smoke alarms.'*
>
> **Public Health Manager, BSMHFT, in evidence to the CSJ**

Particular concern was expressed over failures to treat the large proportion of children and young people with emerging mental health problems at the time that their problems are emerging. The profound implications of this on the individuals themselves, as well as for mental health professionals and statutory provision, quickly became clear. The same Public Health Manager, BSMHFT, referred to the fact that the opportunity is being missed to apply appropriate interventions for 60 to 70 per cent of those with emerging mental health difficulties at the time they are appearing – '*a shocking situation*.' Our witness explained that ' … *of course some of those affected will learn to cope by themselves, get by*.' However, they warned that many others do not have the basic resilience or support mechanisms in place to cope, and that:

> *'they will likely become the more acute and chronic cases at a later stage where, very often, more negative coping behaviours are becoming entrenched which makes it more difficult for clinicians and services to actually work with individuals in any kind of positive way. So we are setting ourselves up by not adopting a preventative ethos at the most appropriate time. We're really setting ourselves up for huge pressures on systems further downstream, which are in many cases overwhelming the current provision.'*

A Service Development Manager, BSMHFT, also explained that there has been a focus on working with the more severe and enduring mental health problems, so that where it is recognised that there is a clear mental health diagnosis, there are more likely to be protocols and interventions to deliver.[47] They said:

> *'We haven't been that targeted on the preventative side of mental health and seeing where these difficult complex cases can be intervened with at a much earlier point*

45 World Health Organisation, *The Global Burden of Disease: 2004 update*, 2008, cited in Centre for Economic Performance, and The London School of Economics and Political Science, *How Mental Illness Loses Out In The NHS*, June 2012, p2 and p7 [accessed via: http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf (07.02.14)]

46 NHS mental health expenditure (England, 2010/2011), cited in Centre for Economic Performance, and The London School of Economics and Political Science, *How Mental Illness Loses Out In The NHS*, June 2012, p2 and p10 [accessed via: http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf (07.02.14)]

47 It should be noted that the views expressed by the Service Development Manager, BSMHFT, throughout this report, are their individual views and may not represent those of BSMHFT

and achieve better long-term outcomes. You shouldn't have to wait until there's a clear diagnosis and then come in through the traditional route, because these children and young people won't use the traditional route … They will hit our secondary care services eventually, they just might have spent a few years getting there and we've missed again that chance of doing something at that early point. Also by then we could be dealing with very entrenched complex presentation which is going to take years and years of mental health services to either support or manage ongoing risk.'

It appears that barriers to an early intervention approach are indeed causing severe pressures within and outside of the mental health system. For example, our attention was drawn to those faced by A&E departments across the country. In England over the past 10 years inpatient admissions for children and young people had increased by 68 per cent due to self-harm.[48] The national charity, YoungMinds, which is committed to improving the well-being and mental health of children and young people, has warned that '100,000 children and young people could be hospitalised due to self-harm by 2020.'[49] The same Service Development Manager, BSMHFT, commented:

' … we see time and time again how many children and young people are in distress and present with overdosing behaviours and that's where they're going as their first port of call … their entrance in … [is] through an A&E department. It is wrong if that's the only recourse they've got … when they're in that sort of position. There's something about our front door, about how mental health services are receptive to this group – why are we waiting until they get to that serious point and then we intervene? If somebody has had 10 trips to A&E, it should have been at point one or point two rather than at the 10th visit that they get help.'

Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, explained the challenges which exist, in the context of reduction in services and efforts to reduce costs on the one hand, and continuing legal obligations towards children and young people on the other.[50] Dr Fuggle believes that one of the potential risks of the emerging situation is that the costs of providing for the needs of children and young people may increase with the reduction of services, leading to '*some perverse difficulties … So you are reducing services, but not actually saving any money. You're not saving money at all.*' Dr Fuggle said that the '*concrete examples*' of this will be the number of those coming into care, hospital and specialist education. Dr Fuggle believes that there is a risk that those will rise, and there is a whole legal infrastructure around them. He gave a current example:

48 Jo Swinson is also reported as stating that 'Worringly these figures are only the tip of the iceberg as they only record hospital inpatient admissions. The true figure of how many children and young people are self-harming is likely to be far far higher,' cited in YoungMinds, *100,000 children and young people could be hospitalised due to self-harm by 2020 warns YoungMinds*, 2 December 2011 [accessed via: http://news.cision.com/youngminds/r/100-000-children-and-young-people-could-be-hospitalised-due-to-self-harm-by-2020-warns-youngminds,c9194954 (07.02.14)]. It should be noted that 'A minority of people who are self-harming will end up in hospital … ;' Hagell A et al, *Key Data on Adolescence 2013*, London: Association for Young People's Health, 2013, p82

49 YoungMinds, *100,000 children and young people could be hospitalised due to self-harm by 2020 warns YoungMinds*, 2 December 2011 [accessed via: http://news.cision.com/youngminds/r/100-000-children-and-young-people-could-be-hospitalised-due-to-self-harm-by-2020-warns-youngminds,c9194954 (07.02.14)]

50 It should be noted that the views expressed by Dr Fuggle throughout this report are his individual views, and not those of Islington CAMHS

'The cost of highly specialist, and particularly residential care for children and young people is astronomical. That wipes out my prevention budget for a whole year. You don't need many of those cases until your prevention budget for working with schools in the borough will disappear just like that. The degree to which anybody has the capacity to plan for that is very limited. We have a legal obligation to kids with particular requirements; we can't just say we haven't got the money … Some of those costs are not within the local managers' or service managers' remit. They can't just say we will prioritise prevention. Very few people would really argue against the prioritisation of prevention.'

Dr Fuggle added that in the day-to-day-delivery of services there are '*perfectly reasonable*' legal obligations towards children and young people with high levels of need – the difficulty is the cost of those. Whether those costs are reasonable is a different question, but in the specialist areas, that is the cost. Dr Fuggle went on to explain:

'That to me is one of the major anxieties of the reduction in services, that they won't even achieve their rather narrow objectives if they're reducing costs. That could lead us to even more difficulties so we get into a more perverse cycle of which we get into more and more targeted provision, and more and more specialist provision. And all the more universal type of provision [towards well-being], often focussed in schools and nurseries will become more and more vulnerable. That will lead to greater risks and kids coming back in – you get into a perverse cycle. It is the perverse cycle I am nervous about.'

We also heard about a worrying lack of understanding and knowledge regarding the importance of using evidence-based early intervention on the part of some commissioners. Dr KAH Mirza, a senior CAMHS clinician and academic working at the Maudsley NHS Trust, told us:

'[Early intervention and prevention] are wonderful words, but there is a big difference between rhetoric and reality. What is being flogged as early intervention/prevention varies enormously across the boroughs and is not informed by the rich body of research evidence as to what works in practice.[51] *Many people responsible for commissioning the multi-agency early intervention services do not know the difference between primary versus secondary and tertiary prevention. For example, one of the commissioners I came across opined that "anything that CAMHS do to prevent children from being admitted to hospital is prevention!"'*[52]

Dr Mirza referred to there being a robust body of evidence for school-based interventions dating back to the 1970s, and plenty of evidence for community based systemic interventions to reduce emotional and behavioural problems in children, including substance misuse.[53] However, he informed us that '*very often*' the early intervention services which are jointly

51 Dr Mirza highlighted the following for information regarding evidence-based early interventions: Bronfenbrenner U, Is Early Intervention Effective? *Day Care and Early Education*, 2(2), 1974, pp14–18; and Faggiano F et al, School-based prevention for illicit drugs use, *The Cochrane Database of Systematic Reviews*, (2), 2005, CD003020

52 It should be noted that the views expressed by Dr Mirza throughout this report are his individual views, and do not represent those of South London and Maudsley NHS Trust, or any other organisation that Dr Mirza works for

53 This included: Rutter M et al, *15,000 Hours: Secondary Schools and Their Impact Upon Children*, London: Open Books, 1979; and Kolvin I et al, *Help Starts Here: The Maladjusted Child in the Ordinary School*, London: Tavistock Publications, 1981

funded by the local authority and CAMHS, are '*decreed by the whims and fancies of the local commissioners, who are either blissfully unaware of the evidence base or do not care to find out whether the interventions they offer make a difference to the lives of children.*' Dr Mirza added '*It is high time that the funding process, management structures and outcomes of the so-called Tier 2 CAMHS are subjected to thorough scrutiny,*' and that early intervention '*should be informed by the evidence base in literature*, and '*not subjected to the vagaries of mindless management and frequent funding cuts.*'[54]

One VSO told us that where there is an effective CAMHS Tier 2 service, either run jointly with the local authority, contracted out, or run by health, there is better support for children before they hit high-level crisis. This can either avoid the need for more intensive intervention, or ensure that the children are referred on in a more timely manner. Given the huge pressure which currently exists on the system, our mental health professionals must be supported, as far as possible, to be able to work preventatively. It is in everyone's best interests and it is wholly counter-productive not to do so.

> *'It is difficult to access early intervention and support for children and young people, and I think probably more so now because there have been more cuts.'*
> **GP, in evidence to the CSJ**

Due to financial pressures and reduced resources – including a lack of specialist provision – some CAMHS thresholds have heightened (as discussed shortly), with services becoming more tightly targeted.[55] A VSO practitioner told us that given CAMHS' '*very strict criteria*' for access to their services, early intervention, to prevent future mental health problems, '*is not explored.*'

Shocking evidence has emerged recently, of an escalation in the number of children in England with mental health problems being treated on adult psychiatric wards. Many are also having to travel great distances from their homes for hospital treatment. Cuts to mental health services – particularly CAMHS, are said to explain the increased difficulty in caring for these children in the community, thereby placing further pressure on inpatient services. The CEO of the mental health charity, Sane, reportedly stated that:

> *'The traumatisation of young people exposed to often frightening conditions on adult wards is another symptom of the crisis in the mental health system and is the predictable result of both the acute shortage of beds for all ages and the cuts to local community services.'*

The CEO of YoungMinds reportedly stated that the increase in children being placed on adult wards is 'predictable following cuts to early intervention services over the last four years.' They added 'The lack of help early on means we are letting children's problems escalate to serious levels.' The CEO also referred to the lack of accurate data on the mental health

54 We discuss how CYP IAPT may improve this landscape later in the chapter

55 However, one NHS Trust was reported to be expanding its range of early intervention services; YoungMinds, *CAMHS Cuts Survey – 'Staff Morale in CAMHS has dropped to its lowest ever,'* YoungMinds Magazine, Issue 118, Winter 2012/2013, p27. Please also see examples of local authorities and the NHS investing in early intervention as referred to in the profile of BOND in Appendix 7

needs of children resulting in commissioning which 'has been based on out-of-date, inaccurate information, leading to out-of-date provision.'[56]

We heard about the wider impact of a toxic mix of higher CAMHS thresholds and lack of other mental health provision (for example, provided by VSOs) in some areas, on some vulnerable children and young people, as well as others. One SHS practitioner stated that where limited resources exist to support children and young people who do not meet the CAMHS threshold '*this is normally put back onto the school and parent to address*.' Indeed, evidence shows the alarming extent to which some schools are lacking the necessary resources and specialist support to help address mental health problems.[57] We also highlight below the challenges presented to some GPs in this context. It seems that some social workers are also facing difficulties in ensuring the appropriate provision of mental health support for some vulnerable children and young people.

> *'The amount of young kids who are self-harming, but because they're not cutting the s*** out of their arms, to shreds, they're not entitled to services from CAMHS. CAMHS say "it doesn't meet our criteria"… Which means that a whole load of children are being left, because we as social workers, we don't specialise in this stuff … and it comes back to us not knowing what services are available, so we have nowhere to go. So we leave these kids floating, knowing [about their self-harming], and we then keep moving on to new issues and just leave the stuff on the system. But it never gets dealt with. And everyone looks at today rather than yesterday.'*
>
> **Social worker, in evidence to the CSJ**

We learned about the pressure being placed on some early intervention services due to the complexity and severity of the mental health needs of some vulnerable children and young people they can be required to support. A CAMHS clinician described the reality, in the context of the haemorrhaging of statutory services, reduction of staff and cases being pushed down to the next available place:

> *'There are services which are resourced and designed to be early interventionist, to prevent increased severe mental health problems in the future. But that's not how it works out in practice. But that's the theory. We're not supposed to be dealing with complex, severe, long enduring problems that come in but we are often involved in cases like that.'*

Our witness went on to explain:

> *'… where we are now in my area, there are no services for children that offer much more than six sessions. Children with very complex difficulties, long histories of trauma,*

56 BBC News, *Rise in children treated on adult mental health wards*, 20 February 2014 [accessed via: http://www.bbc.co.uk/news/education-26255533 (21.02.14)]. We discuss the lack of accurate, up-to-date data in the context of commissioning later in the chapter

57 The Guardian, *Massive rise in disruptive behaviour, warn teachers*, 24 March 2013 [accessed via: http://www.theguardian.com/education/2013/mar/24/schools-disruptive-behaviour (09.05.14)]; Teacher Support, *Primary school teachers report decline in pupil behaviour with damaging effects for their mental health and ability to teach*, 13 February 2014 [accessed via: https://www.teachersupport.info/node/509#.U0bMCF7mOGI (09.05.14)]; and The Guardian, *Teachers left to pick up pieces from cuts to youth mental health services*, 15 April 2014 [accessed via: http://www.theguardian.com/education/2014/apr/15/pupils-mental-health-cuts-services-stress-teachers (09.05.14)]

multiple dysfunctional relationships around them, there's nothing for them … There is a huge variety of people doing … dilute, low level early intervention emotional work with children and it is done by unqualified workers. Nobody wants to pay for therapy or, if they do, they want it fixed in very few sessions which is unrealistic … I think the other problem we've got is not only have we got very few skilled people and few resources to offer, but we're also very much wanting to say "this is what we've got, and this is what you have to have and if you don't want that then there's nothing we can do."'

It appears that existing resources in some areas are not being tailored to meet the particular mental health needs of some vulnerable children. They are instead expected to fit into what is available and offered. In addition, concerns have been expressed over some of those working with vulnerable children with mental health problems not being equipped with the relevant training, skills or experience to meet their needs. Our witness went on to explain that very few people working with children that they had come across are being given any training – specifically in working with children for whom they are providing therapy. They reported that there are people who are feeling '*very unskilled*' doing it, and that:

'Within schools, they will use teaching assistants to do this type of thing. It's very dangerous because what you'll end up with is … you go to TAC meetings, and they'll say "Johnny has had counselling." But if you ask more questions about it, like what the qualifications of the person were, did the child engage with it, nobody can answer. So we don't know what he's had, but on his file it says counselling, and that becomes a fact … but he might not have [had it].'

This is extremely concerning, particularly given that children (and young people) can often find it very hard to describe their mental health problems in a way which might allow even mental health practitioners to recognise what their problems are. As a Public Health Manager, BSMHFT, explained to us:

'Children and young people very often don't have the mental health literacy to be able to describe the sort of emotional distress or mental health difficulties that allow … most clinicians or GPs to really recognise what's going on. They're more likely to talk about … physical symptoms such as headaches or having problems with family members. Only with a lot of specialist training and experience will an experienced clinician or specialist in youth mental health be able to really identify what's going on and pull out the core issues.'

It also raises an issue with respect to the accurate identification of mental health problems. There is a vital need for those working in early intervention/universal services to receive appropriate training and support with respect to their potential to identify mental health problems in vulnerable children and young people.

Completing the Revolution revealed that: 'On many occasions, the Review was told that mental services urgently need to be based on a family-centred approach, not divided up between children and adolescents and adults. This is because the mental health of other members of the family is affected by one person's disorder. We were told, for example, that "children are coping with adult personality disorders," and the adverse impact of parental mental health has been well-documented.'[58]

We do not have a comprehensive and up-to-date understanding of the extent of mental health problems experienced by children and young people; neither do we have an accurate figure of those who are experiencing parental mental ill health.[59] A CAMHS clinician highlighted the extent of challenge that can be faced in the context of vulnerable parents with mental health problems: '*Very often, this is where the gate keeping comes in…you can't make artificial distinctions between a parent's mental health and a child's. But we do.*' They said that if a professional contacts them with concerns about a parent's mental health, and their attitude to their child, then unless the child is presenting with something that is deemed to be a mental health problem, they cannot get involved: '*Yet, unless that parent's mental health changes, that child's world is not going to change.*' They added that perhaps the parent will access AMHS but stated that the way those services are set up now '*is even more concerning*:'

> *'Because everybody now seems to be offered CBT, but even before that the person may have to do other things like groups or self-help, and if that doesn't work then they might be offered individual work, but it will be CBT. CBT is not for everybody. A vulnerable parent often won't engage in any of this, so they get nothing.'*[60]

2.4 Primary care

> *'It's one of the things we are trying to address – accessing primary care … how to make [it] more children and young people friendly and to raise awareness. It's a constant battle because it's not incentivised from the top. It's going around in circles.'*
>
> **GP, in evidence to the CSJ**

Our research has revealed that some vulnerable children and young people continue to face a number of barriers with respect to accessing, engaging with and obtaining appropriate care and support from primary care.[61] Some are not registered with a GP where, for example,

58 *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p108. One of the key principles for mental health policy solutions for children and young people contained in the report was a public health perspective. The CSJ recommended that 'As part of a public mental health approach…all parents (regardless of the age and developmental stage of their children) have access to high quality support and parenting programmes through children's centres, family hubs, schools, GP surgeries or other community-based locations; ibid, pp105–106 and p115

59 The NSPCC estimates that between 50,000 to more than two million children are experiencing parental mental ill health; Jütte et al, *How Safe Are Our Children? 2014*, March 2014, p14 [accessed via: www.nspcc.org.uk/howsafe [(24.04.14)]. As previously stated, 'The vast majority of parents with a mental health problem do not abuse their children;' ibid, p13

60 We found a number of cases of vulnerable parents with mental health problems who were understood by Kids Company to have slipped through the net of professional care. While their needs remain unmet, they can have a severe impact on the welfare, emotional well-being and behaviour of their children

61 We also discuss the barriers that they can face with CAMHS and AMHS later in the chapter

they do not have a functioning parent and/or are neglected. They might not therefore even be known to a GP. It appears that teenagers, in particular, are less likely to use GPs – even less likely, it seems, when they are marginalised. This is particularly concerning given the emerging mental health problems in this key vulnerable age group.[62]

> *'Teenagers use GPs less than any other part of the population. [They] rarely use GPs. GPs are fine as a method where you have a caring parent who is identifying a need in their offspring. Then the GP system works well … But the kind of kids you're focussing on … this is where the system is not in place. GPs are pretty irrelevant to this group.'*
> **Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, in evidence to the CSJ**

Some children and young people do not realise that they can go to see a GP about concerns they may have regarding their wellbeing and/or mental health, and are not aware of when it is appropriate to access services. A Service Development Manager from BSMHFT told us: '*… quite a few of our children and young people will not have GPs or will not have seen their GP for years. They wouldn't necessarily see the GP as their first port of call … a lot of the children and young people we work with don't always associate mental health issues as a GP problem … they don't really know where to go for mental health …* '

> *'… I think that they don't realise that it is okay to go and speak to your GP about your mood. Often if you talk to children and young people, they say "I didn't see my GP because I didn't think it was appropriate to talk to them about how I was feeling …" There's a blockage in [that] if children and young people are not coming forward, you can't help them …'*
> **GP, in evidence to the CSJ**

A UK Youth Parliament survey found that over a third of the children and young people who responded would not consult their GP about certain issues, including mental health.[63] However, those who are vulnerable are likely to find this even more challenging. Even where they do access primary care, the relevant general practice may not be set up to deal effectively with the realities that they can face. For example, some have very chaotic and/or transient lives. This can raise barriers to their meaningful engagement with a traditional general practice model. It can also present some GPs with difficulties. As one GP told us:

> *'I think certainly in [this local authority], we know there is a hugely mobile population. I think it is difficult for GPs because we are constantly having a huge turnover. I think if you get the notes, if there is anything in there about vulnerability that should be documented, and that should be on the notes, but you don't necessarily see [that]. Again, that's part of this issue regarding access to primary care.'*

62 However, some VSOs, like Kids Company, are performing a vital role in supporting vulnerable children and young people to register with a GP and to attend their appointments, as referred to in Chapter Three

63 A study of children and young people's experience of primary care – particularly their views and experiences of GP services, was undertaken in 2010 to 2011, by the UK Youth Parliament for the Office of the Children's Commissioner for England. Findings from the study were referred to in Office of the Children's Commissioner for England, '*It takes a lot of courage': Children and young people's experiences of complaints procedures for services for mental health and sexual health including those provided by GPs*, July 2012, cited in The National Children's Bureau, *Opening the door to better healthcare: Ensuring general practice is working for children and young people*, May 2013, p13 [accessed via: http://www.ncb.org.uk/media/972611/130603_ncb_opening_the_door_to_better_healthcare_final.pdf (14.02.14)]

It appears that some GPs are not developing an informed understanding of the circumstances and needs of some of the vulnerable children and young people who they see. Another GP explained to us that unless a child or young person is registered with a GP fully, their records will not follow them. Unless they stay with a GP long enough for one individual to see them more than two or three times, to have the time to read through their records, then no GP will ever actually get to the bottom of what their problem is. This is assuming that their records actually catch up with them, which we were told takes about six weeks. We heard that this, in turn, can present further difficulties when it comes to referring a child or young person on, and also for the professionals who receive the referral. However, all the while, the vulnerable child or young person can remain in crisis, and can be passed around the system without receiving the support that they may desperately need.

> *'Probably somebody comes to see you in crisis; you don't have the records because they haven't been with you long enough. So you send off a referral without much background … By the time they get to the statutory service, they don't turn up so then they get discharged for not having been seen. Then you just go round and round in circles. The child might move, and therefore have to change GPs each time.*[64] *The notes never catch up, and the referrals never catch up with each other. The statutory agencies are also geographically bound to a certain extent. If a referral does finally get through, you find that "oh sorry you're in the wrong postcode; you have to go somewhere else."'*
>
> **GP, in evidence to the CSJ**

We are also concerned about the quality of care and support experienced by some vulnerable children and young people from primary care services. YoungMinds revealed that children and young people with mental health problems felt that 'many GPs lacked understanding, awareness, empathy and interest, and were reluctant to provide certain types of support.'[65] A qualitative study of care leavers (aged 17 to 24) found that they '… were very critical of GPs … Some said they would not feel able to talk about mental health issues to the doctor because they did not trust them or thought they would not be interested.'[66] Continuity of care and the ability to form a trusting relationship are particularly important for vulnerable children and young people, many of whom suffer with attachment problems and can find it difficult to develop trust. The aforementioned study found that 'some experienced good relationships with doctors or practice nurses, these tended to be [those] who had a regular consultation with a single practitioner, but being able to do so was not a typical experience because of frequent housing moves.' [67]

A GP explained that increasingly, practitioners never see the same person twice, and that if a second appointment is made, the practitioner they saw the first time might have moved on. We were told that very often, this can happen in general practice, and that if a vulnerable

64 We refer to the forthcoming change under the General Medical Services contract with respect to patients' choice of GP practice below

65 Lavis P and Hewson L, '*How many times do we have to tell you?*,' YoungMinds Magazine, 109, 2010, pp 30-31, cited in The National Children's Bureau, *Opening the door to better healthcare: Ensuring general practice is working for children and young people*, May 2013, p7 [accessed via: http://www.ncb.org.uk/media/972611/130603_ncb_opening_the_door_to_better_healthcare_final.pdf (14.02.14)]

66 Cameron C, Access to health services: Care leavers and young people 'in difficulty,' *ChildRight*, 238, 2007, pp22–25, cited in The National Children's Bureau, *Opening the door to better healthcare: Ensuring general practice is working for children and young people*, May 2013, p6 [accessed via: http://www.ncb.org.uk/media/972611/130603_ncb_opening_the_door_to_better_healthcare_final.pdf (14.02.14)]

67 Ibid, pp6–7

child or young person presents in crisis, they will be allocated to whomever is available at the time. They might be given an appointment with a locum doctor – it might be with a junior doctor. It is less likely to be with a partner unless there is something which highlights that the child or young person is someone who needs special attention. The lack of continuity of care and relationship afforded to some vulnerable children and young people can present another barrier to their engagement with primary care, and to GPs in building an understanding of them and their needs. Without trust, it may not be possible for a GP to get to the root of a vulnerable child or young person's difficulties. If they have to see different practitioners each time, it can become even more challenging for them, and also for the GP.

We heard that in one general practice, they '*tend to steer*' their highly vulnerable children and young people to one of the partners. This is on the basis that the partner is more likely to see them the second time and, on occasions in the future if, for example, the child or young person moves away from the practice and returns a year or more later, as sometimes happens.[68] We were also told that GPs and their staff are likely to know who their highly vulnerable children and young people are once they start being seen at the practice, though there may be those they are unaware of. The GP explained that, ideally, a partner would see all the children and young people who are vulnerable '*but it is just not possible at present.*' However, the general practice is moving to an all partner model to ensure consistency and quality, so it is hoped that this will improve. The GP also explained that if a partner has been dealing with families for a period of time, they get to know which parents are likely to have difficulties, because they know their medical/mental health/substance misuse history. However, we were told that it is sometimes difficult for them to link which parents and siblings '*belong*' to each other, due to differing names/partners, and fact that sometimes not all of the family are registered with the same GP. Police have been known to describe such familial structures as 'a brambled genealogy,' which can present professionals with additional challenges.

The two most common routes through which children and young people are referred to specialist NHS services – including, for example, CAMHS – are GPs and A&E.[69] Again, some of those who are vulnerable, are not even registered and/or struggle to engage with primary care. However, it seems that further difficulties exist. One of the reform initiatives includes improvements to the acute care pathway. *The economic case for improving efficiency and quality in mental health* gives examples of approaches which may help to achieve a reduction in savings in this respect. These include 'improving recognition of mental health problems in primary care to ensure effective early treatment and referral to secondary care services where appropriate,' with a view to reducing the need for inpatient care.[70] However, it appears that where some GPs are recognising mental health problems, they can face difficulties in securing the necessary support for patients from secondary care services, due to them not meeting the thresholds (as discussed shortly).

68 We were told by the GP that there are salaried GPs who remain in practices for many years who fulfil this role equally well but that generally salaried GPs do not stay at a practice as long as a partner does

69 Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs,* September 2010, p21 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (21.02.14)])]

70 Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages, Supporting document – The economic case for improving efficiency and quality in mental health,* 2011, p12 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (25.10.13)]

> *'… often referrals get knocked back because they don't meet the threshold. It happens in adult services as well, they're really stretched. I think people underestimate often the amount of mental health that GPs do, and the amount of severe mental health we manage in primary care. I don't think people are generally very aware about the level of risk … and the severity of depression … and self-harm that we manage – that we don't refer.'*
>
> **GP, in evidence to the CSJ**

This in turn is placing further pressure on some GPs – due to the level of risk, and complexity and severity of need that they are being left to manage. We heard that there is a gap in the provision that GPs are able to draw upon in these cases in some areas. Indeed, as a Public Health Manager, BSMHFT, recognised:

> *'… GPs are crying out for … the right sort of support. They are seeing these cases of self-harming, suicide risk, depression in children and young people but when they attempt to make a referral they are told that these children and young people aren't meeting the basic thresholds for intervention that our clinical services are having to set in the current climate.'*

This of course raises concerns over the local commissioning arrangements in some areas.[71]

The Well Centre (TWC): An Example of Innovative, Good Practice

TWC was founded by Dr Stephanie Lamb, GP Principal at Herne Hill Group Practice, and John Poyton, CEO of youth health charity, Redthread. It is based in Streatham, in South-East London, and was launched in October 2011. TWC is a youth health hub, where children and young people (aged 13 to 19) can access integrated primary health care, youth work and CAMHS early intervention provision, under one roof.

TWC is open five days a week. It runs a drop-in service on three afternoons a week – staffed by a GP, youth worker and CAMHS nurse counsellor. On the other two days of the week, the youth work team runs projects, including outreach in local schools.

'TWC has made progress in reaching out to a cohort of young people some of whom are clearly excluded, vulnerable and with complex needs … Despite this brief time frame much was achieved and there is excellent long term potential if TWC and its work has the opportunity to become more fully established. Young people liked the service and their sometimes complex needs were being met…'[72]

Furthermore, an important question arises over the extent to which the mental health needs of such vulnerable children and young people are being met, in light of concerns having been raised about the lack of mental health training and expertise of some GPs.[73] Back in

71 We discuss commissioning later in the chapter

72 Corlett S et al, *An Evaluation of The Well Centre, Streatham*, Final Report – Executive Summary, London: London South Bank University, June 2013, p4 and p8

73 In evidence to the CSJ and, for example: Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, pp177–178; Centre for Economic Performance, The London School of Economics and Political Science, *How Mental Illness Loses Out In The NHS*, June 2012, pp18–19 [accessed via: http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf (07.02.14)]; and The National Children's Bureau, *Opening the door to better healthcare: Ensuring general practice is working for children and young people*, May 2013, p16 [accessed via: http://www.ncb.org.uk/media/972611/130603_ncb_opening_the_door_to_better_healthcare_final.pdf (14.02.14)]

2010, Professor Sir Ian Kennedy found that '… there are significant shortages of professionals trained to care for young people with mental health problems at a time when an epidemic of such problems lies beneath the surface of society.' He identified 'a pressing need to train GPs and others who work with them,' and found that 'The current level of training is poor and getting worse.' [74] Various recommendations have been made since with respect to improving GP training, skills, and expertise.[75]

Currently, less than half of GPs participate in paediatric or psychiatry training placements during their training – a key reason why the Royal College of General Practitioners (RCGP) called for an enhanced and extended four-year training programme.[76] In 2012, Medical Education England approved the RCGP's proposal for this. In October 2013, following an independent review chaired by Professor David Greenaway, *Shape of Training* found that '… GPs will probably need at least four years of training to meet their outcomes and enter professional practice.'[77] In January of this year, the RCGP called for the four-year programme to include specialist training in child health and mental health.[78]

However, the Department of Health has reportedly stated that it will set out its final position on four-year training in 2015, when it responds to *Shape of Training*. The General Practitioners Committee (GPC) has reportedly stated that "approval for extended GP training was needed 'immediately' as there was an urgent need to give trainees the skills to deal with modern general practice."[79] It is imperative that trainees and GPs are equipped with the requisite support and skills to address the mental health needs of children and young people, where appropriate. So too must sufficient resources be available for them to secure specialist intervention for their patients where it is required.

Where vulnerable children and young people do gain access to secondary care services, some can face further barriers to engagement due to a lack of continuity of care and consistent relationships.

> *'The other thing about any mental health service, or health services generally, is the lack of continuity of care … I've had quite a few patients say "I'm not going back because I have*

74 Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, September 2010, p13 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (21.02.14)]

75 For example, Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p178; Centre for Economic Performance, and The London School of Economics and Political Science, *How Mental Illness Loses Out In The NHS*, June 2012, pp18–19 [accessed via: http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf (07.02.14)]; and as highlighted and made in The National Children's Bureau, *Opening the door to better healthcare: Ensuring general practice is working for children and young people*, May 2013, pp18–19 and 29 [accessed via: http://www.ncb.org.uk/media/972611/130603_ncb_opening_the_door_to_better_healthcare_final.pdf (14.02.14)]

76 PULSE, *GPs to train alongside psychiatrists under RCGP four-year training plan*, 15 January 2014 [accessed via: http://www.pulsetoday.co.uk/revealed-rcgp-plans-to-extend-gp-training-to-four-years/13714508.article (25.02.14)]

77 Greenaway D, *Shape of Training: Securing the future of excellent patient care*, October 2013, p53 [accessed via: http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf (25.02.14)], cited in GP, *Fund four-year GP training now, RCGP says*, 31 October 2013 [accessed via: http://www.gponline.com/News/article/1219004/Fund-four-year-GP-training-now-RCGP-says/ (25.02.14)]

78 GP, *GPs need specialist child and mental health training, says RCGP*, 16 January 2014 [accessed via: http://www.gponline.com/News/article/1227458/GPs-need-specialist-child-mental-health-training-says-RCGP/ (25.02.14)]

79 PULSE, *Four-year GP training implementation set for delay*, 20 February 2014 [accessed via: http://www.pulsetoday.co.uk/sign-in?rtn=your-practice/practice-topics/education/four-year-gp-training-deadline-in-doubt-as-ministers-delay-decision-until-2015/20005901.article (25.02.14)]

> *to keep saying the same things over and over again and I'm fed up of it …" There is a lot to be said for, if you want to make a significant impact on children and young people, the trust and continuity is very important … I think people under-estimate, if they look at their Did Not Attend [DNA] rates or their engagement rates generally in secondary care … the importance of continuity of care. I think that's a barrier to engagement.'*
>
> **GP, in evidence to the CSJ**

A GP explained that it is the nature of any service – and the system to an extent cannot work without it – that there is a team of more junior people, and with more experienced people at the top. Those at the top cannot see everybody, so inevitably an individual is seen first for an assessment by a more junior member of staff, who will discuss the case with someone more senior – a consultant. But the next time the individual comes, if they do return, the more junior member of staff might well have moved on. If they have not, they might establish a relationship for two to three sessions, and then they will move on, be promoted, or be given a different case load. However, the consultant stays. The GP stated:

> *'The ideal situation would be where you have a fixed GP who can talk to a fixed consultant and the kid in the middle knows them both, has a good relationship with them both and everybody is talking to each other, no matter what is happening all around them. With these kids who have a lot of chaos and movement in their lives, it would be nice if we could establish some fixed points for them. That would help things, I think, for them. That's our thinking. We are trying to find one fixed point in general practice that they can come to and an easy way in to statutory services …'*

Hope has been expressed that the situation should improve in light of the General Medical Services contract changes which apply from April 2014, a key change being that patients will have a choice of GP practice. From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas, without a duty to provide home visits. If those with transient lives remain registered with the same GP practice when they move, it is felt that this may help to improve continuity of care. However, difficulties may still apply – particularly for vulnerable children and young people with chaotic lifestyles and dysfunctional home environments, and without the necessary funds or ability (for example, due to street gang concerns) to travel. In addition, we were told that secondary care services may not agree to keep them on their books if they live too far away from them.

2.5 Secondary care

2.5.1 CAMHS: the extent of challenge

'Only six [per cent] of current spending on mental health goes to services aimed at children and young people.'[80]

80 Stated on a slide referred to by Professor Peter Fonagy during his talk about CYP IAPT at the National Conference in 2013 [accessed via: http://www.cypiapt.org/children-and-young-peoples-project.php (14.02.14)]

'Let us face some unpleasant realities. First of all, the budget allocated to CAMHS has always been a miniscule percentage of the total funds allocated to children's services in total … [and] we are expected to provide a whole range of services. Secondly, over the previous three years, we have witnessed a shrinking of the budget every year under the euphemistic title of "efficiency savings" …'

Dr Mirza, senior CAMHS clinician and academic, in evidence to the CSJ

The *2008 CAMHS Review* identified that 'Long-standing problems persist for some particularly vulnerable children and young people in accessing a full range of appropriate support, at whatever age. This is despite numerous national reports highlighting the problems and possible solutions.'[81] Six years on, our evidence demonstrates that some vulnerable children and young people continue to face a number of barriers with respect to accessing, engaging with and obtaining appropriate care and support from some secondary care services. We heard that CAMHS has been '*disproportionately impacted*' by the '*endless reorganisation within the health service*,' and that it is a '*de-prioritised service*.'

2.5.1.1 Impact of cuts to CAMHS budgets

YoungMinds has exposed profoundly concerning evidence of the impact of funding cuts on some CAMHS services. This includes on the quality of care they are able to provide, their capacity to meet the needs of children and young people, and on the staff delivering the services.

According to YoungMinds 'thousands of children and young people struggling to cope with mental distress may not get the help they need because of swingeing cuts to CAMHS services.' This follows a survey conducted by the VSO of local authorities across England. Of the 51 local authorities that responded:

- Two-thirds have reduced their CAMHS budget since 2010 – one reported a 60 per cent reduction, and another a 41 per cent reduction;
- Nine reported an increase in their CAMHS budget, ranging from one to 99 per cent.[82]

YoungMinds was prompted to conduct a further survey after receiving reports, during 2012, from those on the CAMHS frontline of their experiences. These were considered by YoungMinds to 'jar with the official view that NHS funding is being protected and that mental health is a priority for

81 *CAMHS Review – Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families and Department of Health, November 2008, p9 [accessed via http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399 (18.02.14)]

82 YoungMinds submitted a Freedom of Information Act request to all 'top tier' local authorities in England, asking what their CAMHS budget was for 2010/2011, 2011/2012 and 2012/2013. YoungMinds had undertaken a previous survey in 2011 – when it submitted a Freedom of Information Act request to 120 health trusts and local authorities asking what their budgets were for the coming year, and whether posts would be reduced and services cut. Of the 55 responses it received, more than half reported that they intended to cut their CAMHS budgets for 2011/2012. The biggest cuts were in local authorities. However, 21 per cent of respondents planned to increase their funding for CAMHS. Details on both surveys are available via the same link; YoungMinds, *Stop Cutting CAMHS Services* [accessed via: http://www.youngminds.org.uk/about/our_campaigns/cuts_to_camhs_services (10.02.14)]

government.' The survey revealed 'major concerns' from those working in CAMHS about the impact of cuts on the services they provide. Key findings, reported in December 2012, included:

- 77 per cent of CAMHS staff reported a cut in the 2012/2013 budget;
- 74 per cent reported a reduction in staff numbers;
- 66 per cent stated that the quality of care had been affected due to budget changes, with 51 per cent stating that the quality was still high;
- 57 per cent stated that they were pessimistic about the ability of services to meet the needs of children and young people.

The pressures on some CAMHS services are evidently taking their toll on the staff who are striving to maintain quality of care. One respondent to the survey reported that the 'level of staff morale in CAMHS has dropped to its lowest ever.' Another stated 'We are barely coping … we feel we no longer have any voice in shaping services.'[83] The findings are considered by YoungMinds to have 'painted a picture of CAMHS services trying to do more with less and staff being placed under considerable pressure just to prevent the system collapsing.'[84]

A witness to our Review told us:

> *'Clinicians in CAMHS have often said "It is so difficult here, the work is so difficult … we have so many cases, we can't think between cases. I have seen so many people that sometimes I get muddled up." There is a kind of overload. The whole attempt of the work is to keep someone in mind, so you have got to have that space, otherwise you can't. Also there are job reductions and cuts … to resources, in fact, partly driven by rising costs.'*

The cuts to CAMHS budgets are even more concerning given that the *2004 ONS survey* had revealed that only a quarter of children with mental health problems were in treatment, and that '… by early 2010 there was no sign of improvement.'[85, 86]

2.5.1.2 CYP IAPT

It is within this context that CYP IAPT is endeavouring to transform CAMHS. Unlike IAPT, which provides new standalone services, CYP IAPT is intended to be a service transformation project for existing CAMHS – delivering improved services to and achieving better outcomes for children, young people and families, by:

- 'Using session by session routine outcomes monitoring;
- Empowering young people to take control of their care, establish treatment goals, choose treatment approaches;

83 Over 300 CAMHS professionals responded to the on-line survey; YoungMinds, *CAMHS Cuts Survey – 'Staff morale in CAMHS has dropped to its lowest ever,'* YoungMinds Magazine, Issue 118, Winter 2012/2013, pp24–27

84 Quote by Derren Hayes, Editor of YoungMinds Magazine, *Survey reveals worrying state of CAMHS*, 10 December 2012 [accessed via: http://www.youngminds.org.uk/news/news/1182_survey_reveals_worrying_state_of_camhs (20.02.14)]

85 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, p216, cited in Centre for Economic Performance, and The London School of Economics and Political Science, *How Mental Illness Loses Out In The NHS*, June 2012, p16 [accessed via: http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf (07.02.14)]

86 The Guardian, *GPs demand end to therapy delays for mentally ill children*, 21 March 2010 [accessed via: http://www.theguardian.com/society/2010/mar/21/gps-therapy-delays-mentally-ill-children (21.02.14)] cited in Centre for Economic Performance, and The London School of Economics and Political Science, *How Mental Illness Loses Out In The NHS*, June 2012, p16 [accessed via: http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf (07.02.14)]

- Improving access to and choice of evidence-based therapies;
- Introducing evidence-based organisation of care;
- Build [sic] capability to deliver positive and measurable outcomes for children, young people and families;
- Transform [sic] services covering 60 [per cent] of the [zero- to 19-year-old] population by 2015.'[87, 88]

The CYP IAPT programme provides training for therapists, supervisors and service managers in evidence-based practice. It is delivered by learning collaboratives constituted by HEIs working with local area CAMHS partnerships of statutory and voluntary sector providers and commissioners.

Our evidence suggests that the CYP IAPT programme, whilst offering the potential for positive transformation to CAMHS services, is facing a number of severe challenges. It is trying to ensure that CAMHS has an appropriately skilled workforce, and to affect changes in service delivery, at a time when it appears that many CAMHS services are facing enormous pressures. Some are contending with significant budget cuts, a reduced workforce, hugely stretched capacity and diminishing resources – whilst, at the same time facing increasing demand. That said, it must be acknowledged that more of an outcomes focussed approach is required, and for the funding that does exist to be used as efficiently as possible, as well as for CAMHS services to work in effective partnerships. Commissioning in some areas also appears to be presenting difficulties – particularly, it would seem, to appropriate support being tailored to the specific needs of some vulnerable individuals.

The CYP IAPT programme is intended to be extended through to 2015. Meanwhile, we have heard that many statutory children's services, including clinical psychology, are being scaled back or reconstituted under the pressure of financial cutbacks, with the potential for increasing delay for ongoing support with complex and chronic cases. We were told that '*We lack consistency in our approach to childhood mental health care provision between and often within organisations and professions*.'

2.5.2 CAMHS – referrals, thresholds and waiting lists

> *'Thresholds for access to services provided by the local authorities have increased in parallel with CAMHS – leaving a large number of therapeutic orphans who are gravitating towards a negative developmental trajectory.'*
>
> **Dr Mirza, senior CAMHS clinician and academic, in evidence to the CSJ**

Professor Sir Ian Kennedy previously noted the option of self-referral as a means of improving access to services, which he recognised as having implications for those providing and commissioning services. He also commented on the voluntary sector having much to offer in

87 Children and Young People's IAPT, *CYP IAPT* [accessed via: http://www.cypiapt.org/children-and-young-peoples-project.php (18.02.14)]

88 As at July 2013, the programme was expected to be working with 54 per cent of zero- to 19-year-olds in England by the end of the year; CYP IAPT, News release, *New sites to join Children and Young People's IAPT programme*, 26 July 2013 [accessed via: www.iapt.nhs.uk/silo/files/cyp-iapt-new-sites-press-release-july-13-.doc (18.02.14)]

supporting children and young people with self-referrals.[89] We are encouraged to note that self-referral is reported to be growing in CYP IAPT Year One and Year Two sites, although we do not know the extent to which this may include vulnerable children and young people.[90]

> *'It's often a tortuous course to get into CAMHS. There are some CAMHS services that will only accept referrals from particular organisations … It's a way of gate keeping what comes into CAMHS …'*
>
> **CAMHS clinician, in evidence to the CSJ**

However, as highlighted earlier, some vulnerable children and young people are in fact facing barriers to accessing secondary care services via the primary care route – with direct referrals from GPs getting '*knocked back*' due to high thresholds. It has also emerged from our evidence that, even where some are engaging with VSOs, those VSOs may not be able to make a direct referral for them to CAMHS, thereby constituting a further barrier to access. We were told that this is because some CAMHS will only accept referrals from particular organisations – to the exclusion of some VSOs, and that this is being used as a means of gatekeeping.[91]

In parallel to the position in social care in some local authorities, we heard from numerous witnesses that CAMHS' thresholds have become higher in some areas. These are creating barriers to some vulnerable children and young people gaining access to the support that they need. YoungMinds has found that many CAMHS services are raising their referral acceptance criteria, which means that they are becoming increasingly strict about which cases they take on.[92]

It appears that some CAMHS services are focussing on children and young people with severe mental health problems. We heard a CAMHS therapist describe the criteria used to enable access to their service. A consultant psychiatrist, who was also present at the time, subsequently expressed their concern to us:

> *'The eligibility criteria they described are almost identical to those of the Mental Health Act i.e. the criteria used to detain someone in hospital under a section of the Act. I thought that was surprising as those are the criteria used for allowing deprivation of someone's liberty when, due to significant risk, there are no other options. That is an extreme situation. To my mind, the criteria for initial assessment at CAMHS should be low, it should just be expressed concern by any professional. Certainly a child repeatedly turning up in A&E after repeat overdoses and suicidal ideas …'*

It seems that there is also an issue regarding 'exclusion criteria.' Dr Karen Broadhurst told us '*I think CAMHS needs looking at, especially this business of the exclusion criteria – "we can't*

89 Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, September 2010, p72 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (21.02.12)]

90 Stated by Professor Peter Fonagy during his talk about CYP IAPT at the National Conference in 2013 [accessed via: http://www.cypiapt.org/children-and-young-peoples-project.php (14.02.14)]

91 This is discussed further in Chapter Three

92 YoungMinds, *CAMHS Cuts Survey – 'Staff Morale in CAMHS has dropped to its lowest ever,'* YoungMinds Magazine, Issue 118, Winter 2012/2013, p27

have this person because they are not in stable accommodation," or "they've just been sexually assaulted, they're not ready for it." They have got loads of exclusion criteria … That is what I am hearing around the country.'

Dr Mirza, a senior CAMHS clinican and academic, commented that there is an expectation that CAMHS will deal with all the problems – '*an overextended remit that CAMHS can ill afford to bear, given the frequent funding cuts*.' Dr Mirza told us that his local CAMHS have lost about 30 per cent of their budget over the past few years. He explained that they have to manage the same number of children (under the age of 18 years) who have severe mental illnesses, such as psychosis, severe depression, and those who are self-harming or suicidal. Dr Mirza said that, invariably, CAMHS services such as his have to give priority to those with severe mental illness over those who are showing behavioural problems. He stated that this may sound like good rationing of services, and that many would argue that CAMHS should focus on the former group, due to CAMHS being the only people with the necessary expertise to manage their problems. However, Dr Mirza recognised that for the child who is presenting with behaviour problems, and at risk of exclusion from school, '*this is in no way good news*.' He also acknowledged that '*being placed in the lower end of the long waiting list of a CAMHS service is no consolation to the child or family*.'

> *'Children and young people with mental health needs often have to go on long waiting lists in order to get the help they need. Targets to improve waiting lists can be counter-productive and lead to unintended consequences, such as a child or young person being given an initial appointment quite quickly, but then having to wait on internal waiting lists. This makes it seem that the waiting times are low and providers are meeting their target, when in fact they aren't.'*
>
> **YoungMinds, in evidence to the CSJ**

It appears that some CAMHS services are facing greater demand and pressure from increasing referrals as other resources in the local community (provided by, for example, VSOs) diminish or close. Reference was made by numerous witnesses to the extensive waiting lists that exist for an appointment with some CAMHS services.

The VSO told us that some specialist CAMHS '*often don't have other services to refer children and young people on to. This will lead to [them] not receiving the help they need and is likely to lead to their problems becoming chronic and enduring*.' Again, this runs contrary to an early intervention approach.

A SHS practitioner told us '… *the time you wait for an appointment is unbelievable, it's three months*.' Dr Mirza stated that '*one of the collateral damages of the so-called "efficiency savings"'* is that '*more and more children with behaviour problems have been waiting longer to get a* service.' It can take so long for some children to be seen, that their needs can become acute in the interim period, or they feel it is no longer an appropriate service for them.

We also heard about referrals not being taken up and families being left effectively stranded. One VSO practitioner stated:

'Why was the referral not accepted? It would not have been written if there was another service that could provide help. Sometimes referrals are returned with suggestions which demonstrate little understanding … sometimes referral decisions have not been clearly communicated. I think a phone call to clarify would be helpful … I have read letters from CAMHS when they have declined the referral and the parent is at a loss as to what to do next.'

As discussed earlier, as some CAMHS services reduce and thresholds rise, our evidence reveals that some GPs, social workers, schools and VSOs, are left trying to manage the complex and severe mental health needs of some vulnerable children and young people.[93] This is while they are being held on waiting lists or unable to access support from CAMHS altogether. We have repeatedly heard examples of desperate and persistent attempts having been made by a number of VSOs to secure appropriate support from CAMHS for vulnerable children about whom they had serious concerns.

2.5.3 CAMHS – accessibility of and approach to service provision

CAMHS has historically been problematic in terms of its accessibility and approach to service provision.

'Children and young people have told us again and again what they want, which is easy access to services that are in age appropriate, non-stigmatising environments. This might be one-stop shops, which are on the high street, rather than in a clinic; and they want flexible services where they can be seen in a place of their choosing, such as a cafe, school or at home. They also want services to listen to what they have to say about service provision, and involve them in the planning, commissioning and provision of services.'
YoungMinds, in evidence to the CSJ

Services for vulnerable children and young people need to be able to adapt to what they need. We heard that one of the biggest difficulties in the system is that a lot of CAMHS services are built on the 'clinic based' system – i.e. appointments are based in the CAMHS clinic, and patients have to get to it. This can be '*the largest barrier*' for many, in cases of neglect. Some may not know how to reach the CAMHS clinic, and/or be able to afford the travel expense. We were told that the locations of some clinic bases can be very inaccessible and can require, for example, some people to take two buses – whether in a rural community or, for example, in London.

'You're going to be losing a lot of people if you just have a clinic based model – accessibility is a huge problem. Some are changing and adapting and have outreach services. You can make an appointment to see the child at home or at school but it is not the case with the majority of services. The way that statutory mental health services operate at present, it is a traditional clinic based model. I think you lose a huge percentage of people through not attending appointments.'
CAMHS clinician, in evidence to the CSJ

93 We discuss the challenges faced by some VSOs in Chapter Three

Considerable frustration was expressed to us by numerous witnesses over the inflexibility of some CAMHS services, for example, in conducting home visits.

> *'I think CAMHS almost feels like a spent force to some degree … Their parameters of engagement with our families (who are quite often very difficult families) – the appointment will be based at the CAMHS offices, and it is three strikes and you're out. They won't visit the homes. It's non-contextual and that is hopeless for our kids.'*
> **Headteacher, Special School, London, in evidence to the CSJ**

Despite the substantial number of children with mental health problems, approximately half do not access any service, and only a fifth access specialist CAMHS.[94] One VSO doubted that many of the children and young people who it works with are even aware of the existence of statutory mental health provision, or that they would want its support. It was recognised that some CAMHS clearly need to raise awareness of their existence and the nature of their work, and to improve their communication. This could help in terms of CAMHS gaining access to more vulnerable children and young people who they might not otherwise be able to see.

> *'CAMHS doesn't particularly advertise what it does, if it were situated in places where children frequent, youth clubs, city centres, that kind of thing – more high profile – then it would be easier for some children to access it … We haven't got a particularly helpful website. There aren't ever any posters up. We do have participation days/workshops – the difficulty with that is that it's often speaking to the converted who are already engaging with CAMHS, so it's not spreading the net wider for those children who might have difficulties and don't know about it. It's about advertising, publicising what we do, going in to schools.'*
> **CAMHS clinician, in evidence to the CSJ**

However, we are conscious of a grim reality faced by some vulnerable children and young people in this respect. Given the pressures on some CAMHS services, and higher thresholds and tighter eligibility criteria being applied, the status quo may regrettably be considered to serve them well.

> *'… when money is tight, as it is … thinking about improving access to people who would not normally access your service goes. It's about "how can we maintain our current service with less people? … How can we shave off our bills and salaries and provide our service at less cost?" The NHS is charged with saving 20 per cent over the next few years … I don't think at the forefront of most people's minds is "how can we reach more people?"*
> **CAMHS clinician, in evidence to the CSJ**

As discussed in Chapter One, vulnerable parents often face significant and multiple barriers to engagement with statutory services (amongst others). Some may struggle where English is not their first language or, we were told, if they are English, it should not be assumed that

94 Ford T et al, Service Contacts Among the Children Participating in the British Child and Adolescent Mental Health Surveys, *Child and Adolescent Mental Health*, 10:1, 2005, pp2–9, cited in YoungMinds, *Stigma – A review of the evidence*, p6 [accessed via: http://www.youngminds.org.uk/assets/0000/1324/stigma-review.pdf (07.02.14)]

they can necessarily read. A CAMHS clinician explained that '*often*' parents do not understand the reasons that their children behave in the way that they do, and that the services are not there to support them in that. Some have mental health problems themselves. One VSO stated that a large number of its parents prefer not to engage with statutory mental health provision, due to a lack of education about what is involved. They said that if that was better communicated, it would help. YoungMinds told us that parents also experience many of the same issues faced by their children – that they have to fight to obtain the appropriate help and support for them, and their concerns are often not taken seriously. YoungMinds stated '*The parents we work with tell us that they often feel unsupported, isolated, misunderstood, frustrated and sometimes at their wits end. They may not be able to share their concerns with other members of their family or friends.*'

It is apparent that some vulnerable parents can also struggle to achieve or maintain effective communication with the CAMHS practitioners who are working with their children. In Daniel's case, CAMHS were understood by Kids Company to have conducted an assessment. However, this was not shared with Daniel's mother, who reported that she had not received any documentation from CAMHS in relation to their interventions with him. She was also left unsure about whether Daniel had been given a diagnosis. A SHS practitioner told us:

> *'Once the work has commenced, parents are very positive about the work of CAMHS and the outcomes from their interventions. The communication issue still arises that parents are unable to contact their child's therapist even when they leave many messages. This is probably because the service and therapist are so stretched there is no time to return all these calls.'*

We were told by Christopher Henriette, South London Youthwork Manager and Safeguarding Officer, XLP, that '*parents can feel like they do not know what's going on, especially as there can often be a lot of medical jargon and navigation of bureaucratic systems.*' YoungMinds has suggested that it would be helpful for local agencies to commission parent support groups for families with children who have mental health problems.

One VSO informed us that, the less articulate and organised the family, the less likely they are to benefit from the statutory mental health service. However, where the service is provided on a personalised basis, their experience is better and it can significantly impact on a family's ability to cope. They added that a distinct improvement is seen where treatment has been effective and dovetailed with other support to the family. Where treatment is provided in isolation, we were told that there is less benefit. A CAMHS clinician explained that a more relationship-based approach is required to service provision, and recognition that in order to make sense of what is happening for a family, and for them to make sense of it, they need a trusting relationship – with very few people who have worked together – to form a full picture of the family. In their view, that is the only way that anyone is going to make sense of it. However, they observed:

'I think probably what happens is, people aren't given or don't take that time to make a relationship with a family. They make assumptions and..refer them to a service. Parenting groups is a good one. I have heard of services that say "we will not see a child for an assessment unless the parent has done a parenting group first." But … lots of parents are pretty terrified about going to these groups … [and] aren't capable of taking on huge paper based courses because they didn't learn well at school. What they really need is someone to form a relationship with them to help build that confidence on a one to one long before they can face going to a group. But this is just not what's available.'

CAMHS clinician, in evidence to the CSJ

Again, as discussed in Chapter One, vulnerable children and young people can also face multiple barriers to engagement with statutory services (amongst others).[95] Many are growing up in dysfunctional and chaotic home environments, and do not have a functioning parent to encourage them to attend their appointments, or indeed accompany them. Some have no-one to explain the importance of appointments to them, some have no-one to wake them up or to prompt them; some have no money to travel. Without this support, many will not attend and how could we reasonably expect them to? Some can effectively be left stranded, and in circumstances where they are traumatised by their experiences, neglected, abused, fearful and alone. Where we are expecting vulnerable children and young people to fit into a traditional, structured and inflexible system, we are simply setting them up to fail. In a number of the Kids Company cases that we reviewed, children failed to engage with CAMHS at the assessment stage, or with the support subsequently offered. At the age of 13, Claire wrote to her CAMHS psychiatrist, explaining that she knew that she needed to come to her weekly individual sessions but could not get there and needed someone to bring her.

'Attempted suicide leaves a huge emotional scar … I haven't shared it with CAMHS. The only reason I've shared this is because you are finding out what does or doesn't help young people.'

Child, in evidence to the CSJ

YoungMinds informed us that the children and young people it works with tell the VSO that '*… they often feel let down by services and sometimes they slip through the net altogether. They are often not listened to or have their problems taken seriously and they often have to fight to get the help and support that they need.*'

In Chapter One, we referred to Dr Karen Broadhurst's research around care proceedings. This gave her access to a significant amount of information regarding the 75 cases in the study.[96] Dr Broadhurst told us that a clear theme that emerged was mental health coupled with substance misuse, and conflictual relationships with teen partners. A number of young mothers in the study had been involved with mental health services as a teenager, or had been referred '*and issues were pretty much unresolved …*' Dr Broadhurst explained:

95 As discussed in Chapter Three, some VSOs are performing a critical role in supporting vulnerable children and young people to engage

96 Broadhurst K et al, *The Coventry and Warwickshire Pre-Proceedings Project: Final Report*, London: Cafcass. eScholarID:200864, 2013; Holt KE et al, *The Liverpool Pre-Proceedings Pilot: Interim Report*, London: Cafcass. eScholarID:200865, 2013. Please note that the key themes identified in the data by Dr Broadhurst were not the focus of the research but incidental to it

'… they didn't desperately engage with that help … Some of this was a referral to CAMHS, an appointment based system in an office. They don't attend and they get struck off. The key issue is how we offer mental health services to teenagers. Because teenagers are not going to be snapping off your hand to go down to a mental health service for a counselling service. There is a stigma attached.' [97] *She also highlighted that 'They were exhibiting clear relationship issues stemming from these … traumatic childhoods.' Dr Broadhurst questioned the effectiveness of the local authority standard case work model, and referral to CAMHS for teenagers presenting with the types of difficulties experienced by those in the study. We share the concerns raised and believe that careful consideration should be given to more effective engagement with and interventions for this vulnerable cohort.*

'It's about their body language and what's being said. I've had one appointment and I don't want to go … again … I didn't feel comfortable with the person from CAMHS.'
Child, in evidence to the CSJ

Christopher Henriette, of XLP, told us that '*children often describe treatment as going to see a stranger, which they find hard, especially in counselling relationships.*' We question the extent to and way in which the nature of a therapeutic relationship, and the detachment that is required on the part of the person delivering the counselling, is explained to children beforehand. Mr Henriette believes that there should be enough different types of counsellors, so that if a child does not engage with one, they can be offered another. He added:

'In our mentoring programme … we find a child and we find an adult … And we spend a long time making that match. In counselling, we're expected to go to any counsellor and work with them, when actually there's a real need for an inter-personal rapport to then feel like you can share. Because you're sharing your inner most pains, and wants and needs, and you need something really secure for that to be appropriate. Especially as a teenager.'

Mr Henriette has suggested that more joint work is required in community settings, and more of an understanding gained with respect to how difficult it is for vulnerable children and families to see professionals who they feel do not understand.

Again, many vulnerable children and young people can experience attachment problems, which can impact on their ability to engage with services and to develop trust in them.

Attachment is all about learning to regulate anxiety within a secure environment, and how to care for yourself and other people, and to experience what it is to be cared for – the importance of boundaries. For example, one of the major types of insecure attachment is avoidant, so you don't trust others and avoid intimacy, you avoid services, you don't engage yourself very well …'
Public Health Manager, BSMHFT, in evidence to the CSJ

97 Stigma and discrimination constitute a critical priority area of *No health without mental health*. The Government is working with Time to Change – a national campaign to challenge mental health stigma and discrimination (http://www.time-to-change.org.uk). Time to Change states that nearly nine out of ten people who experience mental health problems say they face stigma and discrimination as a result

As highlighted in Chapter One, issues of concern exist regarding the extent to which some social workers are equipped to understand the attachment problems experienced by many vulnerable children and young people, and to use that understanding to inform their approach towards them. We referred, earlier in this chapter, to the lack of continuity of care and consistency of relationship that some vulnerable children and young people can experience both within and between some primary care and secondary care services. A CAMHS clinician also reported that '*relationship-based work, which is what attachment problems require, is not always covered by mental health services. And that is the bedrock of most of the problems that you'll see with children populating social care. So what is supposed to happen for these children?*' We discuss further issues regarding attachment below.

Dr Mirza, a senior CAMHS clinician and academic, reinforced the importance of practitioners conveying to vulnerable children and young people that they care about them:

'*Something I want to say to everybody working in these organisations: you have an opportunity to recreate the bond that a mother forms with a child. Use that moment to show that you care, in your body and through everything that you do. Let them know that you care about [them] … and sometimes that is all that is needed to make a difference … the human connection that you make with the kids and showing that you care is the quintessential basic ingredient of all forms of therapy. Because kids have strong antennas to pick up your body language and use the dyadic bond to regulate their emotions and behaviour, to learn and grow in that relationship – like all infants.*'

The risk factors that exist in the lives of many vulnerable families and their impact, can present complex challenges to mental health professionals in the design of services. Tragically, domestic violence, parental substance misuse, abuse and/or neglect, can be the cause of many vulnerable children and young people's distress. Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, explained that, in his view, the challenge for designing services is how to create them for distressed families and distressed children and young people:

> '*… How do we design services so they can seek help without being frightened? … It seems to me that we can go around and around with all sorts of ideas about clever designs. In this service we work in nurseries and schools, we are very accessible. And it works … But there are more difficult problems around accessibility other than just resources and design. The problem of access is [in the mind]. Obviously it is not a good thing if we are going to be smaller, I appreciate that, but I don't think it as straightforward as that. I think we've still got problems. We don't know how to design services so that we can somehow create a place which is safe for families to come for help when things are awful.*'
>
> **Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, in evidence to the CSJ**

Some VSOs, like Kids Company, are providing a safe place for some distressed families and distressed children and young people, where they feel comfortable seeking and engaging with help. Critically, some have built relationships and created an environment which such individuals have grown to trust, and to which they have formed a positive attachment. We believe that the potential for CAMHS to work collaboratively with VSOs, with a view to encouraging greater access to CAMHS services, is greatly underutilised.

We need an agile, flexible service that places the vulnerable child and young person at the forefront in the approach taken to engage with them, and that can adjust to their needs. This is precisely what some are thankfully endeavouring to provide. We heard examples of atypical clinic based models and outreach services in various parts of the country, which enable a more adaptable approach to working with vulnerable children and young people, and with persistent efforts being made to engage with them. We heard about one child who is benefiting from such an approach, and who CAMHS has succeeded in engaging over a number of years through its outreach service. A CAMHS clinician told us that they are '*trying to understand [their] trauma, understand what is going on for [them] and meeting [them] half way – not expecting [them] to always want to see us.*' They explained that it depends on who is leading the organisation and how visionary they are, in terms of a forward thinking, flexible approach being taken. They added '*Not everyone is signed up.*' There is clearly huge room for improvement. Again, commissioners have an important role to play in this regard.

We welcome the efforts being made by CYP IAPT and participating CAMHS services to involve children and young people in the development of CAMHS, and design and shaping of its services.[98] However, we do not know the extent to which vulnerable children and young people may be contributing their input.

2.5.4 Diagnosis and intervention issues

2.5.4.1 Attachment

> *'Attachment styles and ways of engaging with the world are learned from parents or carers or trusted others – how to contain anxiety, how to regulate your own emotional state – that is the basis of mental health.'*
>
> **Public Health Manager, BSMHFT, in evidence to the CSJ**

> *'When you talk about well-being, when you talk about attachment – you're always talking about mental health. It is a false divide most of the time. If you're looking at a childor young person's well-being, you're looking at their mental well-being.'*
>
> **Witness, in evidence to the CSJ**

A number of witnesses have referred to the '*false divide*' between attachment and mental health. We were told that the attachment diagnosis/treatment issue is '*certainly complex and convoluted.*' We learned that attachment problems are not necessarily considered as a standalone mental health problem by some mental health services. A CAMHS clinician told us that, in their experience, *'Attachment problems are not seen as a mental health problem unless you've got some other diagnosis like OCD that can go into treatment.'* They explained that the children who are referred to them – usually held within early intervention services under a CAF – will often tend to exhibit features of attachment problems '*across the spectrum*,' and do not distinctly fit within one category of attachment classification. They stated:

98 See, for example, IAPT, *Children and Young People's Improving Access to Psychological Therapies: Newsletter*, September 2013 [accessed via: http://www.cypiapt.org/docs/cyp-iapt-newsletter-september-2013.pdf (18.02.14)]

'As with much of mental health, people do not fit neatly into categories … In my opinion, the very fact that there is, as far as I am aware, no formal classification under the DSM for insecure or disorganised attachment as representing a "disorder" itself signifies that there is no real acknowledgement of these individuals' potential high levels of distress, nor of the impact on their mental health and that of their families if they are not offered specific packages of treatment – rather than nothing, or piecemeal interventions under a postcode lottery.'[99]

We were also told that systemic relationship-based work is not covered by many mental health services – particularly those working with over 16-year-olds.

Attachment disorder should mean the need for treatment, and recommended treatments exist. However, we were informed that the prioritising of provision of specific treatments for attachment disorders does appear to vary across CAMHS services, '*with very little recognition in AMHS*,' although some good practice certainly exists.[100]

We are encouraged to note that NICE has released scoping documents on the attachment and related therapeutic needs of children and young people (aged zero to 18 years old) who are adopted from care, in care or at high risk of going into care.[101] However, a number of concerns have been raised. We were told, for example, that services for those who are fostered and adopted tend to be '*very small and, where they exist at all, are likely to be tagged onto generic CAMHS services*,' usually with a joint-funding arrangement between health and the local authority – '*on occasions consultative only*, *rather than offering specific treatments themselves*.' We also heard how the various interventions mentioned in NICE's *Children's attachment: final scope* '*tend to be offered piecemeal, if they are offered at all*.' For example, we were told that Video Interactive Guidance might be offered in some health services and not in others, and there is '*rarely*' any form of specific treatment plan which involves therapeutic input to the parent(s) – '*which is often key to making any kind of real change*.' Our witness added '*This also links to the lack of appropriate therapy provision within AMHS who want it all to happen in six to eight sessions of CBT, if they ever get that far*.'

We also note that there will be many other vulnerable children and young people who do not fall within the aforementioned groups but who also have attachment problems or disorders – including lone children.[102] A CAMHS clinician stated '*The groups are … in my*

99 NICE states that 'Although particular types of attachment classification (especially disorganised attachment) may indicate a risk for later problems, these classifications do not represent a disorder;' NICE, *Children's attachment: final scope*, p4 [accessed via: http://www.nice.org.uk/nicemedia/live/14174/66022/66022.pdf (18.02.14)]. Our witness observed that the problem of diagnosing insecure and disorganised attachment as a disorder may be due to there being such a spectrum of difficulty. For instance, they stated that not everyone with an insecure attachment is not coping, so it is about the degree to which it impacts on the individual's level of functioning and that of their family's which would render it appropriate for treatment

100 For example, the Great Ormond St attachment and trauma team – information on which is available at: http://www.gosh.nhs.uk/health-professionals/clinical-specialties/child-and-adolescent-mental-health-services-camhs/services/parenting-child-service/attachment-and-trauma-team/

101 This follows a request by the Department of Health and the Department for Education for NICE to develop the guidance. Draft guidelines will be published in 2015; NICE, *Children's attachment: final scope* [accessed via: http://www.nice.org.uk/nicemedia/live/14174/66022/66022.pdf (18.02.14)]

102 The final scope document states that groups that will not be covered include 'Children and young people with attachment problems or disorders who are not looked after, or who are not at risk of being looked after, or who have not been adopted from the care system … '

opinion, a very small part of what needs to be done and they are often insufficient without any kind of longer-term follow-up. Thus we are neglecting huge swathes of highly distressed children and young people and their families.'

2.5.4.2 Lack of diagnosis/personality disorder

In a number of Kids Company cases that we reviewed, the position regarding diagnosis was unclear. For example, Daniel's mother remained unsure whether Daniel had been given a diagnosis but told Kids Company that CAMHS did say that he had paranoid and depressive behaviour, and that she thought that psychosis was mentioned. In Callie's case, she had been diagnosed by a CMHT psychiatrist with depression and personality disorder – in the context of low self-esteem and self-harming. However, Kids Company felt it needed clarification of her exact diagnosis in order to ensure that the support she had requested from it was appropriate for her.[103]

We were informed that an issue exists with respect to some medical practitioners being reluctant to label children or young people as having mental illness/psychiatric disorders – in some cases '*for good reasons*', in light of potential stigma concerns. We were also told that some labels are perceived as more negative than others (for example, personality disorder, and psychosis) – '*so there may be good motivations for reluctance to label unless absolutely sure.*' A further issue exists, in that many teenagers with symptoms of mental disorder may not easily fit into a diagnostic category or may show symptom changes over time. A witness observed:

> *'It is almost as though many young teenagers vulnerable to (non-neurodevelopmental) mental difficulties initially show very fluid distressing symptoms, which will often only start to fit a more clearly defined "diagnostic category" in later adolescence. If we could move away from commissioners mainly relying on predicting incidence rates of diagnosable disorders to fund clinical services, and look instead at providing appropriate educational and targeted interventions for all those with observable symptoms of emerging and ongoing emotional/mental distress, we might be getting somewhere.'*

A lack of diagnosis can present additional challenges to those in, for example, social care or VSOs, who are trying to support and manage the mental health problems and social care needs of vulnerable children and young people.

> *'Social workers would say the definition of how you get help from CAMHS is too narrow. Too often we get personality disorder thrown back and "there is nothing we can do." That isn't very helpful.'*
>
> **Senior Manager, Children's Services Department, in evidence to the CSJ**

In addition, 'it is not good practice' to diagnose personality disorder in those under the age of 18.[104] However, we heard that '*some people do speak about emerging personality*

103 Daniel's case summary (Case Two) and Callie's case summary (Case Five) can be found on page 32 and 41 respectively

104 HM Government, *No health without mental health: Delivering better mental health outcomes for people of all ages*, February 2011, p40 [accessed via: https://www.gov.uk/government/publications/delivering-better-mental-health-outcomes-for-people-of-all-ages (12.02.14)]

disorder,' and of views being expressed over some vulnerable children '*showing characteristics of personality disorder*.' In one of the Kids Company cases that we reviewed, a Child and Adolescent Psychotherapist stated that it seemed as though the child (in their early teens) had an emerging personality disorder. We note that the Mental Health Foundation describes 'Personality disorders in children or adolescents are sometimes called conduct disorders. However, most conduct disorders in children do not necessarily lead to personality disorders in adulthood.'[105]

> *'Personality disorder in general used to be one of those frustrating "dustbin diagnoses" where often the medical model tended to use it as a rationale to say the issues are so entrenched that we can't do anything about it. But our experience … is that indeed you can treat and work with children with these personality issues, which for many are probably better framed as complex attachment issues, at the early stages when the negative behaviours are still emerging.'*
>
> **Public Health Manager, BSMHFT, in evidence to the CSJ**

This can again leave those working with such vulnerable children in uncertain territory over how best to support them. Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, referred to the need to gain clarity about a group of children who have a developmental trajectory, with their difficulties starting in adolescence and continuing into adulthood. Dr Fuggle thinks that there is a recognisable pattern of presentation that is useful, and that what is needed is to develop more of a psycho-education approach to these children, as opposed to focussing on whether they meet diagnostic criteria. Dr Fuggle explained that:

> *'… [personality disorder] is a bit of a conceptual muddle at the moment … you can get overly medicalised. We haven't got any other ways of describing these difficulties … What is more critical, is a shared understanding about what it is – for social workers and schools to understand some of the key features that are consistent with a personality disorder, because they are the kids that cause the most difficulty and they are the ones who need the most help … The challenge for me is more about how we get a shared conceptualised framework for these kinds of presentations. I am saying this with some caution because I don't know the answer.'*

We were informed that forensic mental health services can be very helpful in challenging the notion that 'it's a personality disorder, we can't do anything.' [106] However, a Senior Manager in a Children's Services Department highlighted the tragic extent of difficulty that a vulnerable child may need to reach before their mental health needs are finally identified. They said:

> *' … it is almost like you've got to be in the criminal justice system and have that forensic need before you can get to that level of clinical analysis … One of the issues is how do we re-constitute CAMHS services so they take on more of the features of the more forensic services for their clinical provision? I find it is still a fairly old fashioned surgery based*

105 Mental Health Foundation, *Personality Disorders* [accessed via: http://www.mentalhealth.org.uk/help-information/mental-health-a-z/P/personality-disorders/ (04.03.14)]

106 We profile the Thames Valley Forensic Child and Adolescent Mental Health Team as an example of good practice in Chapter Four

service. The CAMHS services do a lot of activity, but in our experience, there is quite a lot of clinical preference that goes on … You have people who have their own pet projects. That is anecdotal but I think there is a lot of that which goes around … it is difficult to get a handle on the effectiveness of that as a local authority. We are a minor player. It is quite tricky for local authorities to hold CAMHS to account.'

Hope was expressed that this issue could be addressed through Health and Wellbeing Boards (HWBs). In this context we heard how local authorities with a young population may not face a struggle to secure children and young people's mental health on the agenda of their HWBs. However, it is felt that those with an ageing population may face more of a challenge – where the main priority, from a GP/CCG perspective, is around the costs and complexity of dementia services.[107]

2.5.4.3 Diagnosis/interventions

Even where a diagnosis is given, it appears that a vulnerable child or young person, or professionals working with them, may not gain the support that is needed. A solicitor stated '*it is a known concern that following the diagnosis of an impairment or condition, professionals in CAMHS often disappear without providing support or information. This means that there is likely to be no early or timely intervention, and issues will only be dealt with at the point of crisis.*' A senior CAMHS clinician explained:

'I do think there can be a problem with the way that CAMHS services describe the difference between diagnosis and intervention. When a CAMHS assessment has identified a specific diagnosis, the clinicians who have made that diagnosis frequently do not explain to families and other non-mental health professionals that, in a significant number of cases, the intervention for the identified mental health diagnosis may not be one which specialist mental health services have at their disposal.'

The clinician outlined this with the following example:

'A CAMHS team may make a diagnosis of, for example, an autistic spectrum disorder [ASD] in a child, but the intervention for that would usually involve educational input (in many cases addressing [SEN]), certainly up to the age of 16. Perhaps, in cases of this kind or in cases where there are complex needs and significant risks for which CAMHS are not going to provide the principal interventions, it would be of most help to families and other professionals if CAMHS clinicians were to adopt a more collaborative approach. This might involve thinking with education and social care about what a given child's needs are once the diagnosis has been made rather than appearing from the perspective of others to be saying "we've made the diagnosis, and that is all we're doing."'[108]

107 We discuss the lack of identification and prioritisation of children and young people's mental health needs in some areas of the country later in the chapter

108 We discuss the lack of cooperation and coordination between some statutory services, and the interface between therapeutic provision and risk management in Chapter Four

This latter point would seem to raise an important communication issue. We were told that other agencies can be left thinking that CAMHS have given a diagnosis but are not doing anything in relation to it. This may be the consequence of CAMHS having given a diagnosis but not having adequately explained that:

> *'… having done this, in some cases, there's nothing specific in the CAMHS battery of tools that can be used to help this child's long-term needs, and actually what they require is better housing, or education, or structured environment, which are not the key bits of a specialist mental health intervention.'*

Our witness recognised that unless this is handled very carefully across agencies:

> *'people think you're dumping on them or … don't understand what CAMHS are talking about, and then say "what's the point in referring something to CAMHS … ?"'*

2.5.5 Conduct disorder

ADAM (15 years old)[109]

Adam first became known to social care as a young child, from when he is reported to have witnessed and experienced domestic violence. He has experienced behavioural difficulties since a very young age, and was issued with several fixed-term exclusions while he was at primary school. Adam was placed on a child protection plan when he was nine, as a result of physical and emotional abuse by his parents. Adam received CAMHS intervention at the age of nine, and ten – following a re-referral by Adam's school due to its concerns about Alex self-harming.[110] He was discharged after each referral. Adam was removed from the child protection plan within one year. Social care later recorded that concerns remained the same until Adam was 12 – over physical abuse, domestic violence and Adam's father's (Frank) alcohol misuse. An Educational Psychologist (Ed Psych) report referred to the family having been offered parenting classes, outreach support and social support input over a two year period. However, it stated that the desired changes were not sustained as the family approached social care again with similar concerns about Adam's behaviour difficulties, and were resorting to physical chastisement to make him conform. Adam's mother, Anna, had reportedly attended parenting classes one day each week for three months, and the outreach support was provided over a two month period, when Adam had been excluded from school. This support was offered and accepted but it was not considered to be enough, and was not delivered in the parents' mother tongue.[111]

Adam was placed on a CPP again at the age of 12 – initially under the category of physical abuse and, later, additionally neglect. By the time Adam was 15 years old, six Review CPCs had been held on his case. A number of action points were repeatedly carried over from one CPC to the next. For example, Frank's re-referral to a substance misuse organisation remained outstanding for a period of 15 months, as did the domestic violence task – requiring the Core Group to identify appropriate resources for the parents to gain an insight into the impact of domestic violence on children. At the sixth Review CPC, a timescale of a further five months was allocated for each action point. An incident had arisen of potential physical abuse by Anna; however, the furthest social care appears to have progressed with the child protection investigation was 'discussions held.'

109 An analysis of mental health issues in Adam's case can be found in Chapter Four
110 This was disclosed by Anna
111 Ibid

In the meantime, Adam's behaviour escalated. Violence against pupils at school, and incidents with staff members, led to him attending Kids Company's AEP, and to multiple fixed-term exclusions. Concern was raised over Adam's involvement with a gang. After a violent incident against a pupil, Adam was sent back to the AEP on a full-time basis, in circumstances where the school informed Kids Company that it would normally have permanently excluded him. However, the school asked for Adam to attend the AEP until his statement of SEN came through (which Kids Company had advised making an application for). Social care referred Adam to CAMHS for therapeutic support. Having also been referred by Kids Company to participate in a hospital research study, an initial assessment showed that Adam was showing features of conduct disorder, and recommended further assessment by a psychiatrist to confirm diagnosis. CAMHS found 'no evidence of a depressive disorder, anxiety, [PTSD], psychosis, ADHD or an autistic spectrum disorder [(ASD)].' At 14, Adam's final statement of SEN was issued by the local authority. His SEN was described as relating to features consistent with, for example, moderate learning, and social, emotional and behavioural difficulties, and speech and language difficulties. His statement prescribed the need for ongoing support from social care, and advice and support from CAMHS. At around this time, one of Adam's friends was fatally stabbed close to where he lived. Not long after this, Adam was arrested and charged with ABH. CAMHS agreed to produce a report on Adam to be used for the SEN Tribunal, to consider Anna's request for a residential educational placement for Adam.

Following the fifth Review CPC, Kids Company stated that it was aware that the position on diagnosis might not be clear-cut, and sought to discuss how CAMHS thought it best to proceed. The next month, Kids Company recorded Adam as being highly at risk from street violence, after someone attempted to stab him. He was then seen running away from a group of boys linked to a gang. Adam was now so worried about the problems he was having on the street that he was convinced that going into temporary care outside of the area was the only way for him to stay alive and safe. He was then issued with a six month YOT Referral Order in respect of his ABH conviction. An Independent Ed Psych report highlighted that the local authority had specified a 'specialist setting' in Adam's statement of SEN but had not yet named a specific school for him. It also stated that Adam was found to have severe expressive language difficulties – by a speech and language therapist who had assessed him at 14. It noted that these had not previously been identified or supported with professional speech and language therapy. Kids Company informed the CSJ that the local education authority had in fact disputed the need to include such an assessment in Adam's statement of SEN, despite this initially being recommended by its own Educational Psychology service. The Independent Ed Psych stated that careful and prompt consideration of a specialist residential provision for children with behavioural, emotional and social difficulties was necessary.

Kids Company informed social care of incidents involving Adam carrying a knife and his escalating behaviour. It believed Adam 'to be significantly at immediate risk of seriously or fatally injuring another peer, or being seriously or fatally injured himself.' It also shared its concerns with CAMHS. Kids Company recorded that CAMHS confirmed, after meeting with Adam, that they would be closing his case, that Adam did not meet CAMHS' threshold, and that they did not recognise a mental health problem in Adam from a medical point of view. The social worker's report for the sixth Review CPC noted that the failure to finalise Adam's statement of SEN was 'affecting [his] emotional well-being and confidence,' that still being out of full-time education was 'affecting his self esteem and morale,' and that he was becoming increasingly involved in anti-social behaviour in the community.

At the sixth Review CPC, it was decided that a referral would be made to a specified panel for a funding agreement for a therapeutic residential setting for Adam, with negotiations to take place over splitting the funding between the education and social care departments of the local authority. Kids Company has informed the CSJ that finding a residential therapeutic provision willing to take Adam on at this point proved impossible, given the severe presentation of his behaviour by this stage.[112]

112 A number of further issues arising from this case, in the context of mental health, are discussed in Chapter Four

The lifetime cost of a one year cohort of children with conduct disorder has been estimated at £5.2 billion.[113]

> *'These kids are at risk of developing serious problems – they are impulsive, have emotional difficulties, and are struggling to negotiate the developmental expectations. They often come from families that are unable to provide firm, consistent care and control. Kids with "conduct disorder" … are the ones who are not getting a proper service across the whole of CAMHS. That is a big reality. Many CAMHS would argue that they are providing a service for [them]. Of course some CAMHS do … for some [kids]… but not … all … When they have a co-existing condition, for example, depression or ADHD, they are more likely to get a service from CAMHS.'*
>
> **Dr Mirza, senior CAMHS clinician and academic, in evidence to the CSJ**

Our evidence has revealed that there is a particular cohort of vulnerable children who are not gaining appropriate care and support from some CAMHS – those with conduct disorder. We have been told that these children often have co-existing emotional difficulties and/or learning difficulties. Some may also have enduring mental illness such as depression, ADHD or PTSD. The *2004 ONS survey* revealed that only 25 per cent of children with conduct disorder and emotional disorder were seen by CAMHS.[114] Our research gives us serious cause for concern with respect to the current position.

Conduct disorder is the most common mental health problem in childhood. The proportion of children aged 15 to 16 with a conduct disorder more than doubled between 1974 and 1999.[115] The report, *The economic case for improving efficiency and quality in mental health,* highlights the prevalence, difficulties and associated costs of conduct disorder (in the context of 'Early identification and intervention as soon as mental health problems emerge.') It states that 'Half of all children with conduct disorder develop anti-social personality disorder as adults,' and that 'conduct disorder is associated with a 70 fold increased risk of being imprisoned by the age of 25.'[116, 117]

113 The cohort amounts to six per cent of the child population; Friedli L, Parsonage M, *Mental health promotion: Building an economic case*, Northern Ireland Association for Mental Health, 2007, cited in Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages, Supporting document – The economic case for improving efficiency and quality in mental health,* 2011, p19 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (25.10.13)]

114 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, cited in HM Government, *No health without mental health: Delivering better mental health outcomes for people of all ages*, February 2011, p39 [accessed via: https://www.gov.uk/government/publications/delivering-better-mental-health-outcomes-for-people-of-all-ages (12.02.14)]

115 Collishaw S et al, Time trends in adolescent mental health, *Journal of Child Psychology and Psychiatry*, 45:8, 2004, pp1350–1362, cited in YoungMinds Mental Health Statistics [accessed via: http://www.youngminds.org.uk/training_services/policy/mental_health_statistics (07.02.14)]

116 NICE, *Antisocial personality disorder: Treatment, management and prevention* (CG77), January 2009, cited in Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages; Supporting document – The economic case for improving efficiency and quality in mental health,* 2011, p6 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (18.02.14)]

117 Ferrgusson DM et al, Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood, *J Child Psychol Psychiatry*, 46, 2005, pp 837-849, cited in Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages; Supporting document – The economic case for improving efficiency and quality in mental health,* 2011, p6 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (18.02.14)]

The cost of crime attributable to adults who had conduct problems in childhood is estimated at £60 billion a year in England and Wales, 'including £22.5 billion a year attributable to conduct disorder and £37.5 billion a year to sub-threshold (moderate or mild) conduct problems.'[118]

It seems that we are in a serious predicament with respect to these children. Argument has been made that CAMHS cannot meet the current demand of this cohort. Dr Mirza, a senior CAMHS clinician and academic, spoke frankly:

> *'This is a reality from which no-one can escape. CAMHS in the UK does not have the capacity to provide a good service to children with conduct problems unless and until they are willing and able to change the structures and models of service delivery.'*

In Dr Mirza's view, CAMHS could '*usefully*' be part of a wider consortium for dealing with children with conduct disorder.[119] He explained that although the majority of those with conduct disorder and juvenile delinquency only require social and educational approaches to treatment, the problems of a substantial minority of these children may have antecedents – such as ADHD, or consequences – such as severe depression, that may require the input of health professionals. Consequently, he believes that a separate, comprehensive service for those with conduct disorder may well need tripartite funding by social care, education and health. He explained that this is a reinvention of the '*triple alliance*' that has long been the basis for much child guidance work – '*but that has been increasingly undermined by cuts in social care and education.*' Dr Mirza added that:

> *'These cuts have often left the health service struggling valiantly on to provide the same comprehensive coverage from within its own resources – to the detriment of "core" mental health provision.'*

Rather than take the lead on this service, in Dr Mirza's view, CAMHS would have expertise to conduct comprehensive assessments of children with conduct disorder (including physical and mental health problems), and to inform other professionals (within and outside of the health sector) on how to best treat and manage their needs. He referred to CAMHS also having a lot of expertise in psychological therapies, and suggested that CAMHS could perhaps provide significant support for other professionals to be trained up and supervised to provide evidence-based interventions in children with conduct disorder.

118 Sainsbury Centre for Mental Health, The chance of a lifetime: Preventing early conduct problems and reducing crime, November 2009, p6[accessed via: http://www.centreformentalhealth.org.uk/pdfs/chance_of_a_lifetime.pdf (25.10.13)]

119 Dr Mirza referred to Professor Robert Goodman's monograph of 1997 regarding commissioning in CAMHS, in which Professor Goodman argued that CAMHS should focus on children with core mental health problems – such as anorexia nervosa, schizophrenia, severe depression, obsessive-compulsive disorder and severe hyperactivity; Goodman R, *Maudsley Discussion Paper No.4 – Child and Adolescent Mental Health Services: Reasoned Advice to Commissioners and Providers*, The Maudsley, 1997 [accessed via: https://www.kcl.ac.uk/iop/mentalhealth/publications/discussion-papers/assets/mdp04.pdf (07.02.14)]

Dr Mirza stated that the most effective interventions for children with conduct disorder are parent training, and systemic/family interventions. Indeed, *The economic case for improving efficiency and quality in mental health* states that 'There is good evidence that parenting interventions are effective,' and that 'Many of the benefits from childhood interventions extend into adult life.'[120] It also refers to the estimated total gross savings that could be achieved over a 25 year period, as exceeding 'the average cost of the intervention by a factor of around eight to one.'[121] As referred to later, two of the evidence-based therapies included in CYP IAPT's training are parent training and Systemic Family Practice. Dr Mirza informed us that:

> *'Unfortunately, at present, there is little evidence of good partnership between agencies that provide parent training (often employed/commissioned by local authority and CAMHS), and there is little emphasis on measurement of outcomes or research.'*

In the meantime, some GPs, social workers, schools, and VSOs, will be left to hold some very challenging cases, of children with serious and complex needs, and with high risk levels and vulnerability. Again, some do not have the necessary training, skills or experience to be able to manage these cases appropriately. As referenced above, conduct disorder can, if untreated, develop into anti-social personality disorder. It must be in everyone's best interests to prevent this from happening – first and foremost the children's. We are extremely concerned to discover the lack of early intervention approach being taken.

2.5.6 Street gang violence and mental ill-health

As referred to earlier in this report, a significant number of vulnerable children and young people are involved in street gangs or impacted by street gang activity. The CSJ's report, *Dying to Belong* illustrates the traumatic experiences endured by many such vulnerable children and young people, in their home environments (for example, childhood abuse and domestic violence), and how these can be contributing factors to particular patterns of behaviour.[122] During our Kids Company case review, we discovered vulnerable children who were at risk of or suffering violence from street gangs – some from a young age. They presented with emotional and behavioural difficulties – severe in a number of cases, or more serious mental health problems.[123] On the information available to us, most had

120 Dretzke J et al, The clinical effectiveness of different parenting programmes for children with conduct problems: a systematic review of randomised controlled trials, *Child and Adolescent Psychiatry and Mental Health*, 2009, cited in Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages; Supporting document – The economic case for improving efficiency and quality in mental health,* February 2011, p6 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (24.02.14)]

121 Knapp M, McDaid D and Parsonage M (editors), *Mental health promotion and mental illness prevention: The economic case*, Personal Social Services Research Unit, London School of Economics and Political Science, 2011, cited in Department of Health, *No health without mental health: A cross-Government mental health outcomes strategy for people of all ages; Supporting document – The economic case for improving efficiency and quality in mental health,* February 2011, p6 [accessed via: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health (24.02.14)]

122 Centre for Social Justice, *Dying to Belong: An in-depth review of street gangs in Britain*, London: Centre for Social Justice, 2009, p96. For further discussion on trauma and PTSD see Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, pp77–84

123 Please see Chapter One for further discussion of these cases, in the context of child protection

experienced childhood abuse and/or neglect, and most had experienced and/or witnessed domestic violence.[124]

Research tells us that PTSD 'is the most frequent psychiatric outcome of exposure to violence.'[125] Furthermore, it has been suggested that 'gang membership increases the risk of posttraumatic stress.'[126] We have concerns about vulnerable children and young people who may be suffering with PTSD as a result of the violence that they are witnessing and/or participating in – with undiagnosed and untreated needs. A recent study by University College London (UCL), of 79 children and young people supported by Kids Company, has shone a disturbing light on the extreme community violence that many vulnerable children and young people are being exposed to in London.[127] Professor Essi Viding and Dr Eamon McCrory reportedly stated:

> *'We know through our brain imaging work that children exposed to sustained violence adapt in a similar way as soldiers exposed to combat, in that their brain function changes to be more attuned to threat … The children in our study had twice the normal levels of anger, over three times the levels of [PTSD] symptoms and almost four times higher levels of disassociation, which can lead to violent detached behaviour.'*[128]

Professor Sandra Jovchelovitch, from the London School of Economics, has conducted research on social exclusion in the favelas of Brazil. She has reportedly expressed her belief that the levels of violence revealed in UCL's study are *'comparable to the favelas of Rio.'* Professor Jovchelovitch has also reportedly warned that *'These kids grow up in a culture of "easy dying" in which human life is not valued. If we ignore this evidence, we are creating a time-bomb.'*[129]

We heard that expertise and skill is required on the part of clinicians undertaking an initial assessment, with respect to being alive to the potential for vulnerable children and young

124 A recent report from UCL stated that 'Childhood maltreatment is a key risk factor for maladjustment and psychopathology,' and that 'Although maltreated youth are more likely to experience community violence, both forms of adversity are generally examined separately. Consequently, little is known about the unique and interactive effects that characterize maltreatment and community violence exposure…on mental health.' UCL concluded that 'Exposure to maltreatment and community violence is associated with increased levels of clinical symptoms. However, while maltreatment is associated with increased symptoms across a broad range of mental health domains, the impact of community violence is more constrained, suggesting that these environmental risk factors differentially impact mental health functioning;' Cecil C et al, Double disadvantage: The influence of childhood maltreatment and community violence exposure on adolescent mental health, *Journal of Child Psychology and Psychiatry*, doi: 10.1111/jcpp.12213

125 Wilcox HC et al, Posttraumatic stress disorder and suicide attempts in a community sample of urban American young adults, *Arch Gen Psychiatry*, 66, 2009, pp305–311, cited in Coid JW et al, Gang Membership, Violence, and Psychiatric Morbidity, *Am J Psychiatry*, 170, 2013, pp985–993

126 Li X et al, Risk and protective factors associated with gang involvement among urban African American adolescents, *Youth Soc*, 34, 2002, pp172–194, cited in Coid JW et al, Gang Membership, Violence, and Psychiatric Morbidity, *Am J Psychiatry*, 170, 2013, pp985–993

127 UCL, Experience Of Adversity: Preliminary Descriptive Findings (unpublished), June 2013. A number of findings from the research (unpublished) were shared by Charlotte Cecil, Developmental Risk and Resilience Unit, UCL, at Kids Company's annual conference held at the London School of Economics and Political Science, on 26 September 2013 [accessed via: http://www.lse.ac.uk/newsAndMedia/videoAndAudio/channels/publicLecturesAndEvents/player.aspx?id=2029; Audio 13.40 Session (13.01.14)]; further details can be found on pp25–26 of this report

128 London Evening Standard, *The Gangs of London*, 25 September 2013 [accessed via: http://www.standard.co.uk/news/london/frontline-london-these-young-gangsters-have-lost-so-many-friends-theyve-stopped-going-to-their-funerals-8838684.html (13.01.14)]

129 London Evening Standard, *Frontline London: These young gangsters have lost so many friends they've stopped going to their funerals*, 25 September 2013 [accessed via: http://www.standard.co.uk/news/london/frontline-london-these-young-gangsters-have-lost-so-many-friends-theyve-stopped-going-to-their-funerals-8838684.html (20.01.14)]

people to be suffering with PTSD in these circumstances. The extent to which clinicians are thinking along these lines was questioned. Witnesses expressed the hope that CAMHS and AMHS clinicians would consider the potential for PTSD in children and young people presenting to them for initial assessment where they have experienced or witnessed street gang activity. They recognised that this would have education and training implications.

We believe that this issue needs to be addressed as a matter of urgency. The pressing case for this has been made all too evident from the findings in Queen Mary, University of London's study *Gang Membership, Violence, and Psychiatric Morbidity*. The research reveals that 86 per cent of those who confirmed they were gang members had an antisocial personality disorder.[130] Furthermore, 59 per cent had anxiety disorders, 25 per cent had psychosis, more than half had substance misuse difficulties, and approximately one third had attempted suicide.[131] Professor Jeremy Coid, director of the forensic psychiatry research unit at Queen Mary, University of London, reportedly stated that:

> *'No research has previously investigated whether gang violence is related to psychiatric illness, other than substance misuse, or if it places a burden on mental health services … Here we have shown unprecedented levels among this group, identifying a complex public health problem at the intersection of violence, substance misuse, and mental health problems among young men.'*[132]

The report states:

> *'Street gangs are concentrated in inner urban areas characterized by socioeconomic deprivation, high crime rates, and multiple social problems … Our findings imply that gang members make a large contribution to mental health disability and burden on mental health services in these areas. This represents an important public health problem, previously unreported.'* [133]

Dr Charlie Alcock, CEO of London based MAC-UK charity, reportedly stated, in response to the findings:

> *'If someone is wielding a knife, it's highly unlikely that anyone will ask if they are depressed, but this could be exactly what they are feeling. However it's presenting in an*

130 The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV-TR) defines antisocial personality disorder as: '(A) There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years [as indicated by three or more of the listed features]. (B) The individual is at least age 18 years. (C) There is evidence of conduct disorder with onset before age 15 years. (D) The occurrence of antisocial behavior [sic] is not exclusively during the course of schizophrenia or a manic episode,' cited in Wikipedia [accessed via: http://en.wikipedia.org/wiki/Antisocial_personality_disorder#DSM-IV-TR (07.02.14)]

131 The report states that 'It is probable that among gang members, high levels of anxiety disorders and psychosis were explained by PTSD. However, this would only partly explain the high prevalence of positive screens for psychosis in gang members. Psychosis is more likely than PTSD to lead to psychiatric hospitalisation in the United Kingdom. Further research should determine whether the high prevalence of positive screens for psychosis among gang members was explained by psychotic illness or severe PTSD with psychotic symptoms;' Coid JW et al, Gang Membership, Violence, and Psychiatric Morbidity, *Am J Psychiatry*, 170, 2013, pp985–993

132 London Evening Standard, *Gangs suffer mental illness, groundbreaking London study shows*, 12 July 2013 [accessed via: http://www.standard.co.uk/news/london/gangsters-suffer-mental-illness-groundbreaking-london-study-shows-8704862.html (12.07.13)]

133 HM Government, *Ending Gang and Youth Violence: A Cross-Government Report Including Further Evidence and Good Practice Case Studies*, Norwich: The Stationery Office, 2011, cited in Coid JW et al, Gang Membership, Violence, and Psychiatric Morbidity, *Am J Psychiatry*, 170, 2013, pp985–993

> *atypical way … These young people in gangs are the most marginalised in the country. Their health, social and financial inequalities are mindblowing. The traumas that they are exposed to, from domestic violence to gang activity, is only exacerbated when they are in a gang.'*[134]

With street gangs 'becoming increasingly evident in UK cities,' it is imperative that more of an early intervention approach is taken.[135] This is not only for the protection of those who are at risk of becoming or have become members of street gangs, but also for the protection of potential victims of street gang crime in wider society. However, this is not just a matter for our mental health services. As discussed in Chapter One, social care also has a critical role to play. So too does education, as argued in the CSJ's report *No Excuses: A Review of Educational Exclusion*.[136]

2.5.7 Dual Diagnosis[137]

> *'… dual diagnosis is an issue for every mental health service in the country … it is still … seen as very separate in some areas, where you have an addiction service and a mental health service, and there is no joining up.'*
> **Service Development Manager, BSMHFT, in evidence to the CSJ**

In December 2010, a new drug strategy was published by the Home Office 'to tackle drug dependence and promote a recovery-led approach to help people rebuild their lives.'[138] We know that those who experience mental health problems have a higher risk of substance misuse.[139] In addition, emotional and behavioural problems in children 'are associated with an increased risk of experimentation with, misuse of and dependence on drugs and alcohol.'[140] The lack of appropriate care and support being afforded to some vulnerable children who are presenting with emotional and behavioural problems gives us serious cause for concern in this context. Unfortunately, in a number of cases, we discovered a lack of early intervention approach taken towards those presenting with emotional and behavioural problems, and misusing drugs and/or alcohol.

134 London Evening Standard, *Gangs suffer mental illness, groundbreaking London study shows*, 12 July 2013 [accessed via: http://www.standard.co.uk/news/london/gangsters-suffer-mental-illness-groundbreaking-london-study-shows-8704862.html (12.07.13)]

135 HM Government, *Ending Gang and Youth Violence: A Cross-Government Report Including Further Evidence and Good Practice Case Studies*, Norwich: The Stationery Office, 2011; and Bullock K, Tilley N, Understanding and tackling gang violence, *Crime Prev Community Saf*, 10, 2008, pp36–47, cited in Coid JW et al, Gang Membership, Violence, and Psychiatric Morbidity, *Am J Psychiatry*, 170, 2013, pp985–993

136 Centre for Social Justice, *No Excuses: A Review of Educational Exclusion*, London: Centre for Social Justice, September 2011

137 I.e. 'co-existing mental health and drug and alcohol problems;' HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p41 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

138 Home Office, *Drug Strategy 2010 – Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life, 2010*, cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p41 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

139 Ibid

140 Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p41 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

A Public Health Manager, BSMHFT, referred to a '*traumagenic model of mental health*.' They explained that some poly-substance misuse is associated with individuals who have experienced perhaps the more severe levels of childhood abuse – what they are presenting with is actually, in some cases, childhood trauma based delayed PTSD. Our witness stated '*It can display and present itself similarly to many of the symptoms of psychosis, the hallucinations, the paranoia, that all very much link in to their early negative experiences. And when you start looking at the experience developmentally of a lot of these children and young people who have had their resilience battered, and have had these traumatic experiences, it becomes more of a logical consequence to see self-harming and substance abuse and other issues just as ways of coping*.'

No health without mental health stated the importance of appropriate services being 'available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet this breadth of need.' [141] However, our evidence appears to reveal an issue of concern over the extent to which some statutory services are capable and willing to support those with dual diagnosis. We heard about some services requiring a child or young person's drug misuse to be resolved before they are given treatment for their mental health problems. A GP told us that:

> *'Certainly there is no doubt about it that mental health services, if there is any concern at all that someone may have a substance misuse problem, that's always a problem, because "they're self treating with their substance misuse"… that is a classic issue and very difficult.'*

They went on to explain that this is more relevant, in their experience, with AMHS, than CAMHS. Psychological therapy services, they stated, will '*usually*' ask for the individual to be referred to substance misuse services, '*mainly*' because the evidence on conducting psychological therapy with someone who is not cognitively aware, because they are on psychoactive substances, '*is limited regarding efficacy*.'

Callie has a dual diagnosis, and has done for many years.[142] Kids Company believes that, from the outset, a core problem of Callie's has been that she has consistently fallen between some statutory services – because she has mental health problems and substance misuse problems. We were told that some mental health services have not wanted to work with Callie due to her dual diagnosis – i.e. they argue that her symptoms might be due to her substance misuse and not a mental health problem, and do not seem to have accepted the significant repercussions which can be created by PTSD. Likewise, some substance misuse organisations have not wanted to work with Callie because she was considered as psychotic. They consider Callie to have significant mental health problems and do not want that responsibility. However, Kids Company suspects that Callie has chronic depressive symptoms compounded by substance misuse, and that may be relevant to her psychotic episodes (or not), and stated that she cannot look after her physical or mental health, and cannot access services on her own. Kids Company's overall feeling is that no-one really wants to know because Callie's problems

141 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p41 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

142 Callie's case summary (Case Five) can be found on page 41

are so complicated and they can be seen by some services as compounded by her substance misuse – so she has fallen between services.

We were informed that Callie's case is unfortunately not that unusual but that some services are better than others at dealing with dual diagnosis. Indeed, we heard about examples of good practice. However, we were also told that although a NHS Trust may be willing to carry out joint dual diagnosis work, commissioners will play a big part in the decision as to whether that should be funded. We heard about the challenges faced by commissioners in the financial climate, and whether joining up addiction and mental health is considered to be one of their priorities, if such a service does not already exist in their area. A Service Development Manager, BSMHFT, explained:

> *'All the arguments at the moment are … you've got to do it in your current financial envelope. So if you want to develop something new, you've got to use the money you've already got. So that's the challenge for not only ourselves but for the commissioning groups as well. There's one pot of money. How far do you stretch it?'*

2.5.8 Psychological, psychotherapy and non-verbal therapies

As mentioned above, the IAPT programme provides psychological support within NHS-commissioned services in England for individuals aged 18 and over with depression and anxiety.[143] It is by far the largest existing NHS Talking Therapy service.[144] In *Completing the Revolution, Commissioning effective talking therapies*, the CSJ reported that:

> *'… until relatively recently in most IAPT services only CBT was available, on the grounds that they were following NICE guidelines for depression and anxiety … very closely. Recently, and in keeping with the more relaxed NICE guidelines, some IAPT services have been offering a slightly wider choice of therapy.'*[145]

At the same time, it was noted that:

> *'… many forms of talking therapy that may be able to achieve good outcomes have not yet had the opportunity to undergo the research procedures necessary to achieve [NICE] approval. As a result many people are losing out on accessing a wider range of effective therapies through the [NHS].'*[146]

A witness emphasised that the recognition that access to psychological treatment needs to be available to individuals through their GP, is to be welcomed, in that it has achieved high

143 However, it appears that some IAPT services work with children, as addressed in IAPT, *Working with under 18 year olds: Guidance for Commissioners, IAPT service providers and those working in IAPT services*, September 2011 [accessed via: http://www.iapt.nhs.uk/silo/files/working-with-under-18-year-olds-guidancedoc.pdf. (07.03.14)]. A detailed discussion on the IAPT programme can be found in Centre for Social Justice, *Completing the Revolution, Commissioning effective talking therapies*, London: Centre for Social Justice, April 2012. The aim of the report was 'to propose a means by which choice and access can be significantly improved so that more people recover from mental illness and thus avoid dependency and despair'

144 *Completing the Revolution, Commissioning effective talking therapies*, London: Centre for Social Justice, April 2012, p4

145 Ibid, p17

146 Ibid, p9

visibility in the public eye, and is vital as a part of redressing the balance between physical and mental health treatment provision. However, it seems that a number of difficulties exist. The early optimism for efficacy and cost effectiveness are now being challenged, which we have been told, may lead to further delays in commissioning by CCGs as they examine the cost/benefits.[147]

> *'IAPT is a very important step forward in acknowledging mental health needs at primary care level but we are now seeing that many of those referred do not complete treatment, cost effectiveness is not as good as originally thought and waiting times are increasing with concerns over whether it will continue to be commissioned at current levels by CCGs in the present climate. Although it was never intended to work with complex cases, inevitably many of these will be referred to IAPT as thresholds for statutory mental health services are raised.'*
>
> **Public Health Manager, BSMHFT, in evidence to the CSJ**

With respect to CYP IAPT programme (covering those aged zero to 19 years), the evidence-based therapies included in CYP IAPT's training are:

- CBT – for depression and anxiety;
- Parent training – for three- to ten-year-olds for conduct disorder;
- Systemic Family Practice – for conduct disorder, depression, and eating disorder; and
- Interpersonal Therapy for adolescents (IPT-A) for depression.[148] We understand that '… the evidence … shows that IPT-A can for some youngsters be more effective than CBT …'[149]

CYP IAPT recognises that 'a comprehensive CAMHS needs a range of interventions.' It states that 'In addition to the therapies chosen by [CYP IAPT], there are also other evidence-based treatments and approaches that contribute to a comprehensive CAMHS,' and that 'Commissioners and services will want to see these available to children and young people.' The CYP IAPT encourages 'fitting the measure to the child.' Its measures are stated as 'being designed to offer clients and professionals options which suit need and practice. There will be occasions when clinicians judge that session by session outcome monitoring is not appropriate.'[150]

147 For example, data obtained by PULSE on 85 CCGs under the Freedom of Information Act, has revealed that '68 [per cent] report treatment waiting times longer than the 28-day maximum target … Less than half … of CCGS offered a service that GPs could refer to for severe mental illness. Only 12 [per cent] of CCGs said they have expanded access to psychological therapies for children through IAPT;' PULSE, *IAPT programme struggling to achieve targets*, 24 October 2013 [accessed via: http://www.pulsetoday.co.uk/clinical/therapy-areas/mental-health/iapt-programme-struggling-to-achieve-targets/20004817.article#.UvN4dch-SYI (09.01.14)]

148 IAPT, *Children and Young People's Programme, Key Facts Briefing* [accessed via: http://www.iapt.nhs.uk/silo/files/cyp-iapt-key-facts-july-2013-.pdf (14.02.14)], and Children and Young People's IAPT, *National Curriculum* [accessed via: http://www.cypiapt.org/national-curriculum.php (14.02.14)]

149 Stated by Professor Peter Fonagy during his talk about CYP IAPT at the National Conference in 2013 [accessed via: http://www.cypiapt.org/children-and-young-peoples-project.php (14.02.14)]

150 IAPT, *Children and Young People's Programme, Key Facts Briefing* [accessed via: http://www.iapt.nhs.uk/silo/files/cyp-iapt-key-facts-july-2013-.pdf (14.02.14)]

However, our research has revealed serious cause for concern over an apparent increasing focus on CBT in some areas, and idea that it is a 'magic bullet' that will fix all mental health difficulties. CBT is focussed on cognition and behaviour change, as opposed to what is underlying the behaviour – i.e. the context and experience behind it. Undoubtedly CBT, will be an effective intervention for some children and young people, as several witnesses were quick to point out. A GP told us:

> *'Certainly CBT has a place … because it does give you certain tools for coping with situations. Some of these troubled kids; they don't have time in their lives to have effective long-term psychotherapy, so you have to give them some coping mechanisms and some simple CBT is appropriate in some of those cases.'*

However, a one-size-fits-all approach cannot realistically be taken towards all children and young people – particularly, we would argue, some of those who are vulnerable and very damaged. Some have deep rooted trauma, or anxiety and depressions that are related to their social and environmental conditions. A number of witnesses emphasised the vital need for an holistic and longer-term approach to treatment for some vulnerable children and young people, many of whom have attachment problems.

We were told that CBT relies a lot on an individual being ready to engage and needing to attend regularly. Some vulnerable children and young people need support and preparation before being able and ready to engage with an intervention. We also know that some can often struggle with engagement and to attend regular appointments. It could, we understand, take several months before a vulnerable child or young person may feel comfortable, let alone able to trust and ready to share what they have been experiencing. Some fail to engage with CBT and '*drop out of the system*,' before emerging later, when their mental health problems have become more serious again, in a more expensive part of the system. Some already vulnerable children and young people are being placed at greater risk.

> *'… not all children … are able to access their thoughts. CBT is based on being able to work out the connections between your thoughts, your feelings and your behaviour, but then you develop a very behavioural approach. Very often these problems are not just about the focus on the child, they are about the child in the context of the family. This is where in my view it falls down. But the health service loves it, because evidence-based practice is their thing. They like to be able to say "look at all these statistics that say CBT is the way forward, and actually we can offer six sessions and that's it, we don't have to do any more."'*
>
> **CAMHS clinician, in evidence to the CSJ**

It is essential that support is tailored according to individual needs. The fact that a vulnerable child or young person might complete the relevant number of CBT sessions does not necessarily mean that a positive outcome has been achieved for them. They may in fact have more needs than CBT can address, which could then become more entrenched. In reality, some could, for example, need several months of psychotherapy, as opposed to just learning strategies to cope.

'The business of how children learn and express themselves … – and develop – in terms of their emotions, of course you have to have lots of techniques. It would be a tragedy if things like art therapy, dance therapy and music therapy, and traditional psychotherapy didn't exist. Of course these things are needed. Some of the stories you hear of these kids and what they've been through, of course they need more involved psychotherapy. I wouldn't be saying that [those] with deep trauma are going to be sorted within a six week course of CBT. I don't imagine other people would either.'

GP, in evidence to the CSJ

Furthermore, we are mindful of the concerns that have been raised over a lack of preventative work being undertaken, whereby needs can become more complex, severe and enduring, so that should a vulnerable child or young person ultimately reach secondary care's threshold, their needs potentially could be more difficult for clinicians to address.

We heard that CBT relies on English being an individual's first language because CBT is a collaborative based therapy which requires practice and homework. A CAMHS clinician explained that '*For primary school children, they might do better with drama or art or play therapy – a non verbal therapy. These therapies are sometimes less available.*' Fundamental concern was expressed to us by numerous witnesses over the reduction in counselling, psychotherapy and non-verbal therapies, and its adverse implications for vulnerable children and young people, as more focus is being placed on CBT in some areas. This raises another example of practice which runs contrary to an early intervention approach, and which can compound the suffering of those who are vulnerable.

'We should have a huge toolkit and many different ways of interacting with children of all ages. It shouldn't just be verbal. We should be looking at all ways that children communicate, those who are less literate than others due to lack of stimulation. They can all draw, they can all play with toys and you can help them express themselves in that way … you can't effectively communicate with and treat a lot of primary school children if you haven't got those non-verbal therapies. There are a lot of children you're not going to be able to treat …'

CAMHS clinician, in evidence to the CSJ

'You would not believe, in this borough, we have no long-term counsellors … so if a child needs counselling, we have to do it as part of our caseload. We also have no play therapists … In some cases, I think without proper training some social workers may do more damage to children and families … It makes me physically sick. It's ridiculous and I realise that it's all money driven …'

Social worker, in evidence to the CSJ

Not only are some children unable to access their thoughts, some are unable to express them verbally – as a result of speech, language and communication needs (SLCN). Communication is integral to life. Yet, approximately one in every 62 children (1.61 per cent) is known to have

SLCN.[151] A study conducted in the United States has concluded that communication disability will be the number one public health challenge for the twenty first century.[152] It is a tragedy that many children struggle to communicate. It is a profound injustice to those children to promote, or allow a situation to develop, in which their ability to express themselves is restricted yet further.

> *'I know of services which have been through restructures and the very few therapy posts are going to be cut as far as I can see. I think it's going to be minimal. We need more therapists not less … a lot of these children are not able to put into words the problems that they have and need to use play or art to express themselves. A child should be given a voice through whatever a child is into …'*
>
> **CAMHS clinician, in evidence to the CSJ**

It also runs completely contrary to an early intervention approach. Where children have SLCN, and no access to non-verbal therapy, how will they be able to express their needs and access help? We should be doing all that we possibly can to enable them to seek the support and protection that they desperately need.

Dame Clare Tickell's review of the Early Years Foundation Stage, in 2011, made a critically important recommendation: that the Government introduces a single integrated review as a means of measuring a child's development, combining health and social checks at age two to two-and-a-half.[153] We understand that this would include children being screened for SLCN. We support Action for Children's call for the Government's urgent implementation of the single integrated review, and on the basis that it is 'appropriate, accessible and easy to use.' We also support their request for that review to be repeated at an older age.[154]

> *'I knew that if the recommendation were to be implemented, there was a possibility that it would highlight a shortfall in the right support. This seemed, and still seems, a strong rationale to ask the question so that resources can be directed to this most important of areas if needed. A cynic might say that the continued non implementation of the recommendation is because this has landed in the too difficult box, particularly at a time of contraction in services for children with speech and language delay. I hope that events will prove me wrong.'*
>
> **Dame Clare Tickell, CEO, Action for Children, in evidence to the CSJ**[155]

CYP IAPT requires CAMHS to collect outcome data. CYP IAPT states that 'Having robust outcome data for CAMHS also helps commissioners. Commissioners will increasingly require demonstrable and robust outcomes data from all services. CAMHS will be competing in a marketplace of services where difficult decisions and prioritisation of resources is the norm.

151 Law J et al, *Early language delays in the UK*, Newcastle University and Save the Children, London: Save the Children, 2013, cited in Centre for Social Justice, *Requires Improvement: The causes of educational failure*, London: Centre for Social Justice, September 2013, p54

152 Ruben R J, *Redefining the survival of the fittest: Communication Disorders in the 21st Century*, 2000

153 Tickell C, *The Early Years: Foundations for life, health and learning*, London: The Stationery Office, 2011

154 Action for Children, *The state of child neglect in the UK: Recommendations for the UK Government*, p2 and p30 [accessed via: http://www.actionforchildren.org.uk/media/5115101/12_13_0201_neglect_summary_report_a5_port_v12.pdf (07.02.14)])]

155 At the time of publication, Dame Clare Tickell is no longer CEO of Action for Children

A service that can demonstrate it is effective and good value for money is more likely to be funded than one which cannot demonstrate the outcome of its work.'[156]

This surely places some forms of counselling and psychotherapy, as well as non-verbal therapies, in a problematic position – on the basis that they are harder to evidence (and do not have the same evidence base as that given to CBT), can be long term, and that their outcomes are more difficult to measure. Conversely, we heard that it is easier to conduct research on CBT with respect to evidencing its effectiveness, because it is shorter; session by session outcome monitoring of CBT can also be undertaken. A GP told us *'I can imagine the scenario also of managers looking at budgets – looking at CBT 'oh nice outcomes there' – looking at art therapy 'how do you measure that?"*

> *'Although NICE states clearly that "In using guidelines, it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness," in practice, the absence of [Randomised Controlled Trial] evidence is used by commissioners to imply that such provision does not help people to recover.'*[157]

We raised our concerns with a VSO in the context of commissioning – that whilst CBT will be an effective intervention for some, it will not be for others. Again, although a certain number of individuals may have completed the course, the reality for some will be that the intervention will not have met their needs. Our witness responded that:

> *'[CBT is] a really good example of what can happen … Commissioners understandably love it because it's evidence-based and … they don't need to know about the interventions themselves because NICE are saying this is how it's done. So they commission it off the shelf almost … and yet the outcomes [in this area] are nowhere near what they commissioned and anticipated for it … we … recognise that what works for one person doesn't work for another, that "evidence" in mental health care means something slightly different to physical healthcare, and it's about finding what does work for an individual.'*

We believe that the approach that is being taken towards the treatment of some vulnerable children and young people's mental health, in some areas, runs contrary to the reforms which place an emphasis on the importance of choice for those with mental health problems in the provision and treatment available to them. Furthermore, it flies in the face of the requirement for care to be personalised to reflect individual needs, not those of the professional or the system. We argue that it also contravenes the governing principle of 'No decision about me without me.'

156 CYP IAPT, *Frequently Asked Questions* [accessed via: http://www.cypiapt.org/faqs.php (20.02.14)]

157 National Collaborating Centre for Mental Health Commissioned by the National Institute for Health and Clinical Excellence, *Depression in Adults (update), Depression: the treatment and management of depression in adults*, National Clinical Practice Guideline 90, 2009, p9, cited in Centre for Social Justice, *Completing the Revolution, Commissioning effective talking therapies*, London: Centre for Social Justice, April 2012, p18. For further discussion, see also *Centre for Social Justice, Making Sense of Early Intervention*, London: Centre for Social Justice, 2011

2.5.9 Other constraints on effectiveness and efficient use of resources

Our evidence has revealed a concerning picture with respect to the use of existing resources within some CAMHS and AMHS. We heard that '*the increasing bureaucracy in the NHS is astonishing*.' It is concerning that this may be preventing some professionals from seeing more children and young people. Surely their administrative tasks should be more streamlined and less onerous. We fully appreciate the need to manage risk. However, we question the extent to which the current requirements are necessary, and whether they actually justify an efficient use of professionals' time. This should be addressed as a matter of urgency.

> *'For every new patient we see, for every hour we see them, we spend almost two hours doing paperwork. That reduces our capacity to see children and their families. I am not sure whether we need to maintain this level of lengthy documentation. Some of it is related to traditional, risk averse medical practice. However, there is definitely a lot of duplication that we could do away with. A lot could be done to reduce the pressure on the clinical staff to do administrative tasks with the use of technology. The electronic patient recording systems have been a lot better, but still clinical staff are expected to carry out a lot of paperwork for various reasons … The clinical governance structures in statutory agencies have certainly created safe and sound practice, but can be unwieldly and some aspects of the documentation in CAMHS are economically unviable. More widespread use of technology and clear leadership within CAMHS can reduce inefficiencies.'*
>
> **Dr Mirza, senior CAMHS clinician and academic, in evidence to the CSJ**

We heard that '*there is a major role for social work in CAMHS*.' Many CAMHS do employ social workers, and Skills for Care (as was) published a report in 2010 which clearly stated the importance of social work in CAMHS settings. A key message conveyed by national/regional CAMHS staff who gave evidence to that report, was 'the need to strengthen the social work presence within CAMHS settings through deployment of social workers, and increasing the recognition of the value of the core social work role within these settings.'[158] Concerningly, YoungMinds has found that one impact of the financial cuts is that 'Specialist social work roles assigned to looked-after children's CAMHS services are being lost.'[159]

Our evidence has highlighted the extent of '*routine*' social care work that is being carried out by some CAMHS and AMHS practitioners. We heard about clinicians assisting with wider social issues that some vulnerable children and young people can present with. A number of witnesses felt that this was beyond the clinicians' area of expertise, and pointed out that they were not funded for such work. The extent of challenge that some vulnerable individuals' mental health problems and housing difficulties, amongst others, can present to professionals are only too evident from Callie's case.[160] Callie was not in fact supported by CAMHS or AMHS, although she had contact with other statutory mental health provision. She lurched

158 The report also states that 'Fundamentally, it is thought that social workers should be employed primarily as social workers – with clear recognition of the value of their statutory functions and knowledge for the multi-disciplinary team;' Briggs S (Professor) et al, *Skills For Care: Social Work Research – Scoping capacity to deliver practice learning for social work students in statutory mental health settings*, July 2010, pp16–18 [accessed via: http://www.uel.ac.uk/cswr/resources/documents/FINALREPORT3.9.10_000.pdf (10.02.14)]

159 YoungMinds, *CAMHS Cuts Survey – 'Staff Morale in CAMHS has dropped to its lowest ever,'* YoungMinds Magazine, Issue 118, Winter 2012/2013, p27

160 Callie's case summary (Case Five) can be found on page 41

from one crisis to another. The impact on her mental health as a result of her unstable housing, and challenges she faced in gaining access to housing that was suitable for her needs, was devastating. Some cases will of course be more complex and involve more severe needs than others. However, the additional pressure that some clinicians must be facing by virtue of not working more collaboratively with social care and other relevant agencies on these wider social issues cannot be underestimated.

> *'… the simple fact of it is, say if CBT is one of the interventions you deliver, you can't deliver CBT effectively if the main issue for that child or young person is they're going to be homeless next week. They're not going to be focussed on that … Their priority is "I need somewhere to live next week" … That's the reality of it. That's what we're seeing all the time. With all the will in the world our clinical service will not deliver unless some of those social challenges are sorted as well. And vice versa, their social circumstances won't improve if their mental health issues are still there, but we don't join up enough.'*
>
> **Service Development Manager, BSMHFT, in evidence to the CSJ**

This strikes us as something of an anomaly. On the one hand, we have heard how funding has led to more of a focus on support for those with more severe mental health problems, thereby hindering the potential for preventative work. In addition, it appears that children with conduct disorder, for example, are not receiving appropriate care and support from some CAMHS. However, on the other hand, we have been told that some clinicians are helping individuals with their wider social issues – in some cases, it would seem, amounting to significant periods of time. We query whether this is the most effective and efficient use of their skills, expertise and available resources. We also question where social care is in such cases, and why agencies are not working more collaboratively to support vulnerable children and young people.

> *'… a lot of the time of clinicians is spent working on generic case management. Things like trying to address the housing needs, benefits, the sort of basics of survival in healthcare rather than being able to focus on what they're funded for such as therapeutic interventions … very often … the clinician is left trying to hold on to lots of different pieces of work with an individual that they're not actually funded to provide, before they can get that individual to a place of stability where some actual treatment is capable of being applied …'*
>
> **Public Health Manager, BSMHFT, in evidence to the CSJ**

The issue – in terms of the apparent blurred division between some social care and CAMHS/AMHS work – became more apparent in the context of attachment, as ever, a central and recurring theme. A witness referred to individuals that they have met with who work in CAMHS. They explained:

> *'Week in, week out they work with long-term cases of complex family situations where there is also a mental health issue like self-harm … The divide between social care and CAMHS isn't that clear … Maybe it shouldn't be. There is always a mental health issue to take into account in social care. When you talk about well-being, when you talk about attachment – you're always talking about mental health. It is a false divide most*

of the time. If you're looking at a child's well-being, you're looking at their mental well-being. One answer is that they should both be doing it, and then how do you divide up the resources? One of the consequences then is that CAMHS is always full, because you have a broader definition that came in with the review of CAMHS (about 10 years ago) that said mental health is everyone's business, CAMHS should be mainstream, everyone should have access to it.'

Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, commented:

'I think we should be dealing with housing matters … [We are told] we are not trained that way because we are psychologists, but I am sceptical about all of this. I think the solutions need to be much more radical – a complete workforce redesign.'

In the meantime, conversely, it appears that some social workers are struggling to manage some cases of vulnerable children and young people with mental health problems, due to a lack of training, experience and/or in the absence of appropriate support being available to them or the children and young people. We were given an alarming example of just how grave the consequences of this can be. A social worker explained:

'… I'm not qualified, sometimes ethically it can't happen – we can't speak to this child about this, so … no intervention is ever put in place. Because he was too young and we didn't have the services. It doesn't get written down that … we didn't have the services and … we weren't willing to refer because of financial restrictions. It's just that "this happened, and we were unable to know whether it actually happened or not."'

They went on to explain that it is recorded in such a way that if a person worked *'inside'* they would know *'this is bull****,'* but that if they do not, they would look at it and think *'oh good, the work's been done. This hasn't been addressed but it's good that it's been highlighted. Hopefully someone's going to pick it up.'* However, the social worker told us that the reality is that no-one is going to pick it up – *'And it wasn't addressed specifically for those reasons.'* Social workers need available training/support and resources to give them every possible chance of achieving a positive outcome for all of the children and young people they are working with. It is horrifying to hear that needs are being left, unaddressed, in this way, and must be extremely worrying for the social workers. Again, it also undermines an early intervention approach.

We raised the example, with a CAMHS clinician, of the distress a social worker had expressed to us over not being able to gain access to support from CAMHS for a number of children, including one who had been self-harming. The CAMHS clinician explained that, historically, some CAMHS services have worked to a very medical model:

'… it certainly has caused tense relationships with social care because of that. Because a lot of the cases have complex emotional and behavioural difficulties, it's a very grey area. I think CAMHS services quite often make unhelpful distinctions between these, and say "this is the domain of mental health and that isn't."'

The CAMHS clinician informed us that self-harm can be a difficult area, because a lot of children resort to it as a coping mechanism, and people become very anxious, understandably, about it, because they link it with suicide.[161] Our witness explained that it is a lack of experience in mental health that causes people to become anxious. They stated that:

> *'The in between is about the access to advice and support from a skilled professional … I feel what we should be doing is helping to advise and support people, so that they do not feel overly anxious and we're all clear about the things that we do need to be anxious about.'*

While such provision exists in some areas, there appears to be a desperate need for it in others. Again, this raises the paramount importance of social care and statutory mental health services working collaboratively. We were also informed that a lot of medical based evidence exists for self-harm, but that there is very little social care evidence in that field. However, whilst we know that social workers are dealing with '*self-harm and suicide, etc … the evidence as to what works is not there and is very under researched.*'

Isabelle Trowler, former Director of Morning Lane Associates, provided an encouraging example of an approach taken to provide the requisite support:

'*I think most social workers would say they struggle at times to get the CAMHS support they need for children and young people, when they need it. Part of that will be because there are professional differences about the context in which successful work can take place but resource may also play its part. In the Reclaiming Social Work Model we located Tier 2 clinical expertise within the social work unit under the direct control of the allocated social worker, so that the early identification of mental health needs was core to social work assessment, as well as systemic and behavioural based clinical interventions being readily available.*'

2.5.10 Transition from CAMHS to AMHS

> *'… the CAMHS cut off. There are still places where nobody can be found to support you if you're 16 to 18. It is an absolute scandal …'*
> **Andrew Webb, President of ADCS, in evidence to the CSJ**[162]

161 As is made clear by NICE guidance, a strong link exists between self-harm and suicide; NICE, *Self-harm: longer-term management*, Clinical guideline CG133, 2011; available at: http://guidance.nice.org.uk/CG133. Self-harm is clearly defined as 'any act of intentional harm to the self, irrespective of method used or intended outcome; therefore including suicide attempts;' ibid, and Hawton et al, Self-harm and suicide in adolescence, *The Lancet*, 379, 2012, pp2373–82. An episode of self-harm increases the risks of suicide by 50 – 100 times; Kendall T et al, Longer-term management of self-harm: summary of NICE guidance, *BMJ*, 343, 2011, d7073

162 At the time of publication, Andrew Webb is no longer the President of ADCS

Concerns were shared by various witnesses over '*the ever present*' and well documented 'problem of transition' by children and young people from CAMHS to AMHS.[163] *No health without mental health* specifically referred to how services can improve transitions, including to AMHS, under its fourth agreed objective.[164] However, barriers remain, and many children and young people continue to face significant challenges in successfully negotiating a transition between the services.[165]

We know that half of all lifelong mental health problems first occur before the age of 14, and three quarters by the age of 24.[166, 167] Yet, there is a divide in our statutory mental health service provision right in the middle of that most vulnerable period. Even if an individual meets their local CAMHS threshold and succeeds in gaining access to their services, they may subsequently find themselves cut adrift from statutory support between the age of 16 to 18, depending on when their CAMHS cut-off point is. Following their discharge from CAMHS, they may struggle to find help from elsewhere in the interim, before they reach the admission age of their local AMHS.[168] They may then ultimately fail to meet AMHS' threshold – which, in some cases, can be higher than CAMHS' – to gain access to their support. In these circumstances, their needs may then escalate to the point where they reach crisis – and thereby meet the AMHS threshold.

> *'… I have seen [children] be in CAMHS for years, and then the minute they are 18 that's it, they are dropped. I find that very difficult … and very rarely do they meet the criteria for [AMHS].'*
>
> **Witness, in evidence to the CSJ**

163 For example, Singh S et al, *Transitions of Care from Child and Adolescent Mental Health Services to Adult Mental Health Services (Track Study): A study of protocols in Greater London*, NIHR, June 2008; and Singh S et al, *Transition from CAMHS to adult mental health services (TRACK): a study of policies, process and user & carer perspective*, 2010 – both cited in National Mental Health Development Unit, *Planning mental health services for young adults – improving transition: A resource for health and social care commissioners*, March 2011, p6 and p23, and p9 and p10 respectively [accessed via: http://resources.leavingcare.org/uploads/36aa90bebb6e354d314dfdde286d25d.pdf (14.02.14)]. Also *CAMHS Review – Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families and Department of Health, November 2008, pp83–85 [accessed via http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399 (18.02.14); and Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, September 2010, pp37–38 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (21.02.14)]

164 i.e. that 'More people will have a positive experience of care and support;' HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, pp25–26 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

165 Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Volume Two: Practical mental health commissioning, February 2012, p7 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20%28March%202012%29.pdf (10.02.14)]

166 Kim-Cohen J et al, Prior juvenile diagnoses in adults with mental disorder, *Archives of General Psychiatry,* 60, 2003, pp709–717; and Kessler R et al, Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, *Archives of General Psychiatry,* 62, 2005, pp593–602 – both cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p8 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

167 Kessler R and Wang P, The descriptive epidemiology of commonly occurring mental disorders in the United States, *Annual Review of Public Health,* 29, 2007, pp115–129, cited in HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p8 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

168 ' … there is still considerable variation across the country in the cut-off point between CAMHS and AMHS' – in some areas, CAMHS continues up to 18 years of age, whereas in others it ends at 16, in others it ends at 16 if an individual is out of school, and at 18 if they are still in education; Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Volume Two: Practical mental health commissioning, 2012, p7 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20%28March%202012%29.pdf (10.02.14)].
YoungMinds states that 'The transition from CAMHS to AMHS is subject to extreme local variation, with some … making the transfer to [AMHS] at 16, some at 16 if not in school or 18 if in school, and some at 18 … ;' YoungMinds, *CAMHS Transition* [accessed via: http://www.youngminds.org.uk/about/our_campaigns/transitions (14.02.14)]. We have been told that the age at which support from CAMHS ends and AMHS begins depends upon the individual policy of local services

It is even more important that continuity of care is provided during this particularly vulnerable period. However, the divide in statutory service provision sets the scene for difficulties in achieving quality of transitions. This can be due to the differences in, for example, the training of clinicians, style of service, interventions, systems, structure, funding and culture between CAMHS and AMHS. *The Track study* found that: 'for the vast majority of service users, transition from CAMHS to AMHS is poorly planned, poorly executed and poorly experienced.'[169] It also found that 'up to a third of teenagers are lost from care during transition and a further third experience an interruption in their care.'[170] In describing handovers of cases to AMHS when individuals become 18, one VSO told us '*this area is really poor.*'

Primary care is one potential source of support for those who have nowhere else to turn to for help following their discharge from CAMHS, and for those who do not meet AMHS' threshold. One GP told us:

> *'I think with mental health particularly, children who would meet a CAMHS threshold … they turn 18 and they often don't meet the adult threshold and are managed in primary care.'*

However, as discussed earlier, some children – particularly teenagers it seems – do not use primary care in relation to their mental health needs. Marginalised teenagers may be even less likely to. In addition, if vulnerable children and young people are not benefiting from social care support (for example, as a care leaver), they can be left stranded. That is where some VSOs, like Kids Company, are again playing a critical role. They are helping many such children and young people to deal not just with the practical challenges that they face but also, by working in a therapeutic way, the emotional challenges, and with the opportunity for them to access direct therapy should they wish to do so.

For those who do meet the AMHS threshold, and gain access to support, concerns have been expressed over the quality of their care in some AMHS.[171]

> *'All the sociology shows that young people are still dependent on parents and that "adolescence" often goes on into mid 20s, but we do this cut off at 18. AMHS are completely inadequate for young people … There has been quite a lot of talk about making transition better, but actually mental health services for young people in adult services are not on the whole adequate. They are not suited to young people.'*
> **Witness, in evidence to the CSJ**

169 Singh S et al, *Transition from CAMHS to adult mental health services (TRACK): a study of policies, process and user and carer perspectives*, January 2010, p173 [accessed via: http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0010/64288/FR-08-1613-117.pdf (14.02.14)]

170 Singh S et al, Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study, *British Journal of Psychiatry*, 197(4), 2010, pp305–312, cited in Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Volume Two: Practical mental health commissioning, 2012, p7 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20%28March%202012%29.pdf (10.02.14)]

171 In evidence to our Review and, for example, Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Volume Two: Practical mental health commissioning, 2012, p7 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20%28March%202012%29.pdf (10.02.14)]

We are also mindful of the fact that some children and young people's emotional development can be delayed. For example, someone might be 18 in chronological age but could be 13 emotionally. We question how AMHS can be appropriate for them, given the differences in their services, as highlighted above.

The lack of continuity of care and consistency of relationship experienced by some vulnerable children and young people across the health care system can be compounded by transition difficulties. A stream of recommendations has been made over years to improve transitions services. Good practice guidance, *Transition: Moving on Well*, and *Working at the CAMHS/Adult interface*, has also been published.[172, 173] Yet many are still being failed. There are any number of different models of transition across England, with '… no prescribed "best practice" model' to meet the relevant needs of children and young people.[174] There are examples of services which fuse the expertise of CAMHS and AMHS to support children and young people, and their families – for example, in many early intervention psychosis teams. However, a comprehensive approach is lacking.[175] We note that Birmingham intends to overhaul the way in which it delivers community mental health services for zero- to 25-year-olds, and is proposing a new service to deliver services to that age bracket.[176]

A number of witnesses to our Review emphasised the need to focus on a child's transition to adulthood, as opposed to simply on their age and transition to AMHS. Andrew Webb, President of ADCS, commented:

> *'… to talk about transitions is unhelpful and to talk about services is unhelpful. What we need to do is to work with the child in their journey to adulthood. Adulthood has … a very flexible starting point. Just as it does if you have someone with a profound learning disability whose functional abilities might not change much from between 15 to 24, but in service terms might end up going through two or three completely different services.'*

Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, told us that:

> *'… rather than just focussing on age, there is some sense in trying to arrange services in a slightly more developmental way. What is happening between the ages of 16 and 25 generally is that [an individual] is moving from being a young person to being an adult. It is not just a transition to our services; it is a transition to adulthood. The transition to adulthood is a potential vulnerability. We need to design services that attend to that*

172 Department for Children, Schools and Families, and Department of Health, *Transition: Moving on Well: A good practice guide for health professionals and their partners on transition planning for young people with complex health needs or a disability*, February 2008 [accessed via: http://www.bacdis.org.uk/policy/documents/transition_moving-on-well.pdf (25.02.14)]

173 Lamb C et al, *Working at the CAMHS/Adult Interface: Good practice guidance for the provision of mental health services to adolescents/young adults*, London: Royal College of Psychiatrists, 2008, cited in Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Volume Two: Practical mental health commissioning, 2012, p8 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20%28March%202012%29.pdf (10.02.14)]

174 Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Volume Two: Practical mental health commissioning, 2012, p8 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20%28March%202012%29.pdf (10.02.14)]

175 YoungMinds, *CAMHS Transition* [accessed via: http://www.youngminds.org.uk/about/our_campaigns/transitions (14.02.14)]

176 NHS, *Have your say – Improving Children and Young Adult Community Mental Health Services across Birmingham* [accessed via: http://www.bhamsouthcentralccg.nhs.uk/patient-and-public-engagement/0-25-mental-health-services (04.03.14)]

vulnerability. In doing that, you need to have services that are designed to address issues of work, because what marks the transition from being a young person to being an adult in our society is basically that you earn money.'

Dr Fuggle explained that if he was designing mental health services for 16- to 25-year-olds, he would place education, work and housing at the centre, and would design the mental health aspects around that. In his view, '*the task is that they somehow have to make that jump. You design it around the developmental task. You don't design it around what we are entrusted to do.*' We heard that the biggest vulnerability for young people is that they don't make that transition into earning money very effectively – they drop out of college, and can develop substance misuse difficulties (amongst others), which can lead to all sorts of mental health difficulties. Another witness stated that '*there is coherence around 16 to 25.*' They added:

'That is a whole developmental period that is very under-recognised. Some kids will shoot into adulthood at 18 to 19, while others are still kicking around at 25. The evidence is that the worse the trauma early on, the more difficult it is when you are 20,21,22 – trying to get out of the trap that has been made for you – no education, no qualifications, no employment, no family and no support. Then all the bad positives like criminal history, substance misuse are a trap for 20- to 24-year-olds. It is hugely problematic.'

We believe there is a strong case for redesigning statutory mental health provision, so that rather than thinking about age and transition, services should be arranged in a more developmental way. A call has also been made for the harmonisation of care pathways and service thresholds to be achieved urgently.

Commissioners have a vital role to play in improving transitions. Professor Sir Ian Kennedy recommended that 'Ensuring a smooth transition between [CAMHS] and [AMHS] should be a priority for local commissioners.'[177] *No health without mental health* stated that services could improve transitions by (amongst other things), 'focussing on outcomes and improving joint commissioning, to promote flexible services based on developmental needs.'[178] Guidance exists to help commissioners to commission effective transitions services.[179]

177 Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs,* September 2010, p93 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (21.02.14)]

178 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p25 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

179 For example, National Mental Health Development Unit, *Planning mental health services for young adults – improving transition: A resource for health and social care commissioners*, March 2011 [accessed via: http://resources.leavingcare.org/uploads/36aa90bebb6e354d3514dfdde286d25d.pdf (14.02.14)]; and Joint Commissioning Panel for Mental Health, *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Volume Two: Practical mental health commissioning, 2012 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20CAMHS%20transitions%20%28March%202012%29.pdf (10.02.14)]

2.6 Commissioning

The Health and Social Care Act 2012: A new landscape

- HWBs were established 'as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.' Each unitary and upper tier local authority will have its own HWB.[180]
- CCGs comprising of GPs and other clinicians, now have responsibility for commissioning the majority of NHS care.
- NHS commissioners are supported by the NHS Commissioning Board (NHS CB), which authorises CCGs, allocates resources and commissions certain services, including primary care.[181]
- Local authorities and CCGs are required to prepare a joint strategic needs assessment (JSNA), and a joint health and wellbeing strategy (JHWS). HWBs are the vehicle through which JSNAs and JHSWs are produced:
    - A JSNA is an assessment 'of the current and future health and social care needs of the local community … these are needs that could be met by the local authority, CCGs, or the NHS CB … The policy intention is for [HWBs] to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities … it is important to cover the whole population and ensure that mental health receives equal priority to physical health.'
    - A JHWS is a strategy 'for meeting the needs identified in JSNAs … They should explain what priorities the [HWB] has set in order to tackle the needs identified in their JSNAs.'
    - 'The purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages … Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and well-being.'
- 'CCGs, the NHS CB, and local authorities' plans for commissioning services will be expected to be informed by relevant JSNAs and JHWSs. Where plans are not in line with JSNAs and JHWS [sic], [they] must be able to explain why. The policy intention is that … services and the way in which they are provided meet local needs.'[182]

Our evidence has revealed serious cause for concern in a number of respects regarding commissioning in some areas – aspects of which have already been highlighted. As discussed earlier, some GPs are struggling to secure support for some vulnerable children and young people from secondary care services, due to their thresholds. Prior to the Health and Social Care Act 2012, the Joint Commissioning Panel for Mental Health recognised the extent of opportunity for GPs, with their new commissioning responsibility, to help transform mental health services and support:

180 Department of Health, *A short guide to health and wellbeing boards*, 28 February 2012 [accessed via: http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/hwb-guide/ (27.02.14)]

181 Department of Health, *Health and care structures fact sheet*, 15 June 2012 [accessed via: https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets (27.02.14)]

182 Department of Health, *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*, 26 March 2013, pp4–9 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf (27.02.14)]

' … to make primary care the hub of all mental health services and support, and thus ensure services are better able to meet the spectrum of need of the wider population, as well as those with severe mental illnesses. This model also … can, where appropriate, shift resources (investment and skills) towards the community end of people's care pathways. It may also enable better and more active management of people's journeys into and out of specialist mental health services, in part through increased availability of these services in surgeries and health centres … It gives increased potential for health, social care and other key stakeholders to collaborate at locality level to meet the totality of individual or family needs … It gives GP commissioners and local authorities greater flexibility to design and deliver specific services that meet specific local needs. It extends opportunities for shared care and expands access to specialist professional skills where they are most needed and most useful, closest to people's homes and within their communities.'[183]

However, YoungMinds raised its concerns with us over a lack of prioritisation and identification of children and young people's mental health needs in some areas. The VSO has called for local agencies to ensure that a sufficient number of services are commissioned to meet the needs of a given area. It stated '*At the moment, cuts, especially to local authorities' CAMHS budgets, seem to be somewhat arbitrary and do not seem to be based on needs.*'

Indeed, the Children & Young People's Mental Health Coalition's report *Overlooked and Forgotten*, has since revealed that, whilst there was some promising practice:

- 'Almost two thirds … of JSNAs did not have a section that specifically addressed children and young people's mental health. Amongst the third that did, there was substantial variation in the amount of information included, with many not including more than a short paragraph …
- One third of [JSNAs] did not include an estimated or actual level of need for children and young people's mental health services in their area.'[184]
- 'Where levels of need were estimated there were three types of data commonly used: hospital admissions data; rates of referral to [CAMHS] and calculating local prevalence rates … by extrapolating from national data. Hospital admissions data and CAMHS referral rates only provide information about children and young people who have reached a critical stage and don't provide a full picture of need.'
- 'The most commonly used data for generating an estimate of prevalence of need was from the [*2004 ONS survey*] … undertaken almost ten years ago and prior to the recession and other significant social and cultural changes which are likely to have had an impact on children and young people's mental health.
- Despite the transition from [CAMHS] to [AMHS] being repeatedly highlighted by a range of agencies as in need of improvement, data about the mental health needs of [those] aged 16 [to] 25 was especially limited in the JSNAs …
- One third of JHWSs did not prioritise children and young people's mental health.'[185]

183 Joint Commissioning Panel for Mental Health, *Practical Mental Health Commissioning: A framework for local authority and NHS commissioners of mental health and wellbeing service, Volume One: Setting the Scene*, March 2011, p18, cited in Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p183

184 The review was undertaken of '145 JSNAs and 142 JHWSs that were in the public domain in early 2013, from the total 151 HWBs;' Oliva L and Lavis P, *Overlooked and forgotten: A review of how well children and young people's mental health is being prioritised in the current commissioning landscape*, Children & Young People's Mental Health Coalition, December 2013, p13 [accessed via: http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/ (11.02.14)]

185 Ibid, p6

It is imperative that good, reliable data exists at a local level, and that every HWB and all commissioners know about the true level of need in their area. However, on the basis of the report's findings, some commissioners cannot have any realistic hope of gaining an informed understanding of the local need, or of ensuring that sufficient resources are allocated to meet that need and ensure that positive outcomes are obtained. It is also totally unacceptable that such a lack of priority is being given by some JHWSs to the mental health needs of children and young people. We have been informed that the JSNA has historically been a collaboration of local authority and public health professionals, with the only involvement of the NHS being at commissioner level, as a result of which the focus and priorities set by JSNAs often have very little NHS evidence informing their decisions.

The Children & Young People's Mental Health Coalition has made the recommendation (amongst others), that a national survey of child and adolescent mental health is commissioned, to equip commissioners with up-to-date information on the prevalence of mental health needs in this group, which they can use to better understand local need. It has also joined the Children and Young People's Health Outcomes Forum in recommending that data from that survey, and all other data regarding children and young people's mental health, be divided into five-year age bands – up to the age of 25. This is to ensure that data is available in an easily accessible form, enabling services to be commissioned according to the obvious needs of children and young people at different stages of their development. It strikes us that a national survey of children and young people's mental health would also be extremely valuable.[186] We appreciate that local prevalence could differ markedly according to indices of deprivation; it would be important to ensure that such a survey would also be useful on a local level.

Even with the necessary improvements to data, it seems that commissioners face another challenge, as illustrated by one of our witnesses – '*the problem is how do you transform the data into service provision?*' They explained that not everyone has a mental health problem as identified in this way, and necessarily requires intervention from a CAMHS professional. They said that '*Some children need something in schools; some don't need anything. Others need massive interventions because the mental health issue is the tip of the iceberg and showing you what is beneath it, and it depends what mental health difficulties there are.*'

Our witness referred to there being about 20 to 25 per cent of individuals who develop a mental health problem in adolescence which, for some, continues into adulthood, but ceases for 75 per cent – '*How do you work out which is which? It is quite complicated.*' We were informed that an episode of self-harm is '*the most reliable risk factor for suicide, and the only reliable one*,' but that there is *'a conundrum with depression,'* for example, '*since though depression is often linked with self-harm, there are depressed people who don't harm themselves – and people who are not manifestly depressed who do. Therefore, you have got to take every self- harm seriously.*' However, we were told that the proportion who go on '*to repeat and to complete suicide*' is very small – '*Suicide is a rare event. It is about nine in 100,000.*' In light of the above, our witness raised the following question and, in so doing, reinforced the importance of the prompt and accurate identification of children and young people's mental health problems, and early intervention:

186 I.e. up to the age of 25 and including children under the age of five if assessment instruments are robust enough

'How do you commission services when you have got so many unknowns and so many variables? You have to have common sense – I think that is what they do try to do. And to actually have easy access, therefore increasing the access of children and young people to some kind of initial service, whilst then also being able to identify the smaller but significant number who are in significant trouble. It is getting through that filter, and that is how you pick up on those who are in real trouble and likely to be enduring escalating difficulties for the rest of their lives.'

We referred, earlier, to concerns having been raised in the context of commissioning early intervention services and interventions. Further challenges for commissioners were highlighted. A Senior Manager of a Children's Services Department told us how complex commissioning arrangements can be. They referred to the number of CCGs, as well as public health, a local area team and others – including multiple mental health providers – that are involved in commissioning in their area. It can clearly be a complicated system for some local authorities to navigate their way around. We were told that a lack of consistency within the commissioning system can drive difficulties. For example, our witness said that preventive approaches to mental health should be commissioned by public health, community based services will be commissioned by CCGs, but Tier 4 (i.e. specialist inpatient provision) is commissioned by NHS England. We heard that there is the potential for disconnect between these three commissioners.

In response to this, a Public Health Manager, BSMHFT, expressed optimism and said that they see '*tremendous opportunity in this current, fluid landscape, to join up the dots.*' They reported that commissioners, in their area, '*are desperate for evidence-based guidance to improve care pathways for children and young people and are keen to adopt preventative approaches.*' A Service Delivery Manager, BSMHFT, highlighted the need for guidance on the due diligence required for this, and on how information sharing and governance issues, for example, should be addressed. It was suggested that HWBs should issue overarching guidance.

One witness expressed positive views about their CAMHS commissioning framework, which they described as being '*extremely well managed.*' However, we also heard that '*In the public sector, commissioning seems to be filled with professionals with little or no experience of delivering services,*' and that *'it often appears as though there is very little understanding of what is being commissioned.*' In addition, we were told about decisions around commissioning being driven by the wrong priorities.[187]

' … it's obvious to those of us in frontline services that commissioners sometimes have a very poor understanding of what it is they're commissioning. The priority is presumably and understandably to use resources efficiently and accountably, but my experience has often been that there is little understanding about how to achieve that without compromising care and quality. I think often it's because many of those commissioning services aren't ex social workers or ex mental health professionals or … teachers. Lots that I've met have come over from private business, so it feels as though the professional profile and

187 We discuss evidence from VSOs in Chapter Three – including concern raised over there being a 'financial imperative at the heart of commissioning'

competencies of the role are weighted too far in favour of economics, and I just think that's probably quite a dangerous road to go down.'

Witness, in evidence to the CSJ

There is clearly a need for stronger and more visionary leadership, and innovative commissioning in some areas. We need better informed commissioners, making commissioning choices that have professionals and clinicians from across the sectors engaged in that process – enabling commissioners to better understand the services that they are trying to commission. In Chapter Three, we highlight the greater potential for commissioners to enable partnership working between statutory mental health services and VSOs.

2.7 Conclusion

'Mental health … I see it as a project and something that is so huge that we actually need to take it on … everywhere … I think with mental health, where was it ever really appropriate to bring it up? Was it the education committee? Well, we couldn't spend the whole meeting talking about mental health. Was it in housing? It touches on that. There was never really a platform for mental health. With all of these very controversial changes coming in with the NHS, one of the things that I think local authorities can "grab the bull by the horns' on – is tackling mental health at a local authority level … because it affects children … adults … residents, and … housing … – every service. We are now including this issue in our new [HWB] meetings."'

Councillor Georgie Cooney, in evidence to the CSJ

Our mental health system is considered by some to be in crisis. Whilst we have heard examples of encouraging practice in a number of areas, the situation faced by many vulnerable children and young people with mental health problems in this country is scandalous. Some statutory mental health services are far from child/young person-centred. As with child protection practice, budget cuts are creating additional challenges to the provision of appropriate care and support for vulnerable children and young people with mental health problems in some areas. Some CAMHS services are heaving under the pressures faced – struggling to maintain quality of care and to meet the demand on their services, whilst operating at a hugely stretched capacity. All the while, evidence shows the negative impact that this is understandably having on staff morale in such services.

Aligned with child protection, it appears that society is faced with a bigger problem to address than the available national statistics indicate. The challenges we have discovered exist in circumstances where there is an absence of comprehensive and up-to-date data available on the prevalence of mental health problems in children and young people in England. This is in the context of us having had a recession since the existing data was gathered, and of Professor Sir Ian Kennedy having voiced his concern, back in 2010, over 'a barely detected epidemic

of mental health problems in young people.'[188] More recently, NSPCC's report *Can I Tell You Something?* has revealed an 'alarming increase' in the number of children and young people contacting ChildLine for support on high risk issues – including self-harm and suicide.[189]

No health without mental health states 'We spend a great deal of public money on dealing with the consequences of mental health problems. Much of this money could be spent more efficiently, and many of the personal, social and economic costs could be prevented, by addressing the causes of these problems and identifying and treating them if, and as soon as, they arise.'[190] If we are to save money, and reduce the vast forecast future cost of mental health problems to our economy, it is critical that a mental health promotion, mental illness prevention and early intervention approach is taken.[191]

However, our evidence demonstrates that woefully inadequate focus and resources are being invested in such an approach in some areas. Some vulnerable children and young people are not being provided with timely or appropriate support. For example, some children with emotional and behavioural problems, or conduct disorder, as well as some children or young people who are exposed to street gang violence.[192] The lack of a preventative and early intervention approach can result in mental health problems developing and escalating. Chronic and complex cases are ultimately likely to place yet further pressure and intensive demands on statutory provision, some of which we have heard is already overwhelmed. Again, this is at a time when we can least afford it. As with frontline child protection, our concerns are exacerbated by the impact on early intervention services of the '*haemorrhaging of statutory services*,' and cases being pushed down to the next available place.

It is imperative that practitioners are enabled to work preventatively. However, instead of adopting a preventative approach towards lower level mental health issues, and addressing problems as they emerge – including in complex cases where a clear diagnosis may not exist – some mental health services are adopting more of a crisis response, and are prioritising those with severe and enduring mental health problems. However, we have also discovered evidence of some vulnerable children and young people with such problems failing to obtain the necessary statutory support to meet their needs.

Reference has been made to there being '*resource-led diagnosis*' in CAMHS, and the suggestion made that some of the diagnosis-led resource ought to be channelled into early intervention and supporting others with mental health problems. In response to this, another witness

188 Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, September 2010, p72 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (21.02.14)]

189 In 2012/2013, the number of those contacting ChildLine about self-harm and suicide rose by 41 per cent and 33 per cent respectively (from 2011/2012); NSPCC, *Bullying, self-harm and suicide contacts to ChildLine increase*, 8 January 2014 [accessed via: https://www.nspcc.org.uk/news-and-views/latest-news/2014/childline-report/can-i-tell-you-something_wda100359.html (21.03.14)]

190 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011, p10 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

191 Knapp M, McDaid D and Parsonage M (editors), *Mental Health Promotion and Mental Illness Prevention: The Economic Case*, Personal Social Services Research Unit, London School of Economics and Political Science, January 2011

192 Again, the most common mental health problem in boys aged 11 to 16 years old is conduct disorder, and in girls within the same age bracket it is emotional problems. However, both are also common in the opposite gender; Green H et al, *Mental Health of Children and Young People in Great Britain, 2004*, Basingstoke: Palgrave Macmillan, 2005, cited in Hagell A et al, *Key Data on Adolescence 2013*, London: Association for Young People's Health, 2013, p78

explained that one can predict that many children and young people with emerging mental health problems will have more serious problems if they are left untreated, and that early intervention will '*stave off*' a lot of pressure on the system later on. Recognising that there will always be some extreme and enduring need that will require support from the mental health system, they believe that a dual approach needs to be taken, which would require double funding – for education to build resilience and early universal interventions, and alongside targeted intervention for those cases that are emerging. However, the challenges of such an approach were recognised given the current economic restrictions.[193]

Regrettably, our research has also found that some vulnerable children and young people with mental health problems continue to face significant barriers in accessing, engaging with and obtaining appropriate care and support from primary care and secondary care services. Traditional practice models, and a lack of continuity of care and consistency of relationship, can compound pre-existing barriers faced by vulnerable children and young people – and parents – to their meaningful engagement with such services. Some do not attend appointments; some of those who do are considered to not engage – meaning that their needs may not then be met. It appears that some practitioners can struggle to develop an informed understanding of the circumstances and needs of some of the vulnerable children and young people who they do see. Attachment problems are considered to lie at the heart of many vulnerable children's and young people's difficulties. Yet we were told that relationship-based work '*is not always covered by mental health services*.' We believe it is essential that a relationship-based approach should be taken by all professionals who work with vulnerable children and young people.

Gatekeeping on the part of some CAMHS services, implementing higher thresholds and restricting their acceptance of referrals to certain organisations, is presenting some vulnerable children and young people with further barriers to access. We have been stunned by the complexity and severity of need on the part of some of those who have not been able to gain support from CAMHS. However, even where they do succeed in meeting CAMHS' threshold, long waiting lists mean that some – particularly, it seems, those with behaviour problems – can wait for an extremely long time before they receive a service. Not only can their needs potentially become more entrenched in the meantime, but this delay may well place them at increasing risk of exclusion from school, the main reason for which is disruptive behaviour.

A number of diagnosis and intervention issues can also present barriers to vulnerable children and young people's mental health needs being met and/or appropriately managed. For example, attachment diagnosis/treatment issues, a lack of diagnosis, issues surrounding personality disorder, and the problem with the way that CAMHS services can describe the difference between diagnosis and intervention. These also highlight further examples of challenges faced by practitioners where individuals do not necessarily fit neatly into diagnostic boxes.

Particular cohorts of vulnerable children and young people are not being afforded timely and/or appropriate care and support. These include (amongst others), children with conduct

193 We have been informed that a dual approach, of universal prevention plus targeted intervention strategies, has been recommended by the Royal College of Psychiatry, and other groups, for several years – see, for example, Royal College of Psychiatrists, *No health without public mental health: The case for action*, Royal College of Psychiatrists Position Statement PS4/2010, October 2010, p9 [accessed via: https://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf (04.03.14)]

disorder, children and young people who are exposed to street gang violence – for example, with potential undiagnosed and untreated PTSD, and those with dual diagnosis. Furthermore, contrary to the importance placed on treatment being tailored to meet individual needs, more of a focus is being placed on CBT in some areas. This is as opposed, for example, to adopting an holistic and longer-term approach where necessary, or the use of non-verbal therapies. Some already vulnerable children and young people, including those with attachment problems and/or SLCN, are being placed at greater risk and distress as a result.

It is worrying that increasing bureaucracy in the NHS may be reducing the capacity for practitioners to see more individuals. The situation seems to be yet further complicated by a number of false divides that exist within and between some secondary care and social care services.[194] This raises the question as to whether these services are operating as effectively and efficiently as possible, in order to achieve the best possible outcomes for the vulnerable children and young people they are working with.

The lack of continuity of care experienced by some vulnerable children and young people with mental health problems within and across primary and secondary care services can be compounded by transition difficulties. Despite a stream of reports and recommendations over the years to improve transitions services, many vulnerable children and young people continue to face significant challenges in successfully negotiating a transition from CAMHS to AMHS. Some can be left stranded.

Serious challenges also clearly exist with commissioning in some areas of the country. Various concerns were raised in the context of early intervention – including the fact that some GPs are recognising mental health problems in some children and young people but are struggling to secure the appropriate support for them from secondary care services. Furthermore, where CBT is commissioned '*off the shelf almost,*' where commissioners lack an understanding of what it is that they are commissioning, and decisions are being driven by the wrong priorities, it is impossible to have confidence in such commissioning arrangements. Our concerns are exacerbated by the lack of prioritisation, identification and understanding of children and young people's mental health problems in some areas of England.[195] Where their needs are not accurately identified in a JSNA, this will clearly circumscribe the potential of the JHWS to effectively meet their needs. It also places commissioners in an impossible situation where they plan to commission services based on data which is not comprehensive, and is inaccurate and out-of-date. The fact that evidence has shown that data on the mental health needs of those aged 16 to 25 was particularly limited in some JSNAs does little to reassure us that improvement in transition from CAMHS to AMHS is being prioritised in the relevant communities.[196]

Our research demonstrates that there is not a consensus about the service delivery design for vulnerable children and young people with mental health problems, and no consistency

194 For example, in some social care and CAMHS/AMHS work, attachment and mental health, and between CAMHS and AMHS

195 Oliva L and Lavis P, *Overlooked and forgotten: A review of how well children and young people's mental health is being prioritised in the current commissioning landscape*, Children & Young People's Mental Health Coalition, December 2013 [accessed via: http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/ (11.02.14)]

196 Ibid, p6

of approach. With funding already having been allocated and nothing new available, it has been recognised that introducing a new model or embarking on any serious service re-design is extremely difficult. In light of the current financial climate, we believe that the need for social care and statutory mental health services (amongst others) to work creatively, and in partnership and collaboration, has become even more pressing. This was illustrated by a CAMHS clinician:

> *'The problem that you get into is some social workers, because of their lack of mental health experience, can see a child with serious emotional and behavioural difficulties acting out their distress, not able to verbalise it and using their behaviour to show it. Then they say "CAMHS, you've got to do therapy," without understanding that until the whole structure around that family is stabilised, no therapy can be done. But unfortunately it becomes chicken and egg, where they say "until the child's behaviour stabilises, we can't stabilise the rest of it." And we say "unless we have a safe environment, the child can't use therapy." This is where the gaps are, and there is no easy answer to that, but I think it is about discussion and working together.'*

Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, observed:

> *'I think over the next five years there will be much more real discussion about partnership and integration, because that is how it is. We have to work out how we can do what we can with considerably less … I think there will be more creativity in the next five years about service design …'*

In the meantime, our research reveals that the cross-government mental health strategy contained within *No health without mental health* is being severely undermined, and best practice guidance set out in *You're Welcome* contravened.[197,198] Paul Burstow MP has voiced his concerns about the lack of progress, and over government figures showing that spending on mental health services had fallen by one per cent the previous year. Having obtained government figures revealing 'the best and worst areas for spending on mental health services,' Mr Burstow referred to the 'postcode lottery' in services that individuals are experiencing across the country. Some areas are reported to spend three times more than others on therapies and treatment. He stated:

> *'The NHS default remains stubbornly biased towards physical health – a terrible false economy at the expense of people's lives, as well as the public purse … the NHS is still failing to recognise and respond to mental health with the same urgency accorded to physical health … We will not deliver real improvements in people's health and wellbeing without parity of esteem between physical and mental health … Failure to invest in*

197 HM Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, February 2011 [accessed via: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england (07.02.14)]

198 Department of Health, *You're Welcome – Quality criteria for young people friendly health services*, May 2011 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf (14.02.14)]

mental health is a false economy; it flies in the face of the evidence and, crucially, lets people down at the moment when they are most in need of help.'[199]

More recently, the Chairs of London's ten mental health and community health services trusts have spoken out publicly. They expressed their concern over studies which have shown a reduction in funding for mental health services in England 'of two per cent in real terms over the past two years – the first drop in a decade.'[200]

For all of the money that the NHS is charged with saving, it seems highly likely that we will ultimately incur further, significant costs, and create potentially crippling difficulties for some of our services in both the immediate and longer-term. A lack of preventative and early intervention approach in some areas, as well as higher CAMHS thresholds, and reduced mental health resources, appears to be causing considerable pressures within and outside of the mental health system.[201]

We have repeatedly seen how vulnerable children and young people are not gaining access to the statutory support that they need in relation to their mental health needs – whether promptly or at all. It has been harrowing to witness, as has the impact on them, their families and the professionals who are often frantically trying to support them. Many vulnerable children and young people are falling through the gaps of statutory mental health provision in circumstances highlighted throughout this chapter. Some are not given a diagnosis until they are at a fitness to plead stage of criminal proceedings.[202] Even then some continue to slip through the net. Where is the humanity and social justice in that?

199 The Telegraph, *Paul Burstow: NHS is 'biased' against treating mental health,* 14 March 2013 [accessed via: http://www.telegraph.co.uk/news/politics/9927454/Paul-Burstow-NHS-is-biased-against-treating-mental-health.html (07.02.14)]

200 London Evening Standard, *More support for mental health*, 8 April 2014, p47

201 For example, on A&E departments, inpatient services (including adult psychiatric wards), GPs, schools, social workers and VSOs – in some areas

202 We discuss this further in Chapter Four

chapter three
The voluntary sector

3.1 Introduction

> *'The statutory system is at breaking point … '*
> **VSO, in evidence to the CSJ**

> *'My big thing at the moment is that … in some instances, we are the canaries down the mine and we ought to understand that. If we are in this particular place where thresholds are going up, and we are increasingly in that place, we are the early warning in a way, of when the system is about to fall over.'*
> **CEO, VSO, in evidence to the CSJ**

> *'The irony for me is we are supposed to be there for the best interests of the child. That is our job. Where has that gone wrong? Why don't we feel that we are meant to be advocates? It shouldn't be left for someone else.'*
> **Social worker, in evidence to the CSJ**

This chapter features the evidence from our Kids Company case review, and that submitted by other VSOs.[1] It highlights the invaluable offer and support that some VSOs are able to provide vulnerable parents, children and young people. It also reveals the severe challenges that some VSOs are experiencing at the interface with statutory services, in engaging with them to help secure the best possible outcomes for vulnerable children and young people. Various aspects of this evidence have been corroborated by legal professionals who gave evidence to our review.[2]

We recognise that the voluntary sector is hugely diverse and that some VSOs are more effective and efficient than others. Just as there is significant room for improvement in frontline child protection practice in social care and in mental health provision in statutory mental health services in some areas, the same can be said of some VSOs. However, many

1 A brief profile of the work undertaken by these VSOs is contained in the main introduction to the report
2 As discussed in Chapter Four

effective VSOs have a vital role to play in helping vulnerable parents, children and young people and are often able to establish a relationship with them. Many VSOs experience the reality of their lives and develop an understanding of it by virtue of the nature and extent of support that they provide. They collate valuable information and are often well placed to provide statutory services with a more informed understanding of their circumstances and needs. This could enhance the quality of their assessments, and provide valuable assistance in helping them to provide timely and effective interventions and to improve outcomes. Some VSOs see themselves as already supporting social care and statutory mental health services by, for example, helping vulnerable parents, children, young people to engage with them. However, there is clearly huge potential for improvement in the working relationship between the sectors.

A key recurring theme that has emerged from our evidence, is that the potential for many VSOs to work in partnership and collaborate with social care and statutory mental health services is being seriously under-utilised. Despite bold statements made in statutory guidance, we have found deeply concerning evidence of persistent and multiple barriers faced by some VSOs. Like many of the vulnerable parents, children and young people they are supporting, the voluntary sector voice is often not being heard or heeded. This is having an extremely worrying impact on some VSOs, with devastating consequences for our vulnerable children and young people. Many in the voluntary sector are feeling extreme pressure as a result of increasing demand on their human, financial and other resources, due to a greater number of vulnerable parents, children and young people accessing their services, some of whom have complex and severe needs.

3.2 Child protection

3.2.1 VSO support for vulnerable parents, children and young people

Some families can often feel lost in the system. This can, in turn, have adverse implications on their children obtaining the care, protection and/or support that they need. Some vulnerable parents experience considerable anxiety and fear about attending meetings with statutory services (amongst others). One SHS practitioner told us:

> *'… sometimes if you have been successful in the system yourself, you underestimate the challenge it presents to some people to meet professionals … The families I see a bit in the twilight are the families who have very low literacy and oral skills. They get scared when they come and see professionals because they've got the instincts – they know their children but they don't know how to put over to professionals about the level of need. But because we have spent the time with them that often other people don't, as VSO support workers, we can interject and prompt them in these meetings.'*

By virtue of the nature and extent of support provided by many VSOs, they can develop a trusting relationship and an informed understanding of the circumstances and needs of many vulnerable parents – some of whom have suffered traumatic experiences. VSO practitioners can act as mentors and advocates for them. They can often mediate between the parents

and, for example, social care and schools, for the benefit of their children. The challenges that some vulnerable parents are battling with, and the concerning approach taken by some social workers towards them, reinforces the vital role being performed by some VSOs.[3]

A SHS practitioner told us about a family that she has been supporting, who has been known to social care for at least 10 years, with a history of domestic violence and substance abuse. It took 18 months before the mother spoke to the SHS practitioner, *'She came to school one day and literally had a breakdown. Everything had come on top of her … I started working with the family. She actually said to me "you have done more for me in the last six months than social care have done in the last 10 years."' Different social workers had not believed what the mother was telling them. She had an abusive partner who the social worker tried to insist that the children had contact with. We were picking up the pieces in school – the little girl was wetting herself, and drawing pictures of the family with dad with crosses over his head. The social worker facilitated a meeting one [weekend]. They had to meet in a park, in a public place – that's how dangerous he was. He started saying "I'm not going to be with this social worker, tell her to f*** off." The dad had picked a stick up and was smashing it on the floor. And the social worker still insisted it was safe for those children to see their dad, and they blatantly didn't want to see him. So that's why that mum closed down. She wasn't going to work with social [care]; she didn't trust them. Then we started working … They are off the [CPP] I'm glad to say. They are in school regularly and their attendance has gone up. They are much happier. I supported mum to court, I couldn't go in but I held her hand to go in to face her partner to say "I don't want this to go ahead." She just used to go into a nervous breakdown going into court. She couldn't articulate herself. So I said, "right, I'm going to get on the bus, and we are going to have a coffee." I just gave her the strength to go in and say what she needed to say. Because she would start rambling and the Judge would think "crap mum, blah, blah, blah."'*

Practitioners in some VSOs feel that they also perform a supportive role to those working in social care, amongst other statutory services, some of whom they understand have not been trained in how to manage and support these vulnerable individuals, and may not know their history.[4] A SHS practitioner explained:

> *'One of our roles is in a way mentoring the parents and tutoring them to look further around the issue, and show them the impact and benefits that can be had [by engaging with social care] … so that it's not all punitive, that they are there to help you.'*

Some VSOs are acting as a bridge between services. A number explained that they try to explain that social care is there to support and care for vulnerable parents and their children.

> *'We are also supporting social [care] to engage with the families in the right way so that the families can benefit … social [care] … say "but you haven't done this, you haven't done that." But when we sit with parents and say "well done for getting to this meeting," that's a really good start. But everybody else is sitting around pointing fingers … So that is a big block with any statutory service that they have not got the approach. I am not blaming individuals … but it is counter-productive, without a lot of intervention … to help parents to understand their rights, their responsibilities, what social [care] is trying to*

3 As discussed in Chapter One

4 As a result of some of the challenges highlighted throughout Chapter One

achieve … but also working with social [care] saying "Look, if you say that, I can't get this parent to the meeting. We need to work together in a supportive role."'

SHS practitioner, in evidence to the CSJ

We heard that due to some parents' fear of social care, they are not willing to give their children permission to engage with its services, which the children need support from by virtue of the challenges their parents are facing. In Chapter One we referred to the fear experienced by some vulnerable parents in coming forward to access support, where there are domestic violence and/or substance misuse issues. Where they fail to do so, this can prolong or increase the risk to their children who may be witnessing and/or experiencing the domestic violence, and who may be suffering the negative impact of parental substance misuse. However, some VSOs are providing essential support to such parents, where possible – helping them to confront that fear, in an effort to secure the requisite support for them, and care, protection and/or support for their children.

'I think that … we are that buffer between those two … the way we do that is in our approach – to be understanding … so we say "… it's obvious that you care about your child because you're here now, let's look at what we can do." So it's about balancing that, recognising the strengths and positives of what that parent has achieved, or what's difficult from what they've been through, and saying "we understand that these are some of the issues that have come from that, and let's look at how we can move forward" – balancing it in that way and being more open and congruent about what the service is and what their rights are as a parent and what the service can or can't do. I think it needs to be laid out from the beginning what that service is going to offer, and what could happen or what couldn't. I think that's going to help to build trust …'

SHS practitioner, in evidence to the CSJ

However, the trusted role and relationship that practitioners can successfully build with parents can be severely tested if, having encouraged them to engage with, for example, social care, vulnerable parents do not then have a positive experience of that service. A SHS practitioner told us:

'… we would hope that the people we are referring to are going to be professional and they are going to do a good job but actually unfortunately that isn't always the case. So we may have been in a situation where we have really encouraged a family – "this is a good thing to do, and this is going to be a very supportive position for you to be in" – when the reality isn't always what we would have hoped it to be. And then it can become extremely difficult to get that family to realise "yes, this is useful for me."'

Alessandra Lemma's study, *The Power of Relationship: A study of key working as an intervention with traumatised young people*, demonstrates the important role played by the physical environment, as well as by key workers, in engaging and building relationships with vulnerable children and young people, and the value placed by them on the emotional support provided by key workers. Key points arising from the study, include the following:

- Initially, the children and young people 'appeared to titrate intimacy through the use of the physical environment as the first, safe "attachment"… It was through an attachment to place that they were then able to gradually develop an emotional attachment to their key worker;'[5]
- The flexibility of support provided by key workers:

  'Key workers were very clear that their role was therapeutic but that they were not therapists. This distinction was also clear in the young people's minds, and interestingly they all expressed the view that the emotional support they gained from the key worker was as important, and even more helpful in several instances, than that received from a therapist.'[6]

- The power of relationship: one key worker is quoted as saying 'I think the essence of our work is having this bond and having the attachment and *working with it.*' Alessandra Lemma states that:

  '"working with it" articulates a shared position among the key workers, namely that it is through the key working relationship that the young people whose attachments have been disrupted and/ or were abusive can slowly re-enter a non-traumatising world of relationships … The key working relationship is understood to provide a fundamentally rehabilitative function, gradually removing the obstacles that have impeded the normal lines of emotional and cognitive development. At first this is achieved through the provision of practical help.'

- One child/young person is quoted as saying:

  'They have been with me from the start and they have seen me through … They were there no matter what … They're like my family, sorry (cries) … like … I don't normally talk about this (pause and cries) … ;' and another 'They were not like a key worker, but a best friend. They will go the distance to make sure you are alright … whether you are screaming, shouting, they ain't going anywhere.'[7]

- The key workers' role as 'objects of hope':

  '… several [key workers] conveyed the belief in the importance of offering a "new", positive experience of relating to a person who could provide a counterpart to the young person's interpersonal expectations of a repetition with abusive or emotionally unavailable adults.' The children and young people in the study 'used the key workers' optimism and dogged determination to hold on to the possibility of hope for the future.'[8]

We repeatedly witnessed, across the Kids Company cases we reviewed, the new found hope and possibilities that opened up for the vulnerable children and young people, out of the personal bond that they developed with their key worker and, in some cases, other members of staff. In numerous cases, during periods of crisis, it was the Kids Company key worker who managed, in extremely challenging and chaotic circumstances, to hold on to the vulnerable child or young person, who had otherwise disengaged from other services. The strength of attachment and trust that some develop with their key worker and others, and with the organisation itself, is powerful. We have discovered moving accounts of vulnerable children and young people voicing the importance to them of Kids Company and its staff, and demonstrating this in their actions. When Claire repeatedly absconded from her children's home outside of London, she explained that she came to Kids Company because she knew that the staff cared about her, that she could trust them, that they would not blame her and that they would listen to her.

5 Lemma A, The Power of Relationship: A study of key working as an intervention with traumatised young people, *Journal of Social Work Practice*, (24) (4), 2010, pp409–427

6 Ibid

7 Please note that the emphasis to the relevant text, in each case, was made by Alessandra Lemma; Ibid

8 Ibid

However, tragically, some vulnerable children and young people can be surrounded by a small army of individuals but if no-one has formed a relationship with them, where there is mutual trust and respect, then the whole situation can become even more challenging. Where we talk about accessing services, many of our most marginalised and vulnerable children and young people, due to their fragility, attachment problems and/or chaos within their family environment, are not capable of or willing to access a service in the same way that many others would. Some do not have a parent who will support them to attend appointments, and give them the encouragement and reassurance that they need. However, a crucial role is being performed by numerous VSO practitioners in getting alongside and building a trusting relationship with them. Some VSOs, like Kids Company, are providing them with surrogate parenting, and are supporting them to access and engage with social care services and support (amongst others). As discussed in Chapter One, this can be particularly challenging where a child or young person has lost faith in a system which they feel they have been historically failed by and find extremely hard to trust.

Interviews with children and young people at a VSO in the North of England

'[The support I receive from here] just makes … things a lot easier to like work through.'

'[Member of staff] is like a dad to me and I genuinely do love everyone … here. I feel like I found my family … here. And I feel safe … It's nice to be here … I never felt loved, and when I come here and [member of staff] gives me a hug, and tells me [they] love me … I'm just like, yeah, I'd rather be here than home.'

'I think coming here has helped me because the staff … understand you …'

'It's good because you can like, if you have a worry or something, you can go to one of the members of staff and you can just tell them what's going on … I talked to [member of staff] about what I just told you … And [they were] really, really like supportive about it …'

'[Member of staff] means the world to me.'

'I've stopped drugs and fighting and started to come here and on days that I'm not meant to either, and I'm due to start college … It's not a boring life anymore. In normal school, the teachers are really strict but here is all cheerful.'

'I get a lot of support from [here]. If I had to chose social care or [the VSO], it would be [the VSO]. They've been here for me and don't keep asking me questions.'

3.2.2 Barriers to VSO engagement with social care

The intense pressures faced by many social care services were appreciated by the VSOs that gave evidence to us. Concerns were raised, in particular, about diminishing budgets, reduced resources, a reduced workforce, a 'huge number' of referrals, lack of capacity and time, high staff turnover, bureaucracy and high caseloads.

> *'I think in fairness to social workers there are good and bad, and when you come across a good one they are fantastic … they have a hard job to do.'*
> SHS practitioner, in evidence to the CSJ

CSJ review of Kids Company cases

Social care's failure to adequately investigate or give sufficient weight to information provided by Kids Company featured repeatedly across the cases we reviewed. In a number of these, social care failed to invite Kids Company to attend or provide a report for a child protection conference. In the cases of Michael, Claire and David, 'crucial information concerning the child was not before the child protection conference due to a failure by the local authority to engage with Kids Company, and there being no method by which a VSO can compel a local authority to consult with it, to act upon information it provides if consulted, or to secure an invitation to a child protection conference concerning a child it is supporting. This is a lacuna in the child protection legislation and a matter that should be addressed.'[9]

The following key recurring themes emerged from our case review:

- In a number of cases, the VSO's persistent attempts to share vital information and discuss its concerns were repeatedly blocked or declined by social workers and those in more senior positions, in various local authorities. Social care simply failed to engage with the VSO's concerns;
- We discovered repeated examples of a gatekeeping mentality being adopted by individuals in social care teams in some local authorities, of excluding Kids Company, keeping its staff at arm's length and seemingly not wanting information from it;
- Kids Company was often ahead of social care in terms of being alive to the risk and harm threatening the vulnerable children or young people. However, far from drawing on the VSO's informed knowledge of their history and circumstances, some of those in the relevant social care teams failed to listen to the information or advice given by Kids Company's staff. In so many of the cases, the CEO and others – including key workers, and senior staff members – repeatedly raised alarms in relation to serious concerns over the vulnerable children and young people. However, insufficient attention was paid, and inadequate action taken in response. This often proved to be short sighted. We saw how in several cases, the situation unravelled in just the way that Kids Company had anticipated. This was after the vulnerable children and young people's problems and needs had become more entrenched, and they had been exposed to greater suffering;

'I think in certain instances … they don't want to take an additional complex case onto their workload because it may make their caseload more difficult to manage. They may also not value the contributions of the wider professional network, and perhaps Kids Company as being a charity, which in their view makes us inferior and less qualified to them.'

A witness in evidence to the CSJ

- A lack of transparency and poor communication;
- A lack of respect and professionalism was demonstrated across several cases by a number of professionals within social care teams in various local authorities, towards Kids Company and some of its staff. A number were critical and hostile towards them and appear to have sought to undermine Kids Company's work with the vulnerable child or young person, and sometimes their family. In some cases, an oppositional, accusatory approach and blame mentality was taken towards Kids Company;[10]
- An unfortunate and fundamental lack of understanding of the nature of Kids Company's work was demonstrated by various social care teams;
- In a number of cases, repeated requests on the part of Kids Company to secure support for a vulnerable child or young person were not actioned, and they received poor communication in response. However, once correspondence was sent from solicitors (including pre-action letters), or JR proceedings were threatened or submitted, this invariably led to the relevant support being put in place. [11]

9 See legal foreword. These issues are discussed further in Chapter Four. Please also see 'The Voluntary Sector: A Poor Position for Exercising Influence' at Appendix 6

10 For example, in Daniel's, David's and Claire's cases

11 We discuss legal challenge by Kids Company and other VSOs, including JRs, in Chapter Four

However, despite the vast amount of time and effort that some VSOs are investing in trying to improve the lives of vulnerable children and young people, a number of significant barriers clearly exist, which are leading to inefficient ways of working on the part of some social care services and VSOs. A considerable amount of time is being spent on the part of some VSOs, for example, in trying to help vulnerable children and young people gain access to social care services and support, and trying to share valuable insight or information. Some of their concerns are not being appropriately listened to or acted upon. This can have an adverse impact on vulnerable children and young people as it detracts from the focus on them, and the precious energy, time and resources which should be spent addressing their needs. Further aligned with findings from our Kids Company case review, some VSOs reported a lack of professional respect, and knowledge and understanding of their work, on the part of some social care teams

A second generation failed

The CEO of Kids Company had raised serious concerns over a number of years about the children in a particular family – over their neglect, domestic violence in the home, and parental substance misuse. However, during this period, social care from a different local authority in which the family lived, placed a teenager (Teenager) in care with the family, having not visited the home previously. The mother (Mother) received payment for the Teenager's placement. However, after alarm bells were raised by the CEO, the social worker visited the home, and after seeing the extremely impoverished conditions there, they arranged for the Teenager to be removed.

The Mother's first four children had been taken into care. After she threw one of her sons out of the family home, he was rendered homeless. During this time, the Mother's grandchild (Child A) – her daughter, Emma's child – was placed with the Mother. This decision was initially taken by a Judge, pending the outcome of an assessment by an independent social worker. Their assessment concluded that Emma was not in a position to safely care for Child A full-time. A Special Guardianship Order was subsequently granted to the Mother for Child A. At around this time, Kids Company was attending meetings with senior managers at social care regarding concerns about Emma's partner, Paul's child (Child B), being in the care of Paul's relative – to whom a Special Guardianship Order had also been granted.

The CEO raised her concerns to the local authority about Child A and Child B being placed with their respective relatives, who were both understood to have substance misuse problems. The CEO felt that social care needed to pay closer attention to what was happening within each family. She asked for her concerns to be passed on to the Director of Children's Services, and to be contacted by them directly. At around this time, Child A (very young) was found by police late in the evening, unattended in the local area. Child A had been missing for several hours, which had not been reported. When the police visited the Mother's home, they found several children unattended and the home in a filthy state. The police removed all of the children and arrested the Mother and her partner. Child A was placed in protective custody; the other children were placed with the Mother's friend – on the Mother's recommendation.

Very soon after this, all of the children were returned to the Mother's care. The CEO conveyed her concerns to the Director of Children's Services that Child A should not be placed with the Mother, that it was a very high-risk decision, that there was a big problem in the family, and that other children were at risk. She was informed that social care 'would look at it.' Child A's social worker (who was allocated after Child A was placed in the Mother's care), and regarded by Kids Company as 'excellent,' had tried unsuccessfully to persuade management to agree to the children becoming subject to a child in need plan. More recently, the CEO has informed us that one of the Mother's younger sons, who Kids Company believes has extremely disturbed behaviour, has been excluded from school and has taken part in an attempted offence involving an imitation weapon …

And so the cycle of social care's failure repeats itself down through another generation of this family.

Poor communication

Some VSOs are having difficulty accessing requisite information and quickly (i.e. in a crisis). They are facing challenges in navigating some local authority websites, and finding the relevant information that they need – some of which is not up-to-date.

> *'It also feels like sometimes the information the voluntary sector needs, so that we can talk to the right professional, is hidden at the back of the council websites, which are hard to navigate … if we can get the information flow working so that it is easy to work out the efficient pathway for our interaction with statutory services it would speed up the whole process of referrals and waste less time. It would be good to unify the language used. Sometimes there are slightly different ways to name a service you want to access, which makes it hard when working across boroughs to find information, so you need to know the nuance so that you can find the information.'*
>
> **Christopher Henriette, South London Youthwork Manager and Safeguarding Officer, XLP, in evidence to the CSJ**

There is a lack of standardisation with respect to the relevant terminology used by different local authorities, which can make things particularly difficult for VSOs that work across boroughs, and where families are transient, being moved or evicted. Some such VSOs explained that they find it hard to work out how to interface with each local authority's social care team. We heard that different language can be used in different boroughs to describe services, or it can change as a result of legislative changes, different initiatives and serious case reviews. We were told that it can take some local authorities a long time to make the necessary changes on their websites. This can add to confusion on the part of those on the frontline who are trying to keep up with those changes, whilst ensuring that the vulnerable children they are supporting are safe. In addition, we heard that different forms are used in different boroughs, and that the CAF is not universally implemented. We heard that considerable time can be lost due to a lack of standardisation. An experienced Independent Social Work Consultant and Expert Witness highlighted:

> *'If it's difficult for the professionals to negotiate their way around it … what's it like for the children and families? Very often that gets left out of the equation. People don't join those two questions together in a sense … It really is a problem.'*

We are aware that some local authorities are trying to address this but significant improvement is required.

A key recurring finding from our Review is the lack of communication that VSOs often experience, particularly at the point of making, or having made, a referral to social care. Our concerns regarding how referrals are being handled and processed by some social care services, as discussed in Chapter One, are compounded by the evidence provided by various VSOs. There appears to be a lack of clarity concerning some referral pathways, and confusion on the part of some VSO practitioners over exactly which local authority department they should submit their referral to, according to the particular concerns of the case. One SHS practitioner commented:

> *'I wonder if the system is overwhelmed as well, because there don't seem to be clear referral pathways … so if housing is an issue, or if it's around abuse or drug use, is there*

a different department that should go to, or is it all to one? Often you might refer and it's passed back because you are told "that's not our responsibility, we've got everything else that we're trying to deal with, so actually go somewhere else."'

We were told that practitioners would welcome clearer pathways in terms of who they are supposed to refer in to, according to the needs and challenges of their particular families. These difficulties can present further challenges to a VSO that works across a number of local authorities. One such VSO referred to each borough having different systems for referrals.

One VSO that works across boroughs stated that, in some instances, it has found social care unwilling to take on referrals. On one occasion the social worker was described as being dismissive of the VSO's concerns; they told the VSO that they had *'far more important things to deal with on a Friday before the Bank Holiday weekend.'* Following a referral to a social care team in a different local authority, in relation to the suspected physical abuse of a different child, the VSO was informed that '… *as it was a Bank Holiday weekend, it was [the VSO's] responsibility to ensure the safety of the child.'* The VSO added that it has also experienced some very positive responses from social care but that its experience generally is that:

'the service in all boroughs is completely overstretched and that this accounts for many of the challenges we face.'

It added that some local authorities seem reluctant to act unless the case is absolutely urgent:

'when from our perspective our concerns could be indicative of an on-going situation that needs addressing, or something that could be prevented if action is taken before it becomes urgent.'

The VSO also stated that in some boroughs there is *'culture of not wanting to take responsibility, or of ticking boxes to avert the risk of being blamed if something goes wrong.'*

There appears to be an issue over some VSOs achieving clearly accountable lines of communication having made referrals. Many expressed their frustration about having to chase social care for responses to their referrals and for information – including leaving messages which are not responded to. One described follow-up after referrals as being *'generally very poor.'* Another VSO lamented:

'They're supposed to tell you what action they will take … When I'm tracking 10 of these, I can't hold every local authority to account. I have to pick the most pressing cases and go after them. Otherwise I've done what we're supposed to do … NSPCC guidelines … say you should keep chasing local authorities, but we shouldn't have to. We're a medium-size charity, but as a small charity, you'd find it very hard to continually spend a huge amount of time chasing local authorities. It's a continual process. It doesn't stop with just one phone call.'

This raises an important question over the accountability of these local authorities.[12] A witness told us *'it's a bit of a black hole once we've made a referral.'* They also shared their experience of social care handling referrals of a number of clients who were *'very vulnerable and in very difficult family circumstances.'* They said that social care's response was to send a letter to the family referring to having received a report of physical abuse or domestic violence – *'which … for the [client] at the centre of it, is completely exposing and undermining …'* Our witness also felt that it was obvious where the reports had come from, which therefore impacted on the VSO's credibility with the children themselves, and also potentially with others that they may share this experience with. They added *'So we need social care, and social care needs our credibility.'* The way that social care responds can affect how vulnerable children might view a VSO's service, and it can affect its independence. More importantly, it may also further marginalise vulnerable children if they no longer trust the VSO.

A similar point was also made to us in the context of higher thresholds, in cases where a VSO has succeeded in building trust with a vulnerable parent, then becomes aware of concerns, makes a referral to social care which is not accepted due to the threshold not being met, and the parent then disengages and refuses to allow the VSO to continue to work with their child – thereby potentially placing the child at even greater risk. We referred to some extremely disturbing examples in Chapter One of the types of concerns that are not meeting social care thresholds – including in circumstances where vulnerable parents have disengaged with services that could help to care for, protect and/or support their children.

Some VSOs are also experiencing difficulties in identifying, contacting and sustaining communication with the social workers who have involvement with the vulnerable children and young people the VSOs are working with. Most of those who gave evidence to our Review expressed their frustration over this. They explained that precious time that ought to be spent investing in supporting the vulnerable children and young people, is instead being spent on chasing social care (amongst, in some cases, other agencies).

> *'… what I find often is that I, as a professional, don't know which social worker to go to. Because I start with one and then move to another one, and then that one leaves, and then I move to another one and then that one leaves and the other one comes back. I don't have enough time in the day to chase everyone and find out who's the right person … It's across [several] boroughs if each individual project is having issues. It just doesn't work for me to be able to … chase every single one and find out … You kind of get passed around a lot. So … if I as a professional suffer with that, of course a family will.'*
>
> **Christopher Henriette, South London Youthwork Manager and Safeguarding Officer, XLP, in evidence to the CSJ**

> *'I think a big issue is a lack of communication between not just social care and the families they work with but … across the agencies as well … as a practitioner we spend time trying to figure out what the hell's going on … our families are coming in confused*

12 We discuss, in Chapter Four, the legal position regarding the stipulated timeframe in the *2013 WTSC* within which social care is required to respond to referrals

and so we're like "well, I'm confused from what you've told me." So then we have to try to piece those pieces of the puzzle together. So … I think definitely more communication, more openness is needed.'

SHS practitioner in evidence to the CSJ

We heard of some social workers not responding to VSOs' phone calls, or concerns raised by them. This can have an adverse impact on VSOs and place the working relationship between them and social care under strain. As one SHS practitioner also explained:

'… it not only leaves you feeling isolated in supporting a family but effects the relationship between the family and the statutory service … The non-communication with outside agencies has a big impact on supporting the child and their family. Sometimes it feels like a closed shop and you are banging on the door but no-one will let you in. Sadly, this is how some of the families I support feel.'

We were told that a lack of regular updates 'can be a constant problem.' We heard that VSO practitioners have to sometimes repeatedly chase for information, and are given a lack of feedback. Izzy Neale, TwentyTwenty lead counsellor, told us:

'… at times it is difficult to know what is happening with a [child] who has a child protection plan; it often results in constant calls and emails.'

A witness from another VSO commented:

'It is what we have come to accept as standard working practice and it is not right. It is standard practice for us to chase and chase.'

Some also struggle to establish all of the services which are involved with specific cases. We were stunned by how convoluted processes can become, and the tenacity required by some VSO practitioners to ensure that their concerns are appropriately actioned, and that the child does not get lost, as illustrated by the following example:

A SHS practitioner told the CSJ about a current case involving domestic violence. They explained that the police submitted a Merlin report that was sent to social care.[13] Social care did not do an assessment themselves – they immediately sent it down to a Multi-Agency Liaison Team (MALT). The MALT contacted the child's (Child A) school to ask if it had any issues. It did not at the time; however, it had previously spoken to someone on the MALT, and informed them that *'there were things bubbling, and that it had some concerns and really needed a full assessment.'* Our witness said *'But everyone thinks "ok, it's gone to the MALT, they are the biggest team, so they're going to take the lead." So we're all sitting back in school thinking "well, it's gone to the MALT now, so they're going to identify agencies and probably going to contact us …"'* The SHS practitioner spoke to one of her colleagues in the primary school attended by Child A's sibling (Child B). She was told that Child B's school had grave concerns, and was going to submit a Multi-Agency Referral Form (MARF) to social care. This was on the basis of

13 SHS informed the CSJ that the Merlin is a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason. This can range from being a victim of bullying to being present whilst a property is searched. It also holds data for missing persons. They can be of any age. Entries on the database can be accessed by police officers and civilian workers

potential physical harm to Child B. The SHS practitioner's school also submitted a MARF – because it was concerned about how dishevelled Child A was, and how the mother may have been making herself intentionally homeless. We were told that two schools therefore submitted a MARF, in addition to a MERLIN having been submitted by the police. The SHS practitioner told us *'but we're all sitting there in our meeting saying "well, we've all put this concern in, there's a MERLIN, it's gone to the MALT already, somebody's doing something and they'll contact us soon." It … got to a point where we were like "well, no-one is talking to us, we need to find out what's going on." So we called Children's Services and said "we and another school put in a MARF, these are the names, can you tell us where it is? Is it going to go to assessment? Because we are all holding lots of information and we want someone to … do a full assessment because we can't do that individually because the parent is not engaging with us …" They said "actually, no, it's gone back to the MALT." So they had referred back again and … they hadn't done a full assessment.'*

The SHS practitioner then contacted the MALT to find out what was happening with the case. She *'finally'* obtained the name of a Targeted Family Support Worker (TFSW) who was allocated to do a CAF. The SHS practitioner spoke to the TFSW and asked what was happening with the case. She explained that they had concerns, that nobody was saying anything, and that there were concerns that nothing was going to be done because *'everybody else thinks somebody else is doing something.'* The TFSW told the SHS practitioner that her colleague had previously worked with the family, and they did not engage with the CAF, in which case she was getting ready to close it. Our witness told us: *'She hadn't actually even met the family at all but based her decision on the fact that a previous colleague had closed the CAF … She didn't know what the new concerns were.'* The SHS practitioner told the TFSW that this had gone through social care twice now. She explained to us that the TFSW did not actually know who had referred the case. However, it had actually come from social care, and had come from the police: *'But she just had it that the MALT had referred it in. So I think they really need to … let that person know where the concerns are coming from, so that when she's getting ready to just close it, she's communicating that back up … to the MALT, back up to social care. I said to her "I really don't think you should be closing this case. There are number of people I'm talking to who I know have grave concerns but none of us can get the full picture because the parent doesn't engage. Can we at the very least, before you close the CAF, have a professionals meeting where we can share our information and where you can hopefully, as the lead, document this information in one place and put it under the SHEEP headings, so that you've got each of us talking, and then send it back to the MALT and say "this is why we need it to go back up to Level 3?"'*[14]

We were told that *'eventually'* the TFSW did that. Our witness told us that she does not know the outcome of this case because the TFSW has put the report back together, which is *'hopefully'* going to go to the senior social worker on the MALT, and *'be put back up.'* Our witness said *'But there were grave concerns on all levels. There is a two-year-old child that, because he is not accessing any of our services, we won't know what is going on. But we have known that there is a record that he has been physically abused and that mum is not engaging with any service. He doesn't go to school or a child minder. There are lots of things where we just need to get somebody in to do an assessment and actually account for each child, because we could only in our group account for three of them, and there is one that we just don't know anything about because that school didn't want to engage with us.'*

14 SHEEP: Safe, Healthy, Enjoyment, Employment and Participation

Partnership working

> *'[Working in partnership], it all … completely makes sense. But it just doesn't happen.'*
> **Social worker, in evidence to the CSJ**

> *'Sometimes when dealing with social [care], you feel quite powerless. You can see exactly how a case is going to pan out, and how detrimental certain circumstances may be to the child. Even though you point it out to the social workers, they don't listen to you. They continue doing exactly what they had planned on, and the outcome is exactly as you had predicted.'*
> **A witness, in evidence to the CSJ**

A number of VSOs that gave evidence to us reported having established positive working relationships with social care teams. However, there is clearly considerable scope for an improved working relationship at both practitioner and strategic level between many others. We heard from one national VSO that although there is a good foundation of working together in some local authorities, this is not always consistent across all teams. In others, we heard that there is an apparent reluctance to engage with VSOs, and a lack of knowledge of the experience that resides in the voluntary sector.

Various attitudinal barriers emerged from our evidence. For instance, we were told that working in partnership with VSOs is not promoted in some social care teams.

> *'It's not promoted; there is no promotion of getting engaged … [a VSO] is seen as getting in the way. We don't necessarily see the emotional support that they are giving the young person. We see it as "airy fairy" support that's not concrete.'*

> *'There's a system of we only work with the people that we're meant to work with. So if a child has a need and we know we can get it met by an external agency, if that agency is not a statutory agency, we're not going to promote it and no-one is going to ask us to promote it.'*
> **Social workers, in evidence to the CSJ**

We appreciate the importance of social workers scrutinising the quality of provision that they are bringing into families. However, our evidence revealed that where vulnerable children or young people access the support of a VSO by their own volition, some VSOs are not approached by social care regarding their involvement with them, nor are they asked to provide feedback or updates. A middle manager told us that in their local authority, there is no system in place which makes them aware that a VSO is involved in a child or young person's life (unless of course they ask and are told). They observed:

> *'It's difficult really because … it's all on a voluntary basis. There's no obligation for anybody to record that information, nor to pass it on. It's at the discretion of the family so I completely understand that. I just think where I'm seeing things on the other side, where families have been involved with entrenched issues … it is useful information and it does need to be captured somewhere.'*

Our witness went on to explain that as a result of not knowing about a VSO's involvement with a child, young person or family, it can elongate the process for them, because they can be provided with the same support again. They highlighted the inefficient use of resources that can result:

> *'For instance, families are repeating the cycle of going on parenting programmes or having parenting support, when actually they've received all of that, just under a different umbrella. Because it's never been noted or there's never been an insight to it, it's almost repeated. That's the sort of misuse of services I feel that's going on. In some cases, some families don't get any resources and in others they are getting too many.'*

VSOs can become aware that social care has been informed, for example by the parents, that they are working with their child – *'But you never get a call off the back of that, checking from social care. It would be nice.'* We also heard that a relationship with VSOs is not proactively sought or nurtured by social care, with the onus on VSOs to seek out social workers and make themselves known to them. One VSO illustrated the extent of challenge that this can present:

> *'I've worked with a lot of social workers … some of my staff wouldn't be able to work with social workers because it's a minefield and it's challenging. How do we train our staff to get to a social worker and to get information? From my experience it's a bit pot luck. Recently I spoke to one social worker who wouldn't disclose anything, and another social worker (who had not heard of [the VSO]) who told me loads of stuff … Personally, I think social workers are doing less to cultivate relationships and to work with organisations, or to bring a child to a service, or take an interest in a service.'*

Another stated that, as a VSO working across several boroughs, it is relatively unknown to children's statutory services. Its staff are unlikely to be invited to attend *'initial discussion meetings, child protection meetings etc.'* The VSO believes that this is because social care is unaware that the VSO is regularly working with particular children. However, the VSO explained that due to the pastoral and long-term nature of its work, it may actually have a different view or be able to provide specific information that other professionals in the children's lives may not have. It added that it would welcome more explicit partnerships, and that it would also be useful for its relevant staff to be aware if there are child protection concerns regarding a child who accesses its provision, to ensure that staff are aware of any additional needs – *'especially in relation to physical abuse, self-harm etc..'*

> *'… it's about what we are being directed … and … told to do. What the local authority says about a child carries more weight. Because if you're all sitting around the table, and [VSO] is going to be there representing a child or young person, advocating for them, their views are not going to be counted in the same way … They are not getting involved in the same process as us because they're not statutory … But because we are social work trained, that doesn't mean that there aren't people at a different level that can't have input. There are people who know the person as well, and they have valid things to say and they should be listened to more.'*
>
> **Social worker, in evidence to the CSJ**

'I just feel quite alien to that. The reason why is because it is so removed and distant to the local authority. In my experience of working here and in other boroughs, there isn't that contact with [VSOs]. There just isn't that interface and information isn't shared. I just find it difficult to unpick that and look at why that is happening.'

Middle manager, in evidence to the CSJ

A number of witnesses, including current and previous social workers, told us that the involvement of a VSO and its efforts to share information, can be seen as creating more work and making life more problematic for them. This was explained, in part, in the context of the rigid process that some social workers are required to follow, making it difficult for them to take a step back and work flexibly.[15] One social worker stated:

'… if we do get them involved in … let's say in the child protection process, then that's another professional that we have to work alongside … one more person to chase around for social workers.'

In addition, concerns about being potentially challenged were raised.

'… the reality of it is, you want people to be saying the same thing as you … And more of the time, [VSOs] are not … They're saying "… this is wrong." Yeah, and we discredit them on that basis. And we think we don't want to work with them because they are just going to complicate our life … Cos no-one wants to be in a meeting, especially as a social worker, or [with] the family, being told that you're wrong. And that's the reality … [but] there should be nothing wrong with someone saying you're wrong. People shouldn't take it personally … they should also know, "ok, this is my job, I'm going to get things wrong, and the whole aim is to get things right, so in fact let's tease out your idea, what are you trying to say?"'

Social worker, in evidence to the CSJ

We were told that:

'So many things go under the table that don't get brought up because we know that basically it makes us look bad and it creates more work. And it also makes the local authority look bad.'

Several issues of concern highlighted in Chapter One are far from conducive to encouraging an open and transparent working relationship between some social care teams and other agencies – including VSOs. One that immediately comes to mind is that of children who are considered to be at risk of significant harm but who are being held at child in need level. Some social workers do not feel able to speak out internally about concerns they may have on cases, and we received profoundly worrying evidence of needs being left unaddressed. Involvement by VSOs in a vulnerable child's (or young person's) case could potentially bring any mistakes or concerning practice to the surface. We heard about VSOs not being informed

15 As discussed in Chapter One

about or invited to meetings, and not being asked to produce reports – excluded.[16] The fact that they are not statutory and perceived by some as not following process also appears to put up barriers from a social care perspective. However, by virtue of the nature and extent of their work with vulnerable children and young people, some VSOs are well and often justifiably placed to question and challenge proposals, a lack of action and decisions by social care in relation to them. Some are also performing an essential role in helping to hold some local authorities to account. Our evidence demonstrates the extent to which this is critically needed for some vulnerable children and young people.[17]

> *'The focus is having everything done in the timeframe, to the exclusion of the young people and to … everyone else … but there is a lack of interest. The voluntary sector is seen as a hindrance in a way … It would be really great to sit down and work with the voluntary sector, because they've got skills and knowledge and different perspectives. We just haven't got the time, and there isn't that respect of the voluntary sector. They are seen in a particular light, and doing certain things. Those things tend to be advocating for the young person in a way that impacts on us …'*
>
> **Social worker, in evidence to the CSJ**

Another recurring theme that emerged from our evidence was a lack of professional respect shown by some social workers and those in more senior positions, in some social care teams, towards the voluntary sector – as a valid, key stakeholder in a vulnerable child or young person's life. This, we were told, can be something of a mindset and culture. It is extremely regrettable, particularly in light of the invaluable work that some VSOs are performing, also under immense pressures, to support vulnerable children and young people, and the wealth of their experience and understanding of the difficulties that they can face.

> *'… I do think a lot of [VSOs] do amazing work but … there's no respect for [them], and then because social workers know these organisations have no statutory commitment, they think "well, there's nothing they can do anyway." You know, they can have a moan but it's not going to get them anywhere …'*
>
> **Social worker, in evidence to the CSJ**

The individual at the heart of all of this is the vulnerable child or young person. Where there are barriers, they are the ones who suffer the most. It is imperative that professional differences, where they exist, are put aside for the sake of these vulnerable children and young people. They need to be brought back to the forefront.

> *'I recognise the disrespect from both sides … It is quite interesting that we are all providing services to families, and we are all talking in terms of respect, and how we need to think about language and behaviour in order to denote respect. And yet we are hopeless when it comes to each other. It is one of the things that really has to change … I think one of the tensions is that social workers have a huge set of responsibilities that nobody else has in child protection. It is their responsibility, and people should respect*

16 As discussed further in Chapter Four
17 As highlighted in Chapter One and Chapter Four

them for that … But I also know we can be very badly behaved, and dismissive of the huge help that the third sector can bring in … It's those classic things about reminding oneself that you're all in the same business actually and the end goal is the same, and having that dialogue … a lot of those different and respectful behaviours are about leadership. They have to be demonstrated from the top of organisations.'

Isabelle Trowler, Former Director of Morning Lane Associates, in evidence to the CSJ

We previously referred to the negative impact that poor leadership and conflict at the top level is having on various departments within some local authorities, including social care teams.[18] If, internally, teams are not working together, this is not conducive to effective working relationships with external agencies. Furthermore, the issue of capacity in some social care teams means that they can find it very hard to create or sustain partnership work.[19] In addition, it appears that the high turnover in staff in some social care teams is having an adverse impact on working relationships with those in the voluntary sector, where relationships that can take years to build are lost and need to be created again. One SHS practitioner stated:

'I very seldom have contact with the same social worker, only when a long-term social worker is allocated to the family.'

However, they added that:

'In some cases … there has been a positive impact, especially when the work has been on-going with a long duty social worker and other agencies meeting regularly. It is good for the parent and child to see agencies working alongside each other, and adhering to the support offered at core meetings.'

We were also told that in some local authorities, financial pressures have led to a reduction in staff able to engage with VSOs, and that there is a reliance on agency staff at the frontline, who do not have relationships with other agencies.

'The pressure on local authorities to transform services to take account of diminishing budgets has led to reorganisation, and the loss of expertise in some local authorities and the concentration on the needs of children and families being lost. In one local authority, the council pushed through reductions in salaries of social workers which led to a loss of experienced staff who went to a neighbouring authority. This led to a heavy reliance on agency staff, a dramatic increase in social care expenditure as staff were risk adverse, and finally a council decision to reverse the decision and increase payments to social workers. In the meantime, the services to children and families deteriorated, and this approach also coincided with severe cuts to voluntary sector contracts, so there were fewer agencies to pick up the early intervention that was required. The number of children in care and on child protection plans rose considerably.'

VSO, in evidence to the CSJ

18 As discussed in Chapter One
19 Ibid

Concern was raised about the impact of the high turnover of social workers on vulnerable parents, children and young people. One witness commented '*You are just making more chaos.*' Again, it can also make the situation more challenging for the next social worker(s) to deal with, who may not have a comprehensive knowledge of the history, again impacting on their level of understanding. Furthermore, it can have an adverse impact on VSOs. Concern was expressed about the high number of agency social workers being used in some local authorities. One VSO referred to the *'huge amounts of agency staff being used.'* The impact of some foreign agency social workers on families, and the VSOs supporting them, was described to us by a SHS practitioner:

> *'… [it] takes them at least six months to get to know our systems … and that's why often then with some of these families, we end up holding it because we've got the continuity, and we say to them, "no, look, this has been the history." So I think that also has a knock on effect, and holds up access to services because often social [care] can move them on quicker than even schools can.'*

Where the charity Enthusiasm Trust reported a largely productive working relationship at operational level, it explained that a number of issues exist at strategic level. Whilst consultation and partnership arrangements are in place, they were described as being *'almost tokenistic as opposed to creating a forum of openness.'* Enthusiasm Trust added:

> *'People are insecure, more services are at risk, and we feel that this is having a huge impact on the voluntary sector, more so than statutory services. The voluntary sector is being "pushed" out slowly but surely, taking huge cuts, leaving the hardest to reach children, young people and their families vulnerable.'*

We previously highlighted extremely concerning evidence regarding children in need being neglected by social care in some local authorities, and effectively being left until an incident occurs which lifts them up to the child protection threshold. We also referred to concerns having been expressed to us that some social workers are not equipped, trained or experienced enough to carry out direct work with children in need. However, many of those working in VSOs are extremely skilled and experienced in direct work with vulnerable children (and young people). Our evidence demonstrates the greater extent and quality of time that practitioners in some VSOs are able to spend with vulnerable parents, children (and young people), enabling them to get to know and build trust and relationships with them. We heard that while social workers would welcome the same opportunity, in many cases it is just not possible, due to the amount of direct work they are able to perform. Moreover, we previously highlighted how direct work with children in need can be delegated to unqualified or more junior staff. [20]

> *'… I don't think it is logical to say social workers haven't got the time to do the direct work, so let's leave it to the third sector to do. That can't be a logical position. If it is desirable for social workers to do the direct work … then you have got to find a way to get them doing [it]. What you need to construct is a different way of doing things, where*

20 Ibid

the core people involved with the family are frequently seeing each other and talking about those families … Your eyes are never off what's happening.'

Isabelle Trowler, Former Director of Morning Lane Associates, in evidence to the CSJ

'I need to recognise my limitations. I think one of the problems with social work is that a lot of the way we are trained … is that we can deal with all of these problems, but really we can't. We can deal with a little bit, and we need to recognise where actually an expertise in something else is necessary. That is where voluntary sector and statutory sector partnership works. When you can have an agency dealing with a certain issue well, and they have got the time to do that …'

Social worker, in evidence to the CSJ

We believe that the voluntary sector has a critical role to play in this respect – working alongside social care to support social workers and vulnerable children and young people. This should hopefully enhance a greater understanding of the reality of their lives, and help to inform assessments and effective interventions. It may also minimise the risk of their situations continuing or escalating, and their needs becoming more entrenched. As one VSO told us:

'… if we had charities working together with social [care] to deal with these children in need cases, the problem would be solved. It's so easy … we're experienced in doing it. We have more time to do it because we're not dealing with court cases and child protection issues …'

If improvements could be made in partnership working, so much more could be achieved. Our hope is that this would detract from concerns about VSOs drawing out more need on the part of vulnerable children and young people, because social care would be in a better position to be able to address those needs by virtue of working in a more effective and efficient partnership. The same VSO explained:

'Yes, we might uncover all of these issues, but we will work with you on that. We've got people who will work closely together with you, in order for us to make those changes.'

Not only could effective partnership assist in terms of more efficient working and use of resources in both sectors, it would also save considerable human and financial cost, with better outcomes for vulnerable children and young people in the long term.

*'… leaving care – this is the last opportunity for these [young people] to get support from social [care] … and the problem is … that social [care] again will keep it very internal … Why are we not working with [VSOs]? Why are we not trying to promote these? Because this is stuff that you can get help for that will continue to be in your life … Why are we so stupid … to think "ok, we're going to pull out every service and support away from this person, knowing they've had a completely s*** life?" Why are we not even at that point working alongside those organisations for the best interest of the [young person]? Why don't we know about these services? Why are we not allowed to work more creatively?'*

Social worker, in evidence to the CSJ

One social worker stated that one of the most essential parts of social work that makes people effective is building a network of professionals from other agencies that they can actually call upon when they need them. However, we heard from various witnesses, including social workers, about a lack of awareness on the part of some social care teams about the existence and quality of VSOs in or outside of their borough. A social worker told us:

> *'A lot of social workers don't even know the services that are in their own borough that are run by … social [care], so how … are they going to know about services that are external? And that are in the community and actually doing good work …? … As social workers, half the time we're running around asking "do we have a domestic violence programme? Where do we go to find mentoring and outreach work for young people?"… And the bottom line is half of these services don't exist anyway … so, we've got a lack of services in social [care], but then again we don't know what services are there, because they are constantly being cut and changed and new initiatives are being created …'*

A lack of understanding clearly exists on the part of some of those working in social care as to the nature of work undertaken by some VSOs, as well as their priorities and the pressures that they can also face. This can compound barriers to effective partnership working. For example, short notice can be given to VSOs for meetings regarding the vulnerable children and young people they are working with. There can be a lack of capacity on the part of some VSOs for their staff to attend every multi-agency meeting. We were informed that staff can be stretched due to tight requirements of contracts, and due to those in managerial positions covering a number of local authorities with different structures and different priorities. Restricted funding can hinder a VSO's ability to release staff for more holistic meetings regarding their social circumstances. Calls have repeatedly been made for social care to have a better understanding of what different VSOs do, so that it can better utilise their support. It is felt that a VSO is sometimes not afforded the same amount of professional respect as a key stakeholder – for example, a school, due to a lack of understanding as to what a VSO does.

There is also a lack of recognition and understanding of respective roles, duties and responsibilities between some VSOs and social care professionals (amongst other agencies). In remaining true to its charitable purpose – for example, of education, a VSO can sometimes be prevented from taking on action points at meetings, when perhaps others would like them to do more. Concerns over the sharing of information featured repeatedly across our evidence – over the nature and extent of information which is considered to be appropriate by VSOs to share, according to their working practices. A delicate balance often has to be struck by VSOs. One explained that they can feel like they are being asked by social care to do their research for them. However, a number of VSOs explained that if the social workers engaged the children and young people in similar conversations to the ones they were having, they ought to be able to gain the information sought. There appears to be a tension here – between the disadvantage caused to social workers by the constraints they face in being able to carry out more direct work, and the advantages gained by some VSO practitioners from the greater amount and quality of time that they are able to spend with vulnerable parents, children and young people. As discussed in Chapter One, a social worker's lack of opportunity to carry out direct work can hinder their ability to build relationships, and an understanding

of children and young people's circumstances and needs. Again, this illustrates the potential value of effective partnership working and collaboration.

> *' … [social workers] also have an increased work load and a decreasing amount of staff to deal with that on an on-going basis. So of course they're not going to see a person enough to build up a proper picture of an individual. What they've got to do is pick and choose the information they can get quickly. They're going to take that in and base their decisions on the evidence they've got in front of them. That is quite hit and miss because they can't collect all of the information they need because they just don't have enough time. And when there are serious case reviews, that's what's coming up – there wasn't enough interaction between professionals, there wasn't enough information gathered, there were failings because this … and this … and this was dropped. And … it comes back to capacity … there's a huge issue of capacity within all the teams, especially CAMHS and social [care]. Because there's this decreasing amount of staff, and well trained [and experienced] staff.'*
>
> **Christopher Henriette, South London Youthwork Manager and Safeguarding Officer, XLP, in evidence to the CSJ**

The role of some VSO practitioners, as advocates and mentors, can serve a dual purpose, which needs to be carefully negotiated. They need to balance the information that has been shared with them, in the context of an advocacy and mentoring role, with the need to pass significant and necessary information on to social care for safeguarding. Christopher Henriette, of XLP, explained:

> *'You've kind of got a conflict of interests. Yes, anything to do with safeguarding and the safety of that [child] is paramount and will be shared. We're all bound by that. But sometimes your role is about coaxing the [child] into having a voice and saying it. By virtue of stepping over them and just feeding that straight in to social [care] … you negate your ability to be able to make the [child] do that. Because you've already told … the other professional, everything about that [child]… It's a tight rope for us as voluntary sector because a lot of the time we are advocates … who are in the middle of the process, or bridging the process, which is hard. But it has unique … benefits, because you're in a place where you can support … a statutory professional, like a social worker by saying "this is what I will do, and this is what I won't do. I totally support the process you're going through but this is the role I'm going to take. And this is how I would like to work in this situation … I think it's very rare that it's done well, that everyone defines their role for that [child]."'*

This also illustrates how important it is that the role performed by VSO practitioners is clearly defined – in their own minds, and as expressed to those in statutory services. Some VSO practitioners struggle to understand where a social worker's duties begin and end. Social workers should be transparent about this. It seems that some VSOs can be open to abuse in this respect. We have discovered examples of VSO workers being asked by social workers to take on tasks that they should not.[21] One social worker told us:

> *'Of course we'll pass the buck – "you go do it." Definitely. I've done that … Because everything you're going to do means that I don't have to.'*

21 Examples of which are highlighted in Chapter Four

Some VSOs may find themselves taking on action points that they should not, and without payment for the work.

The absence of clarity can cause confusion and anxiety. It can cripple decision making and breed a sense of distrust. A recognition and understanding of respective roles, duties and responsibilities should enable professionals to be more mutually supportive of one another, and create an environment in which respect can be enhanced. Each should have an understanding of the nature of their work and the parameters which are appropriate for them to work within. This could also encourage greater trust and confidence between the two sectors and lead to more effective partnership working. Where a VSO and its staff have a clear understanding of what is appropriate in any given situation, they are also more likely to have the confidence to push back, if necessary.

Environmental challenges

We heard about the impact that the reduction and/or cessation in preventative services is having in some local authorities – within the councils themselves, and also within the voluntary sector. The VSO, Enthusiasm Trust, informed us that at the same time as those reductions (including in youth provision), its experience is showing that thresholds for social care intervention are higher than they were previously. This means that some children cannot gain access to services through social care, which is *'not undertaking the level of preventative work it did previously.'* We were told that, at the same time, funding within the council for VSOs providing preventative services is decreasing:

> *'… with the huge cuts that have taken place in the voluntary sector children, young people and their families have less access to preventative, non-stigmatising services that they really need.'*

We heard that Relate in Derby, which provides therapeutic counselling services, has had a significant reduction in funding, which means that a large number of children, young people and their families are unable to access vital therapeutic services. This, we were told, also has a knock-on effect on other agencies, as there is an on-going unmet need due to the lack of provision to refer to, or a long waiting list. Enthusiasm Trust added that the pressures are *'across the board'* for children and young people, in terms of the *'huge reduction in preventative services available to them.'* This is also adding to the pressures on surviving VSOs. Action for Children's *The Red Book 2013, Children under pressure*, reveals the increase in referrals and demand on the VSO's services, with 50 per cent of intensive family support managers believing that demand has risen for their help due to cuts in other services.[22]

In Chapter One we referred to children being held at CAF and TAC level, who ought to be receiving children in need services or even, in some cases, placed on child protection plans. Some vulnerable parents welcome support; others do not. The CAF process, for example, is voluntary, in terms of whether a parent engages with it. This can present real challenges for

22 The research involved a quarter of Action for Children's 650 frontline service managers; Action for Children, *Children are 'feeling crushed' under the pressure of adult problems*, 7 November 2013, p9 [accessed via:http://www.actionforchildren.org.uk/news/archive/2013/november/children-are-%E2%80%98feeling-crushed-under-the-pressure-of-adult-problems (27.05.14)]

VSOs (or schools). They can be left trying to manage a case, in circumstances where significant concerns exist, and face an uphill struggle to secure the engagement of the parents to, in turn, support the child. In some areas, it appears that VSOs (amongst others) are having to deal with the repercussions of inadequate children in need services.

> *'… it's really hard. They say "do a CAF form" but then what do you do? It is being pushed back to schools more and more … something we are encountering with some of our families … if the parents have not had positive experiences … with social [care] themselves, they block it. I have been working with a family for a long, long time. I know these children, five or ten years ago, would have met a threshold. It is really worrying, to such an extent that I am even contemplating phoning Child Line or someone, so that something can anonymously be logged because it's terrible what is going on there. But the parents know how to block it because of their own history … They just say "no, I'm not signing or doing that." The way we try to get in is via the SEN route because they want their children diagnosed as autistic because of the money. I'm sorry, I hate to say that, but I'm afraid now there is a change in culture with a very small minority of society.'*
>
> **SHS practitioner, in evidence to the CSJ**

Again, the examples of cases highlighted in Chapter One that are not meeting social care thresholds illustrate the extent and severity of need being held by some VSOs (amongst others). We heard about the considerable anxiety felt by some VSO practitioners about this.

> *'The things we are having to hold. The complexity of the cases … that triangle, we're right up at the top – level 3 and level 4 sometimes. And it seems that if people feel that there are workers like us involved, you feel people take a sigh of relief – "oh well, that abdicates us of the urgency of the matter at the moment." Yet we're seeing on the ground, because we are the people who see these families daily, just the impact. And that is the big thing that we see that other people don't – we see the deterioration in the children, their appearance deteriorates, they are looking more tired … That … worries me – what we are having to hold because there is nowhere else for these people to go.'*
>
> **SHS practitioner, in evidence to the CSJ**

We received evidence from several witnesses regarding a number of VSOs being 'overwhelmed' with demand, and facing a lack of resources. The CEO of one VSO expressed their concern over the voluntary sector taking more on, with less resources than they need in order to discharge their safeguarding responsibilities effectively:

> *'… amateurism. The "if we care enough, it will be okay," without recognising the huge complexities and risks that there are around a lot of the work that gets done.'*

They explained that there are lots of manifestations of that, including the marketisation of what the voluntary sector does, and the extent to which that puts it in a riskier place. They added:

> *'I think it is very tempting, if you are a relatively small organisation, in quite a discreet geographical location, and very dependent on your relationship with commissioners … to step into a space on the basis that if you're not there, particularly when the state is contracting, nobody will be there. That isn't necessarily a good place to be, where*

safeguarding issues are concerned … you're missing a really critical issue, which is that there are responsibilities and duties that statutory agencies have that they can't just pass over. Sometimes you need to say, and we do this "we can't fulfil the contract you're asking us to fulfil, on the money that you are prepared to pay … We can't fulfil our responsibilities and our duty of care for half of what it costs, which is what is on offer." Even if us getting that work – our survival, is predicated on that.'

The CSJ strongly supports the principle and intentions of the Troubled Families Programme (TFP). However, the approach being taken by some local authorities to the TFP appears to be having concerning consequences for a number of VSOs, and the vulnerable individuals they are endeavouring to support. Child protection forms a significant part of the TFP, given that child protection problems are estimated to exist in over a third of troubled families.[23] Concerns were raised by the charity Enthusiasm Trust in relation to a *'conflict of interest'* relating to funding streams and posts being maintained within the council, as opposed to commissioning parts of the work to VSOs. The local authority within which Enthusiasm Trust operates, has apportioned a large amount of the funding for its local approach to the TFP, to staff within the council to work with the families. This is also in the context, we were told, of many local authority staff having been redeployed into posts that are not necessarily their chosen role, but due to reduced budgets they have found themselves in a vulnerable position. Enthusiasm Trust told us that:

'A whole imbalance has been created. This is evidenced by the appointment of full-time posts for the TFP in the [local authority] and the voluntary sector without substantive funding – organisations that are already working with and engaging some of these families.'

The irony of this of course is that whilst many vulnerable families can be reluctant to engage with statutory services, they are often more likely to engage with VSOs.

We heard about the impact of local authorities claiming that a proportion of the funding is being used for the voluntary sector, but through a *'purchasing list'*, which the local authority uses to purchase external specialist provision, in various forms, from VSOs. Enthusiasm Trust questioned:

'Where does that leave the VSOs in terms of being able to fund their employees? Zero-hour contracts according to what requests have come in for individual pieces of work, while local authority staff have full-time posts from the same funding stream.'

It added *'This is clear evidence of the imbalance and inequality of opportunity for VSOs.'* We were informed that local authority officers made the initial decisions about the appointment of posts and fed those in to the voluntary sector, labelling that as *'consultation,'* and proceeding to consult with the VSOs about how the 'Dynamic Purchasing System' would work. It was at that point that VSOs' views were considered. Enthusiasm Trust added:

23 Communities and Local Government, *The Troubled Families programme: Financial framework for the Troubled Families programme's payment-by-results scheme for local authorities*, March 2012, p1 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/11469/2117840.pdf (31.03.14)]

'It feels to us that people are becoming complacent and losing energy and drive to challenge [the local authority] because they are vulnerable due to the funding situation.'

It was suggested to us that transparent processes need to be in place relating to all funding streams that are managed by the council, from the start, and decision making processes that seek out the most relevant services for people, without automatically keeping them *'in house.'*

Another VSO explained the resentment caused in one local authority of the VSO *'coming in new,'* and that *'what they instinctively do is try and re-build their own in-house stuff.'* We were also told about the VSO having a long-term contract in one local authority, but that part of the contract allows the local authority to decide at any point that it does not want the VSO's practitioners involved anymore – *'with no notice or no explanation.'* A law firm has informed the VSO that 'they've never seen anything so aggressive as that …' The VSO said:

'We've chosen to do it because they're exactly the families we want to help. There's no financial advantage in us doing it, it won't cover our costs, and we will need charitable money to back it up.'

It seems extraordinary that some VSOs are not being enabled to perform to their full potential in supporting these troubled families. This is as a result of not being able to work more holistically with them. Some are being placed under more pressure financially as a result of the relevant local authorities' approach to the TFP. One VSO stated *'If we got £10,000 per family, we'd sort them out.'* However, we question the extent to which outcomes can be accurately and fairly measured, and where these are linked to payment by results, in circumstances where a VSO is tasked with a particular focus of work with a child, where their difficulties stem from the wider challenges faced by the family and which the VSO is not supposed to be addressing.

We were also informed that one VSO practitioner was *'having to play the detective'* in a local authority, before being able to start working with the young person, and that families had several people *'intervening around the place.'* Our witness further explained that:

'the levels of communication between teams are just dreadful … nobody is taking this lead role … [the practitioner] is having to go and suggest they just copy each other into emails … The idea of one lead person is a great idea but you've actually got to get to that point …'

We have been told that some local authorities do not know their troubled families very well. An example was shared of a VSO practitioner being asked to see a family where she was told there were three children. When she arrived there were in fact seven. However, one witness shared some positive signs emerging from the TFP in their area – with respect to greater continuity and consistency provided by family key workers, who are supporting and giving parents confidence to access support services.

Angela Gascoigne, Management Consultant, told us about a local response to the TFP which is hoped to continue to respond to the needs of the most complex families in the relevant area, beyond the funding's timeframe. However, we also heard that some local authorities are

taking what is in their view a very pragmatic approach, and will stop the relevant services once the funding ceases. However, if those services are achieving positive outcomes for the troubled families, this would be a very short-sighted and counter-productive approach. Who will then step in to help support them? Their needs are likely to be entrenched, and it is unrealistic to suggest that their challenges will be overcome in the timeframe within which the funding will exist.

3.3 Mental health

CSJ review of Kids Company cases

We repeatedly found across many of the cases we reviewed:

- A failure to produce a health assessment; and
- A lack of coordinated holistic support for the vulnerable child/young person.[24]

As previously stated, our case review revealed that the vulnerable children and young people with mental health problems broadly either failed to gain the care and support they needed, or were given some care and support but it was short lived and/or sporadic, and appears to have failed to address their needs. In these circumstances, Kids Company has provided some with direct therapy, where they have been willing to access it. Those who have not received direct therapy have received therapeutic support from Kids Company key workers who are therapeutically trained.

- Adam, another child, David and Michael have received emotional and therapeutic support from Kids Company. Regular therapy was arranged for Adam but he was resistant to engage with it. Kids Company has offered therapy to the aforementioned child, David and Michael but they have declined to access it;[25]
- Claire and another child attended therapy with Kids Company at their respective primary schools. Later, the latter child attended several sessions with Kids Company's Outreach Therapist; this coincided with them being stabbed on various occasions before attending a secure unit for a period;
- Joseph attended some emotional therapy (art therapy) at Kids Company to address his anger;
- One child attended individual psychotherapy at Kids Company until their primary carer withdrew their consent to this, following a referral to social care;
- One child and one young person have received some therapy at Kids Company;
- Another child was given access to regular art therapy; however, after attending twice, they decided against engaging with it;
- Another child received intensive therapeutic support and weekly psychotherapy for a period, until they were placed in care;
- Callie has engaged with psychotherapeutic work and psychotherapy sessions. She has also received support from a psychologist and a Consultant Adult Psychiatrist at Kids Company, which has also arranged two residential rehabilitation placements for her;
- Daniel attended some psychotherapy with Kids Company; however, we understand that he never resumed this after he expressed the wish to attend sessions at his school, and his school never confirmed a time for him to do so.[26]

24 We discuss these issues in Chapter Four

25 Since our Review, David has accepted Kids Company's offer of therapy which, we have been informed, he continues to access to date

26 Examples of the nature and extent of support offered by Kids Company feature in various case summaries and snap shots throughout the report

One witness explained that ideally Kids Company seeks to act as a bridge for vulnerable children and young people to access and engage with the necessary support from statutory mental health services. However, in reality, Kids Company and other VSOs can find themselves, as demonstrated across our evidence, left holding some children and young people who are highly vulnerable, and with complex and severe needs. This is while they are being held on waiting lists, or unable to access support from CAMHS altogether.

3.3.1 VSO support for vulnerable parents, children and young people

Vulnerable parents (some of whom have mental health problems themselves) can face serious obstacles in engaging with statutory mental health services for the purpose of accessing support for their children. Some VSOs are providing them with support to do so.

Some vulnerable children and young people can face multiple barriers in accessing, engaging with and obtaining care and support from primary and secondary care services. Some are not registered with a GP, or feel reluctant about going to one; some do not have a functioning parent to support them to register or attend an appointment. Such restrictions can in turn present a further barrier to them gaining access to support from CAMHS. However, some VSOs are performing a critical role by supporting vulnerable children and young people to register with a GP. They will also often arrange and/or accompany them to their appointments.

We provided the example of The Well Centre (TWC) in Chapter Two – the youth health hub providing integrated primary health care, youth work (by youth health charity, Redthread) and CAMHS early intervention provision – on the same site. Youth work was found to perform 'a strong and central role in enabling [those between the age of 13 to 19] to engage with their health and with health services. It was also crucial in ensuring that other services and support were harnessed…' The ability of Redthread's youth workers to engage with the children and young people 'on their level' was recognised as 'a way to enable them to take full advantage of the health and wellbeing services on offer at TWC.' This provides a good example of the vital role that effective VSOs can play in supporting children and young people to access and engage with statutory services (amongst others).[27]

Furthermore, some VSO practitioners are investing considerable time and energy in helping vulnerable children and young people to access secondary care services. Where referrals are accepted, they are also supporting them to attend their appointments and to engage with the support offered. Christopher Henriette, South London Youthwork Manager and Safeguarding Officer, XLP, commented that *'when young people can be coached to access counselling and other treatments, then we see incredible change.'*

In addition, some VSOs, like Kids Company, are providing vulnerable children and young people with mental health services directly, when they are willing to access them. Critically, they are often able to offer continuity of care and support where a vulnerable child or young person's experience of statutory services can be fragmented.

27 Corlett S et al, *An Evaluation of The Well Centre, Streatham*, Final Report – Executive Summary, London: London South Bank University, June 2013, p7

'The physical setting in which help is provided is important. Not only is a community setting felt to be less stigmatising, but the young people in this study illustrate through their experience the important function of place attachment as a prelude to forming closer bonds with their key workers. Paying attention to the physical space within which help is provided is therefore not a luxury, but an integral part of the process of intervention. Many mental health settings ignore the importance of the physical environment, but with this particular group of young people the welcoming nature of the setting appears to be a critical factor in engaging them.'

Alessandra Lemma, The Power of Relationship: A study of key working as an intervention with traumatised young people.[28]

3.3.2 Barriers to VSO engagement with statutory mental health services

A Consultant Psychiatrist's perspective (engaged by a VSO)

Being here, I have encountered with CAMHS seemingly lengthy delays to get even an appointment for a child or young person to be seen. I can give you an example of that quite recently: a 15-year-old girl I saw from before Christmas 2012. I was asked to see her by her support worker. It was a new case. The support worker was very concerned about her mental state. I met with this girl and she seemed to me to be possibly very psychotic. When I say possibly, she was reporting signs but I didn't have any third party informants at this point. What she was reporting was acute psychosis – with hallucinations, and the inability to go to school because of that. And she was showing self-harming activity, and what seemed as a very pressing desire to kill herself. To me, there seemed to be a need to see an adolescent mental health team.

The first thing I did was write to a GP – she didn't have one, so I had to get the support worker to get her registered. She had been to A&E a couple of times, but had been turned away – I think perhaps she hadn't revealed the full extent of her symptoms. Then it was a matter of contacting that GP and saying *'which CAMHS is it?'* because I didn't know and he provided me with that detail. I then wrote a strong letter asking for her to be seen urgently. She was seen at the end of April. The support worker went with the girl to the CAMHS appointment. I had this rather sad email from her afterwards saying she had been seen, and CAMHS didn't think she had any mental health issues and were not going to see her anymore. They were not going to do anything.

So for four months (until her appointment), she had been living at home, not going to school, periodically turning up at A&E with minor overdoses or reported fits. CAMHS never rang me back or responded to anything – emails, letters and phone messages. Whether they did with the GP, I don't know. The father said he saw her during a convulsion and took her to A&E. I'm not sure how much of it is real and how much of it is a fantasy, but the point is she was also complaining a lot of headaches, she was collapsing, her father said he saw her twitching after these collapses so I also really wanted to get a brain scan. I asked for an urgent referral to neurology and to psychiatry, CAMHS. It took months of repeated ringing, writing, and nagging. All of which time I was seeing her and her mother regularly (as was the support worker), and continued to feel that she needed urgent neurological assessment. We've had plenty of others that are in and out of A&Es that don't seem to be picked up by anybody. The casualty doctor presumably sends them home.

One time her support worker rang me and said she had taken an overdose and she was in casualty. I said *'can you go down and be there with her – if you can just demand for her to see somebody. They can talk to me on the phone, I'll fax them copies of my reports and letters – just make sure she is seen by someone.'* She did do that and it took hours. She rang me and said the psychiatrist has just been to see her, and he said he needed to admit her to do investigations – neurological and psychiatric. I thought it's quite heavy duty but if that's the way to get her sorted, that's probably the best. In the

28 Lemma A, The Power of Relationship: A study of key working as an intervention with traumatised young people, *Journal of Social Work Practice*, (24) (4), 2010, pp409–427

back of my mind, I was thinking to exclude brain tumour or other organic condition. As a psychiatrist you always do in those situations. Then the support worker emailed me later, and said someone came from CAMHS and said she didn't need admission and they would send her an appointment. We were back to square one waiting for CAMHS again. If that were my kid, and I know I am in a different position in some way, but I don't know what I would do. I don't know.

Then that involved me getting the names of who was there from the CAMHS team, via the support worker, and getting phone numbers and emails and contacting them. Meanwhile I was saying *'what about the mother?'* because we were trying to support her as well, and I would have thought CAMHS might have wanted to talk to the mother and maybe do some family work. I contacted the main character. And I rang the psychiatrist. The support worker managed to get the name. I rang him. The Care Worker Coordinator never got back to me but the doctor I did speak to. I explained the situation and he said *'Okay, we will offer her another appointment and get back to you.'* But they never do, you never hear anything back. I never get any feedback, ever, from psychiatrists.

No matter how many people I refer to them, they never get back to me. I've got a very low opinion of psychiatry in this country. I think it is appalling, and I frankly think most people wouldn't want anyone to go anywhere near it, anyone you cared about. We've got a number of youngsters here who are regularly overdosing but they don't seem to get any psychiatric or CAMHS care. Perhaps, it's the fact that they do it so often and regularly go to A&E.

The thing about psychiatry is that diagnostically, very rarely, there are a few organic causes of mental health problems that you can work out. But other than that, it's like being a detective. Our greatest tools are probably just communication really – being able to hear, and being able to communicate in such a way that information is made accessible both from the person and their relevant third party informants. And curiosity I guess, and time. It all takes time. Particularly with a youngster, you don't want to lose time. If it's a 15-year-old out of school, it needs somebody, probably one person because it's very hard to talk to lots of people about these things, to literally put the hours and hours into it that it takes to coordinate this. Organise a brain scan but meanwhile let's ask about what's going on at school or home. That's how you find these things out – whether the symptoms are real or so-called invented. They're real in a way, either way.

I just don't see psychiatrists doing that. It's quite shocking in the hospitals, how little time, or no time they spend with their admitted patients. In outpatients, at best they are offering 15 sessions with some sort of psychotherapy probably. It's not thorough. It's not rigorous. It's just a bit like a television if it doesn't work. The idea of 'if it's not working, give it a kick.' That's how it feels to me: you either throw drugs at people, or give them a bit of counselling, but without thorough assessment of the family, finding out what's going on at school. I am sure there are some people still doing that but I rarely meet them. It sounds to me that the pressure of time has led to this situation where everything is a shortcut. Unless there is actually a perceived disaster looming, then CAMHS don't want them.

The intense pressures faced by many statutory mental health services were, again, appreciated by the VSOs that gave evidence to us.[29] Aligned with the position in social care in some areas, some VSOs are expending significant time and energy in trying to help vulnerable children and young people gain access to secondary care services and support. Sometimes VSO practitioners can go around in circles, desperately trying to identify and track down the relevant services and individuals, and to seek the provision of coordinated support across the professional network. Again, a number of challenges exist to partnership working, in parallel with a number of those in some social care teams.

29 These pressures are referred to in Chapter Two

Barriers to referrals and poor communication

Some VSOs are also facing challenges around referrals. In Chapter Two, we referred to evidence of higher thresholds being applied by some CAMHS. We also highlighted the fact that some CAMHS will only accept referrals from particular organisations – to the exclusion of some VSOs, and that this is being used as a means of gatekeeping. Comments have been made about CAMHS adopting this approach to manage the quality of referrals they receive. However, some of our witnesses thought otherwise. One stated:

> *'I think it's more about resource difficulties … because if we were suddenly able to refer directly in, I don't think it would necessarily mean that those young people would get a service. Because at the moment, CAMHS has a model where they can only take 60 per cent of all the referrals that come to them into the service. So they are already under massive pressure themselves with dwindling resources … So I think what it comes down to is managing the flow of referrals more than the quality of them.'*

A SHS practitioner recalled how CAMHS in the local authority in which she works had previously been *'really pretty much open doored and they used to do training for us and … basically said you can refer in yourselves as practitioners …'* However, this is no longer the case. CAMHS now stipulates who can refer (no longer the VSO practitioners), and according to the mental health problems of the children in question. One of the children at the school in which the SHS practitioner works is self-harming and is seeing a professional counsellor, from another VSO, who works in the school. However, they have been told by CAMHS that they are not able to refer the child to CAMHS – that social care must do it. The SHS practitioner recognised *'Social [care] are inundated to find the time to do it.'* Indeed, a number of social workers that we spoke to told us that they would welcome VSOs being able to make referrals, given the pressures that they are currently working under.

It seems that the position concerning referrals is not always entirely clear – even to some CAMHS professionals. A CAMHS clinician told us:

> *'I think we're the ones who tend to refer to [VSOs], but they don't tend to refer to us. I don't know that they're specifically not allowed to. I just don't think it happens. It certainly doesn't happen in my area. Whether it doesn't happen because they're not allowed to or whether it doesn't happen because they don't think they should, I actually don't know.'*

Various CAMHS services refer into VSOs. It strikes us as being extremely unfair, and lacking in professional respect, to prevent them from being able to do the same. Indeed, the CAMHS clinician went on to state:

> *'I can't see why a voluntary agency would be any less qualified to identify a child with emotional and behavioural difficulties than a GP would … For me, if you've got concern, that's enough. You should at least be able to pick up the phone and ask advice about what to do next.'*[30]

30 We discuss issues of concern regarding the lack of mental health training and expertise of some GPs in Chapter Two

Frustration was expressed to us by some VSOs, at not being able to refer directly into their local CAMHS. One VSO, which is a Tier 2 provider of mental health services, cannot even refer directly into CAMHS – it has to send children and young people back to their GP with a letter.[31] A VSO may well have an informed understanding of a vulnerable child or young person's circumstances and needs. It may also have more information to give CAMHS in a referral than a GP, and is likely to be under less time pressure to be able to make the referral. Surely it would be more efficient and fair for designated individuals within VSOs to be able to make those referrals directly (keeping a relevant GP informed), and for CAMHS to provide them with guidance in terms of the required standard for referrals? It has been suggested that psychologists and psychotherapists in VSOs should be able to refer directly to CAMHS.

We heard that sometimes referral decisions are not clearly communicated. We also received evidence of some VSOs facing communication difficulties with CAMHS practitioners. For example, we heard about VSOs having to repeatedly chase for a response to correspondence or phone messages, and for information about or feedback on the vulnerable children and young people they are working with.

Partnership working

> *'… in this financial climate of shrinking income, [partnership working] would be a way that resources could be shared and pooled … It's so underutilised; I can't think of anything that we do at the moment in partnership with other organisations at all … anywhere that I've worked. It's been quite separate really.'*
>
> **CAMHS clinician, in evidence to the CSJ**

There is clearly some confusion over what actually constitutes partnership working, and what it aims to achieve for a vulnerable child or young person. At an event hosted by a VSO, a Consultant Psychiatrist spoke frankly about the challenges – *'the big open secret is that we have no idea what partnership working is.'* They recognised that government documents refer to what needs to happen but that, in reality, they don't know what partnership looks like – there are lots of different types. That said, as with social care, some strong partnerships between statutory mental health services and VSOs do exist. However, again, it is clear from our evidence that there is vast room for improvement.

A witness from one VSO, which provides Tier 2 mental health services, explained that there is no onward pathway from them into specialist services. As a self-referral service, the VSO finds it deals with a real diversity of needs:

> *'We see every issue you can imagine and some really very unwell young people who have disengaged from statutory services. They are sometimes so chaotic and vulnerable. They are not going to go back to their GP, they are not going to very often get themselves back to an appointment with CAMHS. There is just no … joined up thinking.'*

31 During his talk about CYP IAPT at the National Conference in 2013, Professor Peter Fonagy stated that it was heartening to see self-referral growing in CYP IAPT Year One and Year Two sites. However, we do not know the extent to which this may include vulnerable children and young people [accessed via: http://www.cypiapt.org/children-and-young-peoples-project.php (14.02.14)]

The VSO estimates that over half of its clients each year should qualify for a Tier 3 specialist service, but told us that almost none of them end up there. Our witness said *'we end up doing a sort of, you know, holding job but it's very unsatisfying. And it's not what we're in it to do.'*

There is a lack of awareness on the part of some statutory mental health services regarding the existence of VSOs in their area. In addition, we were informed that some CAMHS services can lack an understanding and knowledge of the nature of some VSOs' work and their level of expertise. It was also felt that some VSOs need to communicate with statutory mental health services to improve this situation. A CAMHS clinician told us:

> *'We try at times to compile directories … but it's an ever changing seascape … keeping up-to-date with what's there. New initiatives may take us a while to hear about.'*

We found that a lack of understanding of respective roles also exists between some VSOs and CAMHS services. Again, it is extremely important that the parameters are clear and understood, to help enable more effective partnership working.

> *'I think the understanding of our roles – of what we can and cannot do can be a challenge. Us understanding what the voluntary sector can and cannot do, and the resources that are out there … And the other thing is the voluntary sector understanding what CAMHS can and can't do. That sometimes can be difficult, the interface I suppose.'*
> **CAMHS clinician, in evidence to the CSJ**

Dr KAH Mirza, a senior CAMHS clinician and academic working at the Maudsley NHS Trust, told us:

> *'I believe that the chasm between the voluntary … and the statutory agencies is a big problem. We have to build bridges … Most of us are used to working in silos, and we have all got our own budgets and we don't talk to each other. That is one of our major problems. I have known from my own personal experience that it is possible for the statutory and voluntary agencies to work together.'*[32]

Indeed, we were particularly encouraged to see the potential for transforming service provision for vulnerable children and young people during our visit to one NHS Trust. It is looking into more innovative ways of working with children and young people with mental health problems that is focussed on early intervention, partnership working and has youth participation at its core.

Dr Mirza raised the importance of developing trust between agencies, of learning from each other, and of recognising the unique strengths of statutory and voluntary agencies. He said that:

> *'If we could focus on the needs of vulnerable children and young people, it would become strikingly clear that there are things that a statutory mental health service can do that*

32 It should be noted that the views expressed by Dr Mirza throughout this report are his individual views, and do not represent those of South London and Maudsley NHS Trust or any other organisations that he works for

a VSO cannot, and that a VSO can do some of the things that a statutory mental health service cannot.'

Dr Mirza stated that clear delineations of the roles and responsibilities, and regular meetings to clarify expectations *'can help enormously.'* He commented that there are many *'caring, committed and passionate people'* working in statutory and voluntary agencies, and that 'it would be very helpful' for children and young people *'if we were able to work together in a systematic way.'* Dr Mirza added:

'It is about creating structures that can enhance supervision, training, and all those things can help change the culture and help develop joint structures. We know that we can do things better. It is about wanting to get around our problems with territorial issues. People find it difficult to go beyond their organisations and feel that they are working for the common good of the child. That is a serious attitudinal issue. The second issue is that we need to be hopeful about our kids. Without the hope, we cannot go anywhere … '

Again, some VSOs, by virtue of the time that they are able to spend with vulnerable children and young people – and trusting relationship they can often create – build an understanding of their circumstances and needs. This could potentially assist medical practitioners to, in turn, develop a more detailed understanding, and improve the efficacy of their assessments, care and support.

Dr Fuggle, Consultant Clinical Psychologist, Islington CAMHS stated that the voluntary sector has clearly got strengths, some 'fantastic' projects are run, and the ways in which children and young people can experience those services *'in a slightly more trusting way'* is completely welcome.[33] Dr Fuggle also highlighted some challenges:

'The risk is that they do get into these familiarities – "we are doing this, why aren't you?" I think that is profoundly unhelpful. My other anxiety is that our experience of the voluntary sector is that they are good, their staff are good at engagement with young people (they may well be better), they have a far more informal style … But the other thing is what you do after engagement. I think some of the statutory services have got something to share and to work with the voluntary sector … The collaboration side of things I think we need to develop … It seems to be that partnership needs to recognise strengths and not getting into idealising positions of one particular part of the system compared to another. It just needs a mature leadership, because it is very easy to get cross with other agencies and what they do. We all feel strongly about kids. Everybody has come into it that they want to be helpful …'

Environmental challenges

'I also think that because we can't get access to some of these other agencies, because of the demand, people notice the disruptive child and child who acts out in a big way. But I'm seeing more and more children showing signs of depression, sadness, low self-esteem

33 It should be noted that the views expressed by Dr Fuggle throughout this report are his individual views, and not those of Islington CAMHS

> *… I've … witnessed just this term, big time … it's often around the private landlords I'm afraid to say – and that's something that needs to be looked at – the impact [on families] of being moved. Those children have just plummeted … I'm seeing children cry who haven't cried before. It is dreadful to witness.'*
>
> SHS practitioner, in evidence to the CSJ

We referred, in Chapter Two, to the adverse impact of higher CAMHS thresholds, extensive waiting lists, and a lack of other mental health provision (for example, provided by VSOs), in some areas. We heard about the worrying impact on a number of VSOs and those they are trying to support. We were informed that *'as statutory services shrink, and thresholds rise,'* some VSOs are *'left to support increasing numbers of children and young people who may be highly vulnerable but do not qualify for a statutory service.'* An SHS practitioner told us:

> *'I'm now holding family counselling, family therapy, child therapy and group therapy amongst the children and the adults because there are waiting lists. And I've still got to be able to support the families whilst they are waiting on the waiting lists. So now I'm working with a family where there's domestic violence … There's only so much time that I can give to this one family, because I've got another 23 who need my support in other areas as well. It's about trying to juggle all of that, bring that together, chase up other professionals for what they are supposed to be doing.'*

Where VSO practitioners can sometimes secure a faster appointment, this appears to be on a personal basis, as opposed to being enabled by the system itself – as a result of them having established a relationship with CAMHS. A SHS practitioner explained:

> *'… quite often I think I could probably jump the queue with some of my young people because I would ring up the person I needed to ring up, and because they had developed a relationship with me, then it meant I could say "look, this is a really urgent situation …" Clearly that's not the way it should work but I think sometimes … it does work like that. We all get to the point where we've all got our contacts in particular services and we use them because otherwise we could be waiting for months'*

We heard that some VSOs that are providing mental health services for vulnerable parents, children and young people are also facing other severe challenges in the financial climate. One VSO reported that it is struggling to maintain, let alone develop its provision, which limits the number of families it can help. We were informed that some VSOs are holding long waiting lists themselves which, again, can have negative implications on vulnerable children, young people, and their families. A CAMHS clinician highlighted the extent of challenge in their area:

> *'If you are a moderately depressed teenager, very often there is nothing for you. We have voluntary agencies offering counselling that often have six-month waiting lists … At the point in which a family needs support, or where the parent rings up, or goes to the GP in distress, they're going to have to wait. By the time you've made the decision that you need the help, that's when you need the help. In six months time, you may very well have shutdown again by then and it becomes too late. Every time that happens, that's*

another trauma for that parent who already lacks faith in the system, and it's the same very much within CAMHS.'

It is critical that we do all we can to protect effective VSOs that are offering support to our vulnerable parents, children, young people. Some are providing resources which are either rare, diminishing or non-existent in statutory services – for example, non-verbal therapy. A CAMHS clinician told us:

'Where I work at the moment, there aren't any [non-verbal therapists] … If someone came and said, "can my child have art therapy," we haven't got an art therapist and that is not uncommon. They are scarce. You'll have more psychologists; they will outnumber the non-verbal therapists … Some CAMHS … might have one art therapist, one play therapist."'

We also received concerning evidence over the impact on some VSOs of commissioning arrangements in the areas in which they work.

'I hoped that the move to commissioning might create new opportunities, or at least redefine the relationship towards a more equal partnership, but this hasn't really happened. Instead, statutory contracts have come with quite oppressive monitoring regimes, little commitment to partnership and a loss of our (charitable sector) independence. There are pockets of good practice, but the overriding feeling you get is that it's about being accountable for the use of public resources spent on the charitable sector.'
Witness, in evidence to the CSJ

We heard that there is currently *'a financial imperative at the heart of commissioning,'* and that emphasis is being placed on *'how we spend the least money in the most dramatic rather than effective way.'* The same witness went on to explain that commissioners, in their experience, do not understand what it is they are trying to commission, or some of the issues highlighted in this chapter, in relation to partnerships and the different cultures and competing agendas of the voluntary and statutory sectors. We were told that it then becomes very difficult for individual practitioners to effect change – *'I really do think it's a top-down process at the end of the day.'* We also heard concerns over it really being about managing the flow of money through the system. Our witness told us:

'… it's important for all organisations … even charities, to just be cost effective, to evaluate their work, to engage with issues of efficacy and outcomes. But it just seems that, that's one argument and there's the statutory one now, which seems to be about how cheaply we can do this … So there is a big shift which is about money, and I think it's very unhealthy and in the end puts young people at risk.'

However, hope was expressed that over the next 12-18 months, the commissioning landscape might create opportunities to work more in partnership because it is in their interest to work alongside statutory services whether that is social care, CAMHS and AMHS (amongst others), to achieve a seamless joined up pathway from self-referral, coming in off the street to the VSO, onwards. Our witness said:

'The fact that we're currently denied the opportunity to do that is detrimental to our service users. It's also quite offensive in the sense that, you know, what kind of work do they think we're doing?'

'It just seems bizarre that it doesn't happen – that we utilise the best of the voluntary sector and cross utilise our experience … But it's because someone has to be a bit more visionary higher up, we can't go in at our level and say we'd like to do some joint working with you. We can't do that … What the commissioners would say is "well you need to evidence it, because we'll be competing with finances from cardiologists, oncologists, orthopaedic surgeons." So CAMHS will have to say why they think it's good and what's the evidence – that it's actually going to improve outcomes and it provides value for money.'

CAMHS clinician, in evidence to the CSJ

As previously discussed in Chapter Two, there is a need for more strong and visionary leadership, and innovative commissioning. One witness explained that the reason why the partnership potential is not being realised is because it is not being commissioned. We heard that there is so much scope to build safeguarding into the commissioning process, and for partnership to be compelled as a condition of the contract, but that commissioners do not put in any structures in the actual monitoring of the contract to compel it. We believe that this needs to be carefully looked at. We also heard how the names of VSOs can be *'thrown around'* by *'big external and private companies'* competing for contracts *'without ever picking up the phone to us. So they will say, "well, we're talking to x, y and z, and yes we are going to have partnerships with them," and they've never … said it. But commissioners don't follow that up and check it.'*

Working in partnership would enable the provision of 'extra tools in the box' – for the interventions and experience of effective VSOs to complement those of statutory services. In Chapter Two, we referred to concerning evidence of a lack of prioritisation and identification of children and young people's mental health needs in some areas. It is imperative that sufficient services are commissioned to meet the needs of local populations. Again, VSOs have an essential role to perform in helping HWBs to achieve this in respect of vulnerable children and young people.

Indeed, the statutory guidance on JSNAs and JHWSs states that HWBs are required to consider, amongst other things:

'… how needs may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services; and those with complex and multiple needs such as looked-after and adopted children, children and young people with special educational needs or disabilities, troubled families, offenders and ex-offenders, victims of violence, carers including young carers, homeless people, Gypsies and Travellers, people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging.'[34]

34 The statutory guidance also states that 'This is not an exhaustive list, but an example of some vulnerable groups and [sic] [HWBs] may wish to consider – [HWBs] will need to develop their understanding of the vulnerable groups in their area and the issues that affect them;' Department of Health, *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*, 26 March 2013, pp7–8 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf (02.04.14)]

It also states that HWBs 'may find that there is a lack of evidence about some issues, and some seldom heard and vulnerable groups, which could be indicative of unmet needs and deprivation. Local partners such as [VSOs] … may be able to help where such evidence is lacking as they are well-placed to collect both quantitative and qualitative evidence and have good specialist knowledge of the community. They can also help [HWBs] to directly engage with some of these seldom heard and vulnerable groups.[35] … [VSOs] … can provide insight and information to help JSNAs better reflect the needs and views of people in vulnerable circumstances and this can support the development of JHWSs to meet those needs. Such organisations can bring great value to the process and should be seen as a critical friend.'[36]

3.4 Conclusion

> *'Kids love Kids Company and trust them. Social [care] is a scary name for kids, but "Kids Company" – that's our company. It makes you feel safe. Just the name makes you feel safe. Why wouldn't you want to be in partnership to help kids? Social [care] should work in partnership with Kids Company all day, every day.'*
> **Michael, in evidence to the CSJ**

> *'I think that social [care] relying on one agency like CAMHS for a mental health service … is not effective. We have seen that it just simply doesn't work and with huge cuts across the board for children's services, CAMHS simply can't serve all the children who are referred.'*
> **VSO, in evidence to the CSJ**

Some VSOs are offering critical support and, in many cases, a lifeline to some of the most marginalised in our society. Kids Company has been credited with 'giving visibility to the invisible.'[37] VSOs can be extremely adept at securing the engagement of vulnerable parents, children and young people, through the relationship and trust that they are able to build with them – often providing continuity of care and support. Some VSOs are also giving essential support to statutory services by acting as a bridge – helping vulnerable parents, children and young people to access and engage with them. They are also trying to build up resilience within vulnerable families – supporting the parents to support their children.

Many VSO practitioners across the country are valiantly striving, like many social workers and medical practitioners, under intense pressures, in fraught, complex and sometimes dangerous circumstances, to help care for, protect and/or support our vulnerable children and young people. Many are equipped with an informed knowledge and understanding of their history, circumstances and needs. This is precious and needs to be treated with the care and respect that it deserves. Their knowledge and insight can potentially provide valuable assistance to statutory services – to help improve their assessments, interventions and outcomes.

However, a fundamental finding across our evidence is that all too often VSOs are struggling at the interface with statutory services. Some are experiencing multiple barriers to engagement

35 Ibid, p8
36 Ibid, pp12–13
37 Jovchelovitch S, Concha N, *Kids Company: A diagnosis of the organisation and its interventions, Final Report*, London: The London School of Economics and Political Science, September 2013, p6

and to contributing their input, in order to maximise positive outcomes for vulnerable children and young people. A key recurring finding across our Kids Company case review was social care's failure to adequately investigate or give sufficient weight to information provided the VSO – to the detriment of the relevant vulnerable children and young people. In addition, we repeatedly found a failure to produce a health assessment and a lack of coordinated holistic support being afforded to them. Consistent with findings from our Kids Company case review, evidence submitted by other VSOs has revealed that some social care teams are not being receptive to some VSOs' attempts to share valuable information, concerns are not being listened to or properly actioned. They can also experience a lack of transparency and poor communication, as well as a lack of professional respect. In addition, a lack of knowledge and understanding of VSOs' work exists on the part of some social care teams. This is detracting from the focus on the vulnerable children and young people. It can also leave VSO practitioners feeling anxious and alienated. Where statutory intervention is provided, some VSOs feel they do not have the 'full picture' which could potentially enable them to better tailor their own approach or interventions. Significant energy, time and resources that should be spent addressing the needs of vulnerable children and young people are being lost to frustrating, inefficient and inadequate ways of working.

> *'Communication as a whole is another area which I feel needs to be looked at … It's a ripple effect. It goes from worker to worker, team to team, and then from the service to external agencies. And coming back to the original interface between [VSOs] and social [care], they're almost working as two separate entities in my … view. There needs to be a connection. There needs to be a forum where people can get together regularly and discuss key issues, make plans, and have links and work together … That's something that's recognised as a way forward and we would like to develop.'*
>
> **Middle manager, in evidence to the CSJ**

All of the VSOs that submitted evidence to our Review confirmed that the potential for them to work in partnership with social care and statutory mental health services is not being realised. In *Kids Company: A diagnosis of the organisation and its interventions,* the LSE found that 'the interface with the statutory sector is a complex and considerable challenge' for Kids Company, 'involving collaboration as well as constant tension due to divergent organisational cultures, different approaches to theory and practice, prejudices and preconceptions.'[38] The LSE recognises that 'addressing these challenges is imperative for supporting children and young people in need as dialogue and cooperation between sectors can be beneficial to all,' and made a number of recommendations.

> *'It's very rare that we make referrals to social [care] unless we need to … it's a last resort. If we are saying to a local authority 'we need your help on this,' there's a reason for that. We have concerns … I think that's why collaborative working is key. Local authorities need to come and sit down and have a discussion with us, and see what we do and what our processes are. We can learn from them as much as they can learn from us.'*
>
> **VSO, in evidence to the CSJ**

38 Jovchelovitch S, Concha N, *Kids Company: A diagnosis of the organisation and its interventions, Final Report*, London: The London School of Economics and Political Science, September 2013, p7

Statutory services and the voluntary sector urgently need to take more of a positive, focussed, and strategic approach to partnership and collaboration, as do commissioners. Some already are and we heard about a number of encouraging examples; however, far more needs to be done. A call has been made for sufficiently well trained staff in social care who can deliver a high quality service and also work with others to deliver it. The barriers that some VSOs face in engaging with statutory services further undermine an early intervention approach. Vital opportunities are being missed, with grave consequences for some vulnerable children and young people. The extent of challenge is great, particularly given the voluntary sector's weak position in exercising its influence, as well as the weak legislation concerning mental health.[39] Indeed, we have been advised that a lacuna exists in the child protection legislation – 'a matter that should be addressed.'[40]

> *'Working together means less work not more. The problem comes where you've got a complex case to deal with, and there are multiple issues going on, and you feel you're the only one trying to do all of it. And you can't do all of it, no-one can. What helps is to have that discussion with everyone who is involved with that family, so everybody is clear about what's happening, and what the issues are and what the priorities are. And the family is part of that discussion and that they feel people want to try and understand what their priorities are. This is where it falls down. In a situation where everyone is overwhelmed, people begin this gate keeping, where they don't take calls, or they don't want to call somebody back and have another discussion because they're worried they're going to be given more work. Whereas, actually, if they felt there was a culture of sharing out the work and doing joint assessments, doing joint pieces of work and that people could be relied upon to offer that support, then actually the whole thing would calm down. That's what we ought to try and do more of.'*
>
> **CAMHS clinician, in evidence to the CSJ**

We heard that the anxieties of something going wrong are considerable – in both CAMHS and social care. There is something of a tragic irony to this, given the extent to which many vulnerable children and young people are suffering as a result of not gaining the support from statutory services that they desperately need. Witnesses shared harrowing examples of the types of needs that are being left unaddressed.[41] Is it better to freeze some vulnerable children and young people out completely, or allow them to languish within the system, instead of trying to find more efficient and effective ways forward, with VSOs and other relevant partners, to establish their needs and how best to address them?

The disgraceful reality, at present, is that Kids Company and other VSOs can find themselves left holding some children and young people who are highly vulnerable, traumatised, and with serious and complex needs – who are not receiving timely or appropriate care, protection and/or support from statutory services. All the while their behaviour can escalate, their needs can become more entrenched, and they can become exposed to continuing or increasing risk, distress and/or harm. All the while, the VSO can be left battling on, against

39 As discussed in Chapter Four

40 As referred to in the legal foreword. These issues are explored further in Chapter Four. Please also see 'The Voluntary Sector: A Poor Position For Exercising Influence' at Appendix 6

41 Examples of which are contained in Chapter One and Chapter Two

all the odds, desperately trying to contain such cases and find solutions – unclear, in some cases, over a mental health diagnosis. Their difficulties can be compounded by the lack of cooperation between some statutory services, and lack of coordinated holistic support for some vulnerable children and young people.[42] This is in the context of some VSOs struggling to maintain their provision, and with their resources under severe demand.

There clearly needs to be a greater awareness on the part of some social care and statutory mental health services of effective VSOs working with vulnerable children and young people in and outside of their local authority.[43] It seems that some VSOs could take steps to improve their communication. Several witnesses emphasised the importance of VSOs promoting their work, and raising awareness within statutory services of the nature and efficacy of it. An improved understanding could hopefully enhance professional respect and enable statutory services to better utilise the support of effective VSOs. This is also important where it comes to potential commissioning – for VSOs to be able to evidence the cost, value, quality and efficacy of their interventions. VSOs that deliver early intervention mental health services have the opportunity to address this through the Youth Wellbeing Directory and ACE-Value quality standards – created by the Better Outcomes, New Delivery (BOND) programme. YoungMinds, which led the BOND consortium, has informed us that VSOs delivering other services can also use and adapt ACE-Value for the purpose of being 'commissioning ready.'[44] Crucially, the Youth Wellbeing Directory can be used by commissioners and others – including, for example, social workers who identify the need for a VSO early intervention mental health service for a vulnerable child or young person they are working with.

It is important that the voluntary sector retains its vibrancy, creativity and innovation. However, challenges exist. A potential tension for some VSOs is that as they grow bigger, there is a risk that they may begin to take on the very characteristics of organisations that they do not want to become. Inevitably, on one level, the informal approach and role performed by some VSOs and their lack of statutory chains, can make it easier for them to win the trust of vulnerable parents, children and young people than a local authority. This has untold value and should be protected as far as possible. Some VSOs can face challenges in retaining their independence – particularly in the eyes of those who they often succeed in engaging as a result of that independence. It is crucial that social work practice does not inadvertently place this at risk, and potentially marginalise those who are receiving support from VSOs even further where, for example, their trust in a VSO erodes.

> *'… we need social care, and social care needs our credibility.'*
>
> **VSO, in evidence to the CSJ**

42 As discussed in Chapter Four

43 The failure of some social care teams to work in partnership with VSOs is discussed further in Chapter Four

44 A profile of the BOND programme can be found at Appendix 7. Further details on the BOND programme and associated resources can be found on YoungMinds' website at: http://www.youngminds.org.uk/training_services/bond_voluntary_sector

The same can be said of commissioning arrangements. We heard about the adverse impact on some VSOs of being contractually required to operate a practice which runs contrary to their ethos and culture, and risks inhibiting the support that they are able to give to vulnerable children and young people. It would be a tragic irony if through more and more contracting out to VSOs, they should become tied up by the same chains as statutory services under the terms of those contracts. A number of examples were shared with us, during the course of our research, which gave us serious cause for concern in this regard.

Our evidence reveals that the approach being taken by some local authorities at a strategic level – including over commissioning arrangements and the TFP – appears to be having concerning consequences. For example, some VSOs are being placed at a financial disadvantage. Any imbalances and inequality of funding opportunities for VSOs should be promptly addressed. Openness and transparency has been called for regarding all funding streams that are managed by councils and decision making processes regarding the most appropriate services. VSOs should also be given every opportunity to perform to their fullest potential in supporting vulnerable children and young people by, for example, working with them holistically where that is a VSO's normal approach to service delivery.

It is imperative that the continued existence of effective VSOs is supported, and that vulnerable parents, children and young people do not become more marginalised and at risk as a result of practices which negatively impact on VSOs. One of the most important things that vulnerable children and young people need is stability. It is critical that relationships that VSOs have succeeded in building with them are themselves safeguarded as far as possible. When commissioning services, all commissioners should give priority to considering how to protect vulnerable children and young people in this context so that they are not inadvertently adversely impacted on by the drive for improvement.

Furthermore, it is also essential that commissioners understand the different cultures and competing agendas of the voluntary and statutory sectors. Witnesses spoke of the need for a genuine and equal partnership to be encouraged and facilitated through commissioning arrangements. Again, we believe that available resources through the Better Outcomes, New Delivery (BOND) programme could potentially help to strengthen the position of some VSOs in this respect. The statutory guidance on JSNAs and JHWSs also emphasises the important role of VSOs in helping HWBs to ensure that sufficient services are commissioned to meet the needs of vulnerable children and young people.[45]

With a wealth of skills, expertise, and experience, effective VSOs have a huge amount to offer. They are an essential component of a critically needed innovative approach towards vulnerable children and young people. It is of paramount importance that their needs are brought to the forefront. Communication and partnership delivery must be prioritised and promoted from the top. Barriers must be overcome to develop open and transparent

45 Department of Health, *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*, 26 March 2013, pp7–8 and pp12–13 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf (02.04.14)]

working relationships – forging mutual trust and professional respect. Armed with a clear understanding and recognition of their respective roles, duties, responsibilities and limitations, statutory services and VSOs could seek to utilise and compliment one another's expertise in working in partnership and collaboration. Respective strengths need to be identified and drawn upon to work creatively and systematically. Effective VSOs and statutory services need to maximise the best possible outcomes – together – for vulnerable children and young people. It should never be left to one single agency to try to meet their needs alone.

> *'There's a lot more room for [working in partnership] to be realised. It does have to be seen as a partnership and a team working thing, rather than "them and us …" We are potentially building a surrogate family around this child and trying to help them.'*
>
> **Witness, in evidence to the CSJ**

chapter four
Legal and regulatory framework

4.1 Introduction

> *'Ultimately they're in a horrible situation, with the Government endlessly controlling their budgets but Parliament passing on really important duties to local authorities for the most vulnerable sectors of our population. They're in a catch 22 ultimately, because they don't have the funds to deliver the service that Parliament requires them to provide. That's the reality of it.'*
>
> Solicitor, in evidence to the CSJ

> *'… nobody ever wants to say 'actually, we can't see any more kids, we are at maximum capacity and we haven't got enough clinicians to do all this work.' Because politically it's not allowed. No-one is allowed to say that …'*
>
> CAMHS clinician, in evidence to the CSJ

This chapter features the evidence submitted by legal professionals and other witnesses on legal issues relating to vulnerable children and young people, and on the relevant legal and regulatory framework. A number of legal professionals emphasised that the vulnerable children and young people they assist are those who have had problems with statutory services, otherwise they would not be coming to them. It should also be stated that although their experience relates to local authorities across England and Wales, they do not have experience of every local authority. However, one solicitor believes that they could be seeing *'the tip of the iceberg'*.

Again, the immense pressure under which many statutory services are labouring was well recognised. However, the impact that this is having, as further illuminated in the legal context, has left us dumbfounded. The frustration and exasperation expressed by numerous legal professionals at the treatment of vulnerable children and young people by some statutory services was palpable. They shone a particularly powerful and shocking light on the stark reality and injustices that are being suffered by many.

Legal professionals corroborated evidence provided by VSOs regarding the severe challenges that some are experiencing at the interface with statutory services. They provided an invaluable insight into the lack of knowledge and correct application of the law by some social workers, amongst others in more senior positions, in some local authorities. Critically, they also raised various issues of concern arising from the *2013 WTSC*, which they consider likely to fuel inconsistency, confusion, delay and potentially unlawful practice.

We share the sense of disbelief repeatedly expressed by legal professionals, and other witnesses, at the unscrupulous and unlawful practices operated by some local authorities. Some are flagrantly disregarding, circumventing and contravening the very legislation and statutory guidance which provides for the care, protection and/or support of vulnerable children and young people. In addition, the distressing predicament and difficulties faced by some social workers, as a result of the actions taken by their managers and those in senior management became clearer again. We were left incredulous at the lengths to which some local authorities are going, to either completely withhold or restrain services from being provided. We were repeatedly told that this is being driven by financial pressures.

Our evidence demonstrates a staggering lack of accountability on the part of local authorities. Some VSOs, along with legal professionals, are performing a critical role in holding them to account, and providing an essential safeguard for vulnerable children and young people. Our concerns in response to the evidence submitted by legal professionals are heavily compounded by the Government's legal aid/JR proposals. As discussed below, they threaten to eliminate the few remaining sources of legal support that vulnerable children and young people are able to draw upon in order to gain, often, the care, protection and/or support from statutory services that they were entitled to receive from the outset. The relevant proposals show all the signs of having a devastating impact on many vulnerable children and young people, and of eroding any remaining hopes that they may have of finding justice in some of their darkest times.

What also became apparent, during the course of our Review, is that the legislation regarding mental health is surprisingly weak. It seems that this is increasing the vulnerability of some children and young people, who are not being given timely and/or appropriate care and support to meet their mental health needs. Where vulnerable children and young people have social care and mental health needs, a lack of cooperation on the part of some social care and statutory mental health services is intensifying their difficulties and, in some cases, leading them to fall between the gaps. Some can be frozen out by the respective services. Again, in these circumstances, some VSOs can be left trying to hold and manage cases of vulnerable children and young people with serious and complex needs.

4.2 Child protection

4.2.1 Barriers to access and failure to support

> *'From our perspective, it looks very much like there's an army of people out there being paid a fortune in children's services, legal services, at management levels … who actually*

> *aren't there to provide services for children, they're there to prevent services being provided for children. So their role is to do assessments to make sure that children in need don't get services, which is just utterly Alice in Wonderland stuff.'*
> Barrister, in evidence to the CSJ

We heard accounts from various witnesses of a number of local authorities requiring CAFs to be used as referrals. However, there is no legal basis upon which they may do so. We were told that there is no method prescribed by any legislation requiring a referral from any agency to social care to be made in a specific way. We were also told that CAFs can effectively be used in such a way as a stalling tactic, given that they can sometimes take a significant amount of time to complete, and that once it is finally submitted, a local authority may confirm that it does not meet the threshold. An experienced Independent Social Work Consultant and Expert Witness told us:

> *'It's a way of gate keeping out referrals. Because if they demand a CAF, it means that they've not accepted the referral in the first place as being a bona fide referral, and it also makes it less likely that the person will re-refer because perhaps they may think they haven't got the grounds to make a referral. This is very dangerous. I've even heard local authorities say "we don't take [child in need] referrals anymore."'*

The same witness also raised an issue over organisations making or trying to make referrals, being asked whether they are a child in need or child protection referral. Our witness stated that it is up to social care to decide, not the individual or organisation making the referrals. Their argument is that all children who are at risk of significant harm must, by definition, be children in need, but not all children in need are at risk of significant harm. They stated that the decision as to the nature of the referral should rest with the local authority manager.

Legal professionals also shared their experiences of gatekeeping. One solicitor told us *'Those in the referral and assessment team are really gate keeping. I've actually had a client who went for an assessment with a … social worker who said … she was a professional gate keeper … and she was going to decide whether or not she was entitled to services.'* Another solicitor added *'There's a hell of a lot of work with people having difficulties obtaining access to services …'* They gave the following example:

> *'You ring up the local authority saying my client's been sexually abused by her sister's boyfriend for six years, was taken into care, was subject to domestic violence from her brother, her sister and her father, and now you're saying she's not vulnerable and she has no needs. And she doesn't need to be safeguarded. It's like what have you missed? What don't you get?'*

We have been told that '*most*' local authorities are using eligibility criteria in respect of children in need, and received evidence of the unlawfulness and lack of transparency of the thresholds used by some. There is the potential for this issue to be addressed to some extent by the current requirement imposed on LSCBs to publish threshold documents, under the *2013 WTSC*. However, we raise concerns over this below.

In the meantime, while the use of eligibility criteria for adults is based on national guidance, the position for children is known to have developed locally on an ad hoc basis. This was considered in a JR case – *R(JL) v London Borough of Islington*.[1] The Council for Disabled Children provided expert evidence in the case, and noted that the eligibility criteria served to limit 'the ever-increasing claim on local authority resources imposed by the growing and increasingly complex population of disabled children.' Concern was raised about findings demonstrating 'a lottery of provision' and service quality dependent on postcode rather than need. The Judge stated in her decision that the use of eligibility criteria in determining provision for children is a very complex area. The Judge concluded that guidance was necessary not to homogenise practice across the country – she accepted that regional variations are inevitable given local needs and resources – but to 'ensure that the role of eligibility criteria is better understood and confined within its proper ambit.' The move towards localism in the *2013 WTSC* only serves to heighten rather than meet the concerns raised in the Court's judgment in 2009.

We also heard about the extent to which solicitors find 'no further action' being taken by social care in relation to referrals. One said '*It's a problem we see a lot when we look through past social [care] records, and you'll see time and time again, there's been a referral in – no further action. Referral in – no further action. And you read the referral and you think "oh my God, how much support must they put in place from this?" – No further action.*' Another added '*I've just made a complaint to social [care] on a young man who's over 18 now. There were 15 referrals to social [care] about his welfare with no further action before they finally took action.*' We asked whether social care had given reasons for their decisions, and were told '*No – just no further action.*' We were told that these solicitors are seeing no further action taken on cases where they would expect not only for an assessment to have been undertaken and eligible needs identified, but also for support to have been put in place.

We were told about a case (under the *2010 WTSC*), that had very recently succeeded at the door of the Court. A young woman had initially been accommodated under S.20. Her mother had had a drug addiction, been involved in prostitution, and was violent towards her. The young woman had been abused sexually by her mother's boyfriend, so she kept running away to social care. Social care kept trying to put the young woman with family members. She would run away from them and that would break down. Eventually she drifted home. The solicitor told us '*Social care said "you're probably better off with your mum because we're not going to provide you with anything else. It's a family member or nothing – no services provided*"' … *Maybe as lawyers we see more of these because they come to us because they are horrible cases – but we see it time and time again: failure to properly assess, failure to assess, failure to support.*'

One solicitor told us that they are seeing a lot of clients who are over 18 and homeless, who did not receive the support when they were younger; they are consistently requesting records and seeing the same thing.

A solicitor referred to an event they had attended where there were '*a lot of social workers in the room*.' The solicitor told us that:

1 R(JL) v London Borough of Islington [2009] EWHC 458 (Admin)

'They were all acknowledging that already it's the case that the urgent child protection work (where there's a possibility of care proceedings) is what gets prioritised, and the other stuff just slips through the net … Those are the cases they have to prioritise.'

4.2.2 S.20 issues

Accommodation[2]

'No government will change the [CA 1989], because it's political dynamite. They won't get rid of S.20 … that would be beyond the pale. So they've got to find ways of undermining it, through the guidance, these sorts of creative ways by local authorities and by central government which undermine the force of the [CA 1989].'

Barrister, in evidence to the CSJ

With effect from 2010, there has been a mandatory requirement, under statutory guidance, for local authorities to have written joint protocols in place in respect of supporting homeless 16- and 17-year-olds. The intention behind this is to ensure that they are correctly assessed and given appropriate support. However, a solicitor told us:

'Even last year some local authorities didn't have them … I don't think we've necessarily seen anything change, because I don't think that it's necessarily been done as it should have been done in the past under what the law requires them to be doing, and I think it's just more of the same. I think it's inconsistency between local authorities and social workers. Some are good, some are bad. And I don't expect that to really change to be honest even with the threshold document in place.'[3]

Another solicitor explained that, in their mind, the law is clear on what local authorities need to be doing, but that the joint housing protocols often say something completely different. Often, we were informed, they are unlawful. We heard about a solicitor having highlighted to a local authority that their joint housing protocol, which they had published on the internet, was unlawful. Despite being told by senior management in Children's Services that it would be changed, months later it still had not been.

A social worker's perspective

'I think the problem is that the people who draft [joint housing protocols] are not actually experts in it. Especially in local authorities, there is an emphasis on generic work and being able to transfer between doing this … that … and the other. You're moving away from expertise, and you're losing essential skills, which is actually being able to interpret what the law means. You get these things happening, where policies are completely incorrect, and a lot of the time, practices are quite illegal in some respect as well, and it is because of that.'

2 An explanation of a local authority's duties to accommodate children is contained in the legal foreword

3 Threshold documents – required to be published by LSCBs – are discussed below

We were informed that even when local authorities have protocols, they are incredibly reluctant to provide them. This is particularly concerning given that they are service documents. In *Supporting homeless 16 and 17 year olds*, the Law Centres Network (LCN) states that:

> *'Local Authorities do not, as a matter of course, make their protocols publicly available. Nor do they routinely provide information that is accessible to homeless [children] outlining the assessment process or the support they can expect from the Local Authority. This makes it very difficult for [children], without access to independent advice, to understand the nature of the support and accommodation they should be offered and the implications of any choices they make.'*[4]

Supporting homeless 16- and 17-year-olds – Evidence from LCN

A review of local authority protocols relating to homeless 16- and 17-year-olds was undertaken by LCN, with the support of the law firm Freshfields Bruckhaus Deringer LLP. This focussed on whether protocols were consistent with the law, and statutory guidance following *Southwark*.[5] A total of 138 protocols were received from 144 local authorities in England.

'1. Do protocols outline a process that ensures [children's] needs are adequately assessed?'

- 27 per cent of all protocols 'do not make it clear' that social care should be the lead authority; this increases to 35 per cent of all protocols in London.

'A significant number of protocols actively direct [children] away from Social [Care]/Children's Services and to the Housing Department or a "Young Person's Homeless Person's Unit." There is often no reference as to how the [child's] broader or non-housing needs will be assessed by these teams or the role that Social [Care]/Children's Services should play.'[6]

'2. Do the protocols outline a process that ensures that [children] get the support that they are entitled to under [S.20]…?'

- 38 per cent of all protocols do not set out S.20 correctly; this increases to 49 per cent of all protocols in London.
- 61 per cent of all protocols do not apply S.20 correctly; this increases to 64 per cent of all protocols in London.

'Experience shows that many 16- and 17-year-olds do not want to be "Looked After" or "taken into care," but are still vulnerable and need the support that [S.]20 status affords them. As a result they may reject an offer of "[S.]20 accommodation" believing that they will be put into a care home or a foster placement.'[7]

4 The Law Centres Network, *Supporting homeless 16 and 17 year olds*, The Law Centres Network in association with Freshfields Bruckhaus Deringer LLP, February 2013, p2

5 Children Act 1989 and *Guidance to children's services authorities and local housing authorities about their duties under Part 3 of the Children Act 1989 and Part 7 of the Housing Act 1996 to secure or provide accommodation for homeless 16 and 17 year old young people*, issued by Department for children, schools and families and Communities and Local Government, April 2010 – both cited in The Law Centres Network, *Supporting homeless 16 and 17 year olds*, The Law Centres Network in association with Freshfields Bruckhaus Deringer LLP, February 2013, p2

6 The Law Centres Network, *Supporting homeless 16 and 17 year olds*, The Law Centres Network in association with Freshfields Bruckhaus Deringer LLP, February 2013, p5

7 Ibid, pp6–7

'3. Do the protocols outline a process that ensures that [children] are offered appropriate interim accommodation? And do they make clear that [B&B] accommodation is not to be used?'

- Seven per cent of all local authorities 'clearly use B&B to accommodate homeless 16- and 17-year-olds as a matter of course;' this increases to 10 per cent in London.
- 52 per cent of all local authorities 'make no reference to the fact that the [statutory] guidance prohibits the use of B&B' accommodation; this increases to 63 per cent in London.
- 25 per cent of all local authorities use B&B accommodation for 16- and 17-year-olds 'only in emergencies;' this decreases to 16 per cent in London.
- 14 per cent of all local authorities 'prohibit the use of B&B' accommodation for 16- and 17-year-olds 'in any circumstances;' this decreases to 10 per cent in London.

'The use of [B&B accommodation] should be explicitly prohibited in the protocol and must not be used even in emergency situations. [B&B] accommodation is generally unregulated accommodation, with [children] frequently being accommodated alongside adults.'[8]

One solicitor's impression is that there are a number of local authorities, '*maybe more outside London*,' who have made wholesale changes to the way they deal with homeless 16- and 17-year-olds as a result of the *Southwark* case. We received evidence from a number of social workers confirming that the Southwark Judgment has, in their experience, led to positive improvement for homeless older children. However, it is apparent that seriously concerning practices remain and that they are fairly widespread. In September 2013, Newsnight highlighted the plight faced by many vulnerable 16- and 17-year-olds, in its investigation into councils housing homeless older children in B&B accommodation. It revealed that 15,728 of them requested help from local authorities with homelessness. Out of the local authorities that responded to Newsnight's FOI request, 148 had unlawfully housed 16- and 17-year-olds in B&B accommodation in 2012.[9]

During our Review, we discovered several 'centres' (for example) being used by local authorities, which appear to provide housing support for vulnerable children but sit outside of the local authorities' housing department. A solicitor referred to one such centre, and explained:

> *'They just don't seem to offer S.20 accommodation as an option. My client presented to social [care] to ask for accommodation, and was sent to [the centre] which is not what's supposed to happen. You're supposed to be assessed by social care if you present to them. [The centre] did an assessment which doesn't appear to be a social [care] assessment. My client was provided with accommodation but not under S.20. As far as I know you can't get S.20 from [the centre].'*

8 Ibid, pp8–9

9 BBC Newsnight FOI requests, *Councils housing homeless teenagers in B&Bs*, by Jim Reed, broadcast on 26 September 2013, available at: http://www.bbc.co.uk/iplayer/episode/b03brt5d/Newsnight_26_09_2013/; cited in The Children's Society, *The Children's Society response to the Ministry of Justice's consultation on '[JR]: Proposals for further reform*,' November 2013, p8 [accessed via: http://www.childrenssociety.org.uk/sites/default/files/tcs/the_childrens_society_response_to_judicial_review_proposals_for_further_reform_0.pdf (08.04.14)]

The solicitor referred to a further example:

> *'… they are not able to provide S.20. They've confirmed that they aren't but social [care] is sending people there when children ask for S.20 accommodation.'*

In referring to a 'centre' in a different local authority, another solicitor stated that it is being used '*as a vehicle to dump kids in inappropriate B&Bs and hostels*.' These older children may well have social care needs and be at risk. By diverting them away from social care and off to such 'centres' to be housed or, indeed, as discussed below, to the housing department, these local authorities can avoid providing them with social care services which they may be eligible for and in desperate need of. They could also potentially prolong or increase the risk to which some of them may already be exposed.

We also received evidence of some local authorities using loopholes to avoid providing services. An '*obvious*' one, we were told, is S.20(6) – the duty to ascertain the child's wishes and feelings. A solicitor stated that the manipulation of this loophole by some local authorities – following the *Southwark* case – is something that they '*come across all the time now*.' In that case, the House of Lords said that local authorities cannot force a 16- and 17-year-old into S.20 accommodation, if they do not want to be accommodated under S.20. The solicitor explained:

> *'Local authorities have thought, what's our remaining way out of not providing S.20? It's basically if we can get the [child] to say they don't want it.'*

Some local authorities are deceiving vulnerable 16- and 17-year-olds, by failing to provide them with the correct, comprehensive information on their available options. Another solicitor added:

'*Frequently, when [they] go to social [care] and ask for accommodation, they're not given the full explanation of what S.20 involves. They're asked "do you want to be in foster care* [i.e. S.20]*, or do you want to be in independent accommodation* [i.e. through the housing department]*?" … That is the choice they're given … obviously 90 per cent of 16- and 17-year-olds say "I like the idea of independent living," and that's recorded as them saying they don't want S.20 accommodation*.'

We heard how some are not being offered any form of semi-independent living. Without support from, for example, an advocate or, in the absence of legal advice, some are making decisions in response to a restricted offer. They are being denied the opportunity to make an informed decision on this critically important issue.

However, what they do not necessarily realise is that by accepting that choice, they are giving up support from social care. The case referred to above, where there had been 15 referrals with no further action on social care's part, was mentioned again in this context. We were told that the young man had been provided with some 'child friendly' information on the 16th referral, about the difference between being accommodated under S.17 or S.20 and the Housing Act. The solicitor told us that the information was completely inaccurate, based upon which he chose to be housed under the Housing Act and has now missed out on leaving care support.

A social care perspective

'That goes on quite a lot actually. There are different approaches to that particular conversation, which depends on how you interact with each other. The way it has been practiced in different places … some will say "you can either go into care, or you can go down this housing route."'

Social worker, in evidence to the CSJ

'Social workers don't come in to work to do that, but they are required to do that. Their managers … say that they have to restrain those options … The key question to ask is "why do rational people who want to help children end up making those decisions?" They make those decisions partly because they are told to, and partly because they are constrained in what they can and can't do by their managers. The reasons they are constrained is because their managers are told they have X amount of money to work with. Why are those managers told they have X amount of money to work with? Because local authorities are elected. Me and you vote for our local authorities. And we vote for the Government – collectively we do.'

Senior Manager, Children's Services Department, in evidence to the CSJ

The extent to which some of our vulnerable children's rights are being manipulated – and by the various services that ought to be caring for, protecting and/or supporting them – is astounding.

'Misuse of S.20'

A further issue was raised by an experienced Independent Social Work Consultant and Expert Witness – over the '*misuse of S.20*.' They explained that whilst S.20 is supposed to provide voluntary care, '*it is commonly used as a carrot and stick*,' whereby parents are told that if they do not agree to their child coming into care under S.20 – which is a voluntary arrangement – the local authority will go to court to seek a Care Order. They stated:

> *'They're setting themselves up for problems but they get away with it because people don't challenge them. Very often what they do is persuade, or threaten or cajole parents to agree to S.20 and they then treat S.20 as if they've got a Care Order on the child. But they haven't, because once they've got a Care Order, they've got parental responsibility.'*

Our witness explained that S.20 is a provision under which families are provided with support for children in need, and that the local authority legally cannot place any restrictions on the relationship with the parent and child. For example, they cannot legally restrict contact in any way between them, and cannot legally require that contact has to be supervised.

In response to this, a solicitor explained that, in their view, in principle, there is nothing wrong with a local authority saying that it has concerns about how a parent is coping and parenting their child, and that potentially placing them in foster care might be better for them. They advised that if the parents are willing to agree to that by consent, then there is nothing unlawful about the local authority doing it that way; and the parent would retain parental responsibility, and the local authority would need to make that work. They added that the parent would need to be advised of their right to withdraw their consent to the placement at any time. The solicitor said that if the local authority conducts it properly, they

could not see any issue with that. However, they explained that if a local authority is using S.20 in a threatening way, then this would obviously be wrong given that the care proceedings mechanism enables the parent to be properly represented and for a Judge to then decide formally what should happen. In response to us asking why some local authorities might take the threatening approach, the solicitor stated:

> *'I would guess two reasons. One, obviously because of the cost of care proceedings – it's cheaper. But secondly, just the ease. Because obviously if you go down [the] contested care proceedings [route], you don't know that you'll achieve your aim ultimately. Whereas, if parents agree to a S.20, then you've achieved your aim straightaway.'*

They added:

> *'There may be a pattern of [local authorities] threatening S.20 when they want to remove children, but I think there's going to be countless examples when probably they should be bringing care proceedings and aren't doing anything.'*

The experienced Independent Social Work Consultant and Expert Witness who initially raised this had also explained that:

> *'The whole point is, if they've become looked after for child protection reasons, what the local authority should be doing is trying to redress the problems in the family, so they can look at reunification. I just don't think that happens. They are more likely to do that if they have Orders. Whereas, I think if they have children who are just [in care] on a voluntary basis, it takes the heat off. Viz the second serious case review into the death of Peter Connelly.'*

4.2.3 Lack of accountability

> *'We are such a big bureaucracy and there's so many different departments and all the rest of it. And if key people aren't adhering to what they need to do, the child just falls through the gap. And everyone passes the buck because you can. It's easy to say "I never received it," "it's in the post," "I never got your message or phone call."'*
>
> *'Because we're guided by process and because [VSOs] are not … it's almost like they're living in a dream world. But the reality is they're not. They're actually using the law and … saying "no … this is the truth of the situation." … As much as we're not meant to side with people, education and social [care] are very much together. So we have this kind of incestuous relationship …'*
>
> **Social workers, in evidence to the CSJ**

We raised, in the previous chapter, the barriers that some VSOs can face in sharing valuable information and insight regarding some of the vulnerable children and young people they are supporting, with social care. This is despite the importance placed on information sharing.

> *'Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.*

Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious case reviews … have shown how poor information sharing has contributed to the deaths or serious injuries of children.'

Where local authorities are not working in partnership with VSOs, and not inviting them to meetings, or to otherwise contribute their skills, knowledge and experience to the process of caring for, protecting and/or supporting vulnerable children and young people, then they can seriously undermine the ability of VSO practitioners themselves to effectively support them. This can essentially deprive those children and young people of what may otherwise be an advantage to them. In the process, it can also hinder their ability to hold any such local authorities to account.'[10]

Unfortunately, this can become an antagonistic relationship, further eroding the focus being placed on addressing vulnerable children and young people's needs. Kids Company faced a difficult position in Daniel's case, for example. The solicitor who reviewed it told us: '*It is very concerning that the VSO that actively sought to assist the child and his family was treated in a hostile fashion by social [care], which was seeking to avoid its lawful duty to accommodate him under [S.]20 … It is not uncommon that social [care] departments seek to criticise or lay blame at individuals or organisations who seek to help vulnerable children who require support that will result in the use of financial and human resources.*'

> *'It becomes adversarial. Because they're there when the social worker is saying "no, get out, I'm not bothered, get out of my face," and they support the … children, which gives [them] confidence and esteem to express themselves. Not always in an acceptable way but they nonetheless express themselves. So then it can become more confrontational. But it needs to be actually. It needs to be because it bloody well is. This is someone's rights being trodden on, and these children are being exposed to risk.'*
>
> **Chris Callender, Solicitor, in evidence to the CSJ**

Legal professionals further demonstrated the vital need for some local authorities to be held to account, and the essential role that they and some VSOs are performing in this respect. Some shared extremely concerning evidence of social workers having '*altered their records*.' When asked to provide examples, they explained '*They've said the initial assessment was completed in June but the initial assessment refers to things which happened in the end of July*.' Another solicitor added '*I've had one of those recently – it took me a whole day of going through it all to lob it all into a letter*.' We were told that the solicitors have experience of some social workers, or the local authority, who '*doctor*' their records – '*So they look like they're complying with timeframes when they're not*.' This was used as an example to illustrate the importance and value of VSOs attending meetings. Another solicitor explained that, in their experience, where there are advocates for vulnerable children or young people:

10 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p15 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

'From a legal position you are in an enhanced position if the advocate is trained and supported and up to scratch. Because you've got another set of eyes and ears. A local authority will often twist or lie and use deceit to prevent access to services … Whereas when you've got an advocate there, you've got another set of eyes and ears who can say "no, that's not what happened." Where you've got those people on the case, it's usually an advantage to the client.'

A number of legal professionals also informed us of their experience of some social workers lying.[11] One explained:

'It's very hard to ever pin down. Most of the time if you're acting for a vulnerable child and they say "my social worker said this," a lot of the time I won't even raise it … if it's the sort of scenario where it's going to detract from what you're trying to get them, and the legal department will just get completely sidelined, and it will just basically become a social worker's word against your client. And your client will never win that argument.'

Another explained that this is why they love advocates going to meetings, and taking detailed notes which can be written up and quoted.

'We often have to get witness statements from advocates who are in these meetings to contradict what social workers have said. In statements to the court, a social worker will provide a statement saying "this happened in the meeting," and the advocate will say "no it didn't, I've got accurate notes."'
Solicitor, in evidence to the CSJ

The issue of some VSOs being asked to provide services that local authorities should be providing was also raised. This was in the context of the confusion and lack of understanding that exists on the part of some of those working with vulnerable children and young people, in relation to their respective roles and responsibilities. One solicitor told us that they had seen big arguments between VSOs and local authorities, because the local authority was expecting the VSO to be able to provide certain services, which the local authority was failing to provide. They made the point that '*It should not be for the [VSO] to take its resources out of what it's hoping to achieve, to do the local authority's job for it.*' The solicitor gave a couple of examples of the type of services the local authorities were trying to get the VSOs to provide. One involved a local authority saying that it did not need to provide services to a child in need, because their needs could be met by the advocate who had been provided to the child by a VSO they had approached. Another said that it did not need to provide weekly subsistence payments because a young person was receiving financial support from a VSO. The solicitor informed us that in both cases the local authority conceded the points after pre-action correspondence.

'Another tactic local authorities use – usually they … want us to take it as far as we can before they respond … It is another bluffing tactic, "how far are you going to push this?

11 One witness subsequently informed us of the following case: Community Care, *Social worker struck off after faking conversation with vulnerable child on assessment report*, 7 January 2014 [accessed via: http://www.communitycare.co.uk/2014/01/07/social-worker-struck-faking-conversation-vulnerable-child-assessment-report/ (07.04.14)]

> *We're not going to respond, let's wait until you say you're going to initiate a [JR]"… It is money driven again. Because why are you going to wait until we initiate [JR]? Once again it's not a serious issue, or you don't see it as a serious issue, or you don't believe whoever is raising these concerns is going to take it further.'*
>
> **VSO, in evidence to the CSJ**

As highlighted throughout this report, the voluntary sector is in a weak position in being able to exercise its influence with social care.[12] This is further evidenced by an analysis that has been undertaken of local authority duties towards VSOs in the context of conducting assessments, the membership of core group meetings and attendance at CPCs, and the weak position of VSOs in each respect.[13] This is reinforced by the fact that some VSOs are having to threaten or pursue legal action against some local authorities (and, in some cases, repeatedly) to secure the care, protection and/or support that many vulnerable children and young people have unjustly been denied. The Children's Society has revealed that since 2008 it has made 110 child in need referrals under S.17 to Children's Services in Birmingham, 'on the basis that a family was destitute and the child's welfare needs were not being met.' Following the initial referral, only eight per cent of these families were supported by Children's Services. It states:

> *'86 [per cent] were eventually supported, usually following an intervention by a solicitor. This is despite significant advocacy (e.g. letters, telephone calls, meetings and use of complaints procedures) from our support workers prior to any legal action being taken.'*[14]

Kids Company submitted a written complaint to Children's Services in relation to the recent 'professional obstacles to partnership working' on Claire's and another client's case – including the handling of concerns and referrals to social care. Kids Company was informed that the matter would be investigated, was asked to outline specific details of the cases, and informed that it would receive a response on completion of the investigation. Kids Company duly provided the specific details requested, and reiterated that it was very keen to work with Children's Services, to achieve clearly accountable lines of communication, particularly regarding referrals.

Kids Company subsequently made a second, verbal complaint, to Children's Services, regarding, amongst other things, how the case had been handled, how decisions had been made, the social worker's practice and Claire's continued risk of harm. Kids Company was informed that upper management in Children's Services had been contacted, and that the Team Manager and Service Manager would revert to it directly to discuss its concerns further.

Kids Company then submitted a third complaint, in writing, to the local authority and requested a full case analysis by social care. Kids Company stated that, to date, it had not received a response to its first complaint – submitted almost four years earlier. Kids Company stated that while the local authority failed to pursue this, Claire continued to experience serious physical, emotional and sexual

12 Our concerns in relation to this issue are heavily compounded by the Government's legal aid/JR proposals, as discussed below

13 The analysis can be found at Appendix 6

14 The Children's Society, *The Children's Society response to the Ministry of Justice's consultation on '[JR]: Proposals for further reform*,' November 2013, p7 [accessed via: http://www.childrenssociety.org.uk/sites/default/files/tcs/the_childrens_society_response_to_judicial_review_proposals_for_further_reform_0.pdf (08.04.14)]

abuse, which could have been avoided if appropriate actions had been taken at an earlier stage by those in a position to protect and safeguard her. Kids Company also stated that a response to its second complaint – made five months earlier – had yet to be received.

Kids Company extended its main areas of concern in relation to social care to the Chair of the LSCB. In responding to Kids Company's third complaint, the local authority confirmed that it had no record of the VSO's previous two complaints having been lodged with the local authority's complaints department. With respect to the second complaint, it stated that the Team Manager had left a message with Kids Company but having received no further contact did not follow up under the complaints procedure. The Chair of the LSCB, in response to Kids Company, stated that given their understanding that Kids Company wished to progress its complaint to the next level, they had asked to be kept informed and that 'It would clearly not be right for me to intervene in what is a statutory procedure.'

Kids Company submitted its Stage 2 complaint to Children's Services. In response, Kids Company was informed that its complaint appeared to relate to two separate issues: Claire's care by the local authority, and the local authority's relationship with Kids Company. Children's Services proposed that Kids Company's complaint should be split into two parallel investigations, and requested a summary of complaints in respect of each issue. Kids Company agreed that there were two issues but contested that they were very closely interlinked, and that it would seem more than repetitive to restructure the complaints. Children's Services then confirmed that the local authority did not consider Kids Company, under the relevant legislation, to have sufficient involvement in Claire's life at that time to represent her in the statutory complaints process. They stated that if Kids Company wished to pursue its complaint relating to its working relationship with the local authority, then that would be addressed under the corporate complaints process; alternatively, if Kids Company wished to appeal the decision, it would need to contact the LGO. Kids Company did not pursue either aspect of its complaint.[15]

> *'When you're advocating for children and talking about children's rights, in [the local authority I work in] their biggest concern is [JRs] and solicitors letters. Everything they do is from a standpoint of avoiding [them] … Kids Company will support children in going down that road, if it is leaving care allowances, monies they are due or services that they aren't getting – quite rightly … because the local authority will do the minimum that they have to. If they can get away with not doing something, and not providing services, they will do it.'*
>
> **Social worker, in evidence to the CSJ**

Kids Company spends approximately £1.5 million per year on its safeguarding department, including – 'on staff whose sole responsibility is to sadly police the functioning of social [care] departments who cut corners, avoid responsibility, and go through procedures as opposed to affording genuine care and protection to children.'[16] Camila Batmanghelidjh, CEO of Kids Company, told us:

> *'We would not have employed qualified social workers if the State was fulfilling its statutory responsibilities safely and appropriately.'*

15 Claire's case summary (Case One) can be found on page 30

16 Response: '[JR]: Proposal for reform,' Submission by Kids Company, January 2013, p2. Please note that this is a response to the Government's first consultation

We share Kids Company's concerns that the complaints procedures operated by some local authorities do not provide an adequate or appropriate means by which VSOs, or indeed vulnerable children and young people, are able to challenge unscrupulous decisions or malpractice on the part of some local authorities.

Our research has highlighted a host of situations necessitating legal challenge by solicitors. For example, in one case, social care failed to respond to Kids Company's calls when it was trying to support a child who was homeless in their early teens. This was quickly addressed following contact by solicitors. Years later, after the young person's personal adviser left, they were not replaced by social care – in breach of a court order. However, after the local authority received correspondence from solicitors, a new personal adviser was duly appointed.

> *'When a manager … gets a solicitor's letter, or the threat of a [JR], they will respond. They know that if they don't, it is going to cost the local authority thousands … Management where I am now, and the legal team, I don't know how robust they are to defend themselves. They clearly can't be because the moment that letter lands on the table, they start running. They run for the hills and they start caving.'*
>
> **Social worker, in evidence to the CSJ**

As previously discussed, a recurring theme across our evidence is the problem experienced by older children with respect to obtaining accommodation and support under S.20.[17] In a number of cases, Kids Company repeatedly tried to help them, but was unable to persuade social care to make the necessary provision. However, once solicitors became involved, calls would be returned, and letters responded to, where Kids Company previously had been met with a frustrating and poor level of communication. Notwithstanding their protracted battle to secure what the vulnerable children should have been entitled to receive from the outset, several were subsequently placed in accommodation which was unsuitable for their needs – and for significant periods of time. This resulted in the treat of or submission of JR proceedings against the relevant local authorities. However, even in a number of cases where JR proceedings had been submitted, we discovered local authorities that proceeded to act in breach of the court order that had been made in favour of the child. This was in the midst of all of the pain, difficulty, and chaos that they were enduring, and required yet further action on the part of solicitors to ensure compliance by the local authorities.

The injustice that some vulnerable children and young people are facing in the context of their housing needs and support is concerning enough in practical terms. However, the impact that this can also have on their emotional well-being, in terms of the stress and anxiety that it causes them, can be huge. Where a vulnerable child or young person has existing mental health difficulties, the impact can be absolutely devastating.

Lack of knowledge and correct application of the law, and further compliance issues

We previously raised the issue of an apparent lack of relevant legal knowledge on the part of some social workers and, of even greater concern, of some of those within middle and

17 As discussed earlier in this chapter and in Chapter One

senior management.[18] We shared, with legal professionals, a witness' experience of finding it rare that a group of managers in a local authority will get more than 25 per cent of their legal questions right, and of them not knowing what is and what is not a mandatory piece of legal guidance.[19] A barrister responded:

> *'We see it time after time. Certainly at Deputy Director level. Director level I'm not sure. You're talking people on £80,000 to £90,000 a year.'*

We also shared a social worker's evidence, about middle or senior managers' knowledge of the relevant law in their social care team. The social worker told us that they have no idea, and that they go against them to the lawyer directly – '*I get proved right all the time that it was a good call … because senior management was wrong*.' The same barrister replied '*Yes, that pretty much accords with our experience … we could talk all day about it*.'

> *'… especially with senior management, they don't know what decision they're making from one day to the next. It could be the same kind of case; you just need to remind them "you made this decision last time," or different things like that. Or … "I talked to legal and this is what they are suggesting." It's really difficult because they are one down from the Director. And they're in charge of everything … Again, if you're newly qualified, you're stuck. You're not going to question your senior management.'*
>
> **Social worker, in evidence to the CSJ**

Again, we heard about a '*fundamental lack of training*' being given to social workers on the law. One solicitor told us that they have offered to give free training to some local authorities on particular points but they have never taken them up on it. They said:

> *'It is a serious issue if they're getting these basic points of law wrong time and time again. They need training on it.'*

We heard further accounts of some social workers struggling to apply the relevant law correctly. A social worker explained:

> *'Children's Services social workers I have come across, it is not that they are not informed about the law … it is [that they are] not applying the law. [They are] applying their own moralistic or common sense framework, which you do need to do, but you need to keep it within the law and a lot of the time I don't think it is.'*

We were given examples of cases where social workers had failed to understand and apply the relevant thresholds in relation to S.17 and S.20.

18 In Chapter One

19 That witness is an experienced Independent Social Work Consultant and Expert Witness, whose quote can be found in Chapter One

A solicitor referred to a case of a 15-year-old girl, whose mum was repeatedly throwing her out. The girl had been raped and her mum did not believe her. The mum had a history of sexual assault. She would call her daughter a whore and throw her out in the middle of the night. She was not in education – just on the streets and spiralling out of control. The solicitor asked the local authority to provide her with accommodation, and they said no – because the mother would not consent to S.20 accommodation, and that the threshold had not been met either. The solicitor managed to get an interim order to force the local authority to provide the girl with accommodation, which they did and now they have conceded. *'It was too little too late because unfortunately she's now pregnant and social [care] have raised concerns about the welfare of her own child.'*

A solicitor specifically referred to their concerns over the inappropriate application by social workers of the threshold for significant harm and care proceedings. They also raised the concerning lack of preventative action and early intervention being taken by some social care teams to alleviate the risk of children needing to be removed from their homes, or reaching the child protection threshold. They explained:

> *'I think there is a real problem with … the application of the threshold for care proceedings in terms of removal. And social workers applying that significant harm threshold and actually, if rightly or wrongly, they think the threshold is just below that, then not really thinking in terms of the children in need and that actually there may be other support they could provide. And we hear this from our colleagues who do the care proceedings side of things as well. Which is that so many cases that ultimately end up down the line in care proceedings, they're cases where if the support had been provided at an earlier stage to that family, neglect cases basically, where actually if you helped the family with intensive support, the child might not have ended up having to be removed from care. But what social workers are doing, they're waiting until it crosses that significant harm threshold but doing nothing in the meantime beyond checking whether the threshold has been met or not.'*

A social worker's perspective

'… it's almost like … there's a culture where you might say "oh, I'm really concerned about this kid, I can't believe it, that's happened, that's happened – I'm going to try and take it to child protection." And your colleague is sitting next to you and says "it doesn't meet the threshold … remember that case I had etc etc … , do you know how much I had to go through just to get that to child protection?" So it's almost like we work from each other and then it's almost like … in some bad way we're sitting down waiting, because we're thinking of the kid, thinking "oh I hope your parents mess up and do something bad because you know what, we need to get him out of there" … It's like I'm waiting for an incident to happen … so then I can say "right, can we just take this to child protection, because for God's sake, I've been sitting here for months, emotionally drained by all these different things that are happening that I know about … and you read my case notes, and you say "it doesn't meet the threshold." Is there no service we can put in, something else we can do?'

We also heard from legal professionals about social workers' decisions being changed by managers:

'… the manager has to approve the decision and behind the scenes we know managers endlessly reverse decisions and recommendations made by social workers. Very occasionally you might get to see it, but most of the time the outcome of the assessment you get will have been the one passed by the manager and amended by the manager. So you never get to even see the original social workers decision.'

A number of solicitors shared some extremely disturbing evidence regarding the quality of some local authority lawyers' legal knowledge. However, a couple of witnesses (from outside of London) expressed otherwise, with one stating that, in their experience, there are *'good quality lawyers,'* and another that they *'are often highly skilled and knowledgeable.'*

'Unfortunately local authority lawyers often don't know the law. So once [social workers or their managers] get to the lawyer, you can't guarantee the fact they're going to get correct legal advice.'
Solicitor, in evidence to the CSJ

We heard that there is often an improvement once a barrister becomes involved. One solicitor told us:

'You can tell from the local authority lawyer letters when the barrister has started to get involved …'

Another added:

'It varies so much. With some local authority lawyers it's very clear that they know what they're talking about, a minority of them in my experience. Many of them can't write a decent sentence.'

The legal advice that social workers obtain is an essential part of child protection work. For example, we were told that, in the context of a PLO, if social care gets that right, then it should be much more able to hold a child as a child in need, with the right support. Our witness said that by supporting a family properly, the PLO process can help them affect change. They added that if the process is policed rigorously, and social workers have access to the right advice from lawyers, they may be able to avoid the need for a child to be placed in care. It is imperative that social workers are able to gain sufficient, experienced and knowledgeable legal advice.

Solicitors also shared evidence of concerning practice generated, it would seem, by some of those at management level.

'I think there are cases as well where some social work managers tell the lawyer that this is what they're going to say, and effectively write a letter even if the lawyer is against it. We get lawyers who say "I know what I'm telling you, these are my instructions." And reading between the lines they're telling us "It's not my advice, this is what I'm being told to say." So managers are basically writing the legal letters.'

> *'I have occasions all the time when the response to my letter is an email from the manager or the social worker that the lawyer just forwards on to me: "The response is below." They don't bother to even pretend it's come from them. And actually some of them will copy and paste that response into a letter and it makes no sense, but when it's urgent they won't even bother to do that. They just act as a post-box. They're often not actually providing any active advice or analysis on the case. They don't even read stuff …'*
> Solicitors, in evidence to the CSJ

A solicitor also raised concern over local authorities clearly obtaining advice on their legal duties and choosing to ignore it. One said:

> *'Off the record, I have been told "I know you are right but my client will not listen, my client is insistent." It's not an everyday thing but it's certainly happened several times.'*

Another told us:

> *'You get that with the good [local authority] lawyers. They find really subtle professionally appropriate ways of intimating that they've given advice and it hasn't been listened to. But there's loads who don't – they don't know the law; they can't advise on it, they wouldn't know what to do. They are literally acting as a post-box.'*

A solicitor added:

> *'So it's not just a case of managers not knowing the law, social workers not knowing the law, clearly that's a problem some of the time. But there are also cases where they're getting clear legal advice about what the law is. Because I have heard from a barrister personally who does work for quite a few local authorities … that barrister has said that their experience generally is that they are advising their clients appropriately … and the clients are just often ignoring it.'*

We asked why this was the case. We were told it was due to money:

> *'We get told quite a lot off the record, that it's all financial – "We don't have the money to provide this, do you really think we have the money to provide these services to all these children?"'*

A second solicitor stated that it is also what the local authorities can *'get away with'* – :

> *'because even then if you're talking about bringing these cases to court … some clients are so vulnerable and their lives are so chaotic, that it's difficult for them to engage for long enough to bring a case. Clients do just drop off the radar or give up. If you look at the legal aid applications that you've got to fill in, and the evidence that you've got to provide in order to be able to get the legal aid for your client to bring a case. Getting all of that together means that inevitably some people will just say "I can't be bothered."'*

A third solicitor added:

'And on top of that you frequently see the social worker trying to discredit the young person, and attacking [them], saying the young person hasn't engaged, hasn't done this, has been abusive, doesn't want this support, doesn't want that. And I've had a couple of cases recently where … once we've issued proceedings, the local authority social worker calls the young person to a meeting to sit down with them with their manager to see if they really want to go through with these court proceedings. Fortunately the two times that's happened recently both my clients have been savvy enough to tell me about this in advance and I've sent them along with an advocate.'

One of the same solicitors (as above) responded:

'All the time we get social workers, once a letter comes through from us, speaking to the young people and having a go at them – "Why did you get a lawyer involved?" "Why are you instructing a lawyer?" Countless times.'

We were told that this is echoed in local authority lawyers' letters – that the solicitors' involvement is really unhelpful, that they are hindering progress and '*hurting*' the relationship between a child or young person and the social worker.

We heard of legal professionals repeatedly encountering the same issues – systematic failures. A barrister referred to a number of cases involving disabled children – and to a current one of a child with an '*horrendous background*.' They told us that the particular local authority has not engaged with it:

'And it's routine, serially, case after case after case. And we keep going to court, we win cases, but they don't make any difference to the way the council deals with other similar children. And the incredible thing is they keep fighting these cases.'

'Why do we see these cases [regarding S.20 accommodation] over and over again? Why do we keep getting the same legal point against the same local authorities within 12 months? … The only explanation for that is that we're the minority of cases. If we were the majority of cases, then at some stage a local authority would take a view that we're going to have to provide this anyway, we don't want to incur the legal costs … because it's not worth it because we end up every single time having to accommodate these [children]. That would ultimately logically be where it would end up … The only logical explanation is we're only seeing the minority, the tip of the iceberg (and in the majority of cases no-one challenges the decision). That's the reason they can continue these unlawful practices even though they keep getting knocked back by us on them and they settle it once a lawyer gets involved.'

Solicitor, in evidence to the CSJ

The example of the *Hammersmith and Fulham* case was raised in this context – the fact that the House of Lords set out clearly what the local authority was supposed to be doing, and what they should have done in that case.[20] A barrister told us '*Nobody took a blind bit of notice of it.*' They then referred to the fact that the *Southwark* case followed this, which went up to the House of Lords, where LJ Hale expressed her surprise that the issue was back before it again:

20 R (M) v Hammersmith and Fulham London Borough Council [2008] UKHL 14, [2008] 1 WLR 535

'It comes as something of a surprise that the issue has had to reach this House, in the light of the observations in [the Hammersmith and Fulham case] …'[21]

This raises a fundamental issue of concern. Why do legal professionals have to go to the House of Lords to get a local authority to look after a vulnerable child, and twice, on the same issue? What is the point in this country having legislation if it is simply ignored or manipulated by some local authorities, to the detriment of vulnerable children? This is a damning indictment on the extent of injustice that many of them are facing.

We also received evidence of perverse incentives having been created in a number of local authorities, for example, in terms of how their budgets are structured, which leads to them fighting and going to court on cases, instead of providing the requisite support for vulnerable children and young people. For example, a barrister explained that a typical London local authority will have a £500,000 to £600,000 [budget] for accommodating children under S.20:

'But if there's more demand than that then they're in trouble, so they gate keep and keep them away. But if they get a Court Order, they go to a different pot of money.'

We were told by a solicitor that this is despite there being an identified need and often a lawyer accepting that there is an identified need.

We heard of a case involving a young child, who was born in England and has legal status. Their mother came to this country to marry a man who died. We were told that the local authority is paying the mother £53 per week to live on – for mother and child, and that they do not have enough money to eat properly. It is estimated (according to the legal professional who gave this evidence) that the bare minimum that they need is £30 more per week. We were told that the local authority is fighting in the High Court – *'spending thousands of pounds over £30 a week. It's just unbelievable.'*

What is more concerning again is that a lack of knowledge and understanding of the relevant law applicable to vulnerable children spans wider than just social care. One solicitor told us about training they had delivered for YOT workers:

'… their knowledge, considering that they work with vulnerable [children] who often need social [care] support, can be worryingly low. I described S.20 to them … it was a novel experience to them. I did a big training [session] in [North of England] … and they'd not even heard of a personal advisor … just no idea … So personal advisors and pathway plans just hadn't even hit their radar as something that existed …'

We were also told that the relevant legislation is something that magistrate courts need to be more aware of. One solicitor said that it was '*too much of an ask*' for every criminal solicitor to have a detailed understanding of Part 3 of the CA 1989. However they believe it is important to ensure that the magistrates and district judges have a basic understanding of it, so that they can ask further questions – for example, whether social care was involved and, if not,

21 R (G) v London Borough of Southwark [2009] UKHL 26

why not.[22] In addition, the importance of raising awareness of the holistic needs of children and young people in the criminal justice system was highlighted.[23] Another solicitor explained that criminal solicitors are not paid to be able do this additional work – on such low fixed fees; they cannot spend their time sitting with a child, writing off a request for a child in need assessment and considering the report when it is done. They said:

> *'They're going to go out of business even quicker than they already are under the current proposals …'*

4.2.4 The *2013 WTSC*[24]

> *'I know that part of the … reason for this new guidance to come in was to hopefully take away some of the bureaucracy that social workers were having to face and give them more ability to spend more time with the individuals. But I just cannot see that happening realistically on the ground. I just don't think it's going to make those changes. I think in some cases it's going to end up with more duty social workers seeing people for shorter periods of time, but perhaps seeing people more often because they're coming back, and they're not necessarily having their social workers allocated to them, social workers duplicating work. I don't think that can be a good thing for the [children] and I don't think it's going to save time and I certainly don't think it's going to save money. I think in the long-term it's going to result in services not being provided to the individuals. It may not be coming out of that department's budget but it will be coming out of budgets from other places.'*
>
> **Solicitor, in evidence to the CSJ**

> *'The thing about [the 2013 WTSC] is that it has the benefit of being consistent with the Government's ideology … "we don't want you to be tied up in bureaucracy." Localism is the key thing – they want people to work it out locally. That is great, but not if you take away 30 per cent of the resource from the key agency that you want to work it out. That's the problem.'*
>
> **Senior Manager, Children's Services Department, in evidence to the CSJ**

We appreciate the need, as recommended by the Munro Review, for the Government 'to remove unnecessary or unhelpful prescription and focus only on essential rules for effective multi-agency working and on the principles that underpin good practice.'[25] In response, the *2013 WTSC* was intended to clarify the core legal requirements and responsibilities – to make the position clearer for those working to safeguard and protect the welfare of children. We welcome this and the Government's desire for 'social workers and other professionals to focus on the needs of individual children and families and take decisive and effective action to help

22 The CSJ has recommended that youth court magistrates should generally sit in both the youth court and the family court so as to promote welfare awareness; Centre for Social Justice, *Rules of engagement: Changing the heart of youth justice*, London: Centre for Social Justice, January 2012, p212

23 Again, the CSJ has made a number of recommendations regarding specialist youth training for court practitioners; ibid, p16 and pp92–93

24 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

25 Munro E, *The Munro Review of Child Protection: Final Report: A child-centred system*, London: Department for Education, May 2011, p7 and p10

those children.'[26] However, by virtue of a number of aspects contained within the *2013 WTSC*, some of which are referred to below, it is felt that the revised statutory guidance runs the risk of achieving the very opposite. Concern exists that the Government has gone to too much of an extreme. A Senior Manager in a Children's Services Department told us '*… I'm not sure if we've kept even the basics by loosening it too much … [the 2013 WTSC] just says "work it out for yourself."*'

> *'I think [the 2013 WTSC] is going to lead to further inconsistency between local authorities. So you're going to get one local authority doing something in one way and another in another way. And where you've got a child who is between local authorities and they're both treating matters differently, I can see that being problematic.'*
> **Solicitor, in evidence to the CSJ**

We are aware that the Government originally proposed to introduce a number of significant changes to the *2000 Assessment Framework* without holding a public consultation. We find this astonishing, given its importance, and an incredibly poor reflection on how vulnerable children are regarded. The Government subsequently agreed that its proposed changes would not be introduced before holding a public consultation. However, it then proceeded to introduce a number of new aspects into the *2013 WTSC* which had not been subject to that consultation.[27] This is extremely frustrating and unfortunate. A number of fundamental concerns exist on the part of legal professionals and others over some of those provisions.

Early Help

We welcome the importance placed on early intervention and early help in the Munro Review. We also appreciate the crucial need for local agencies to have effective ways of identifying children and families who could benefit from early help. However, there are a number of concerning aspects in the early help section of the *2013 WTSC*. A significant issue exists regarding the wording which states that

> *'Professionals should, in particular, be alert to the potential need for early help for a child who:*

- *is disabled and has special additional needs;*
- *has [SEN];*
- *is a young carer;*
- *is showing signs of engaging in anti-social or criminal behaviour;*
- *is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health, domestic violence; and/or*
- *is showing early signs of abuse and/or neglect.'*[28]

26 GOV.UK, Written statement to Parliament, *Working together to safeguard children*, by Edward Timpson MP, 21 March 2013 [accessed via: https://www.gov.uk/government/speeches/working-together-to-safeguard-children (08.04.14)]

27 This includes, for example, amending, in the *2013 WTSC*, the guidance under Section 11 of the Children Act 2004, and introducing two new concepts of early help assessments and threshold documents

28 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p12 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

We were informed that those categories are, by definition, children in need.[29] Chris Callender, a solicitor, stated '*If it was tested, I just don't think it would stand up to scrutiny.*' A barrister commented: '*And what that shows is that the people who wrote that don't understand the law.*'

The *2013 WTSC* states that:

- *'Local agencies should work together to put processes in place for the effective assessment of the needs of individual children who may benefit from early help services' – i.e. an early help assessment (EHA), which sits outside of the statutory framework; and that*
- *EHAs 'should be undertaken by a lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services. The lead professional role could be undertaken by a [GP], family support worker, teacher, health visitor and/or [SEN] coordinator.'*[30]

Chris Callender referred to the *2013 WTSC* as having created a "'*Pre child in need zone" which never really existed before.*' He added *'It's so thin the way it's described, it's almost impossible to understand what it means.*' Another solicitor stated '*I find it really hard to see how they could ever do an EHA on a case that needed that, that wouldn't cross the child in need threshold.*' They recognised that there are going to be cases where, in theory, someone falls under the definition of being a child in need, but actually does not have a need for any social care support.[31] They may, for example, have fairly low needs, which could be met in the community. However they explained that those circumstances are somewhat limited. Another solicitor added:

> *'An [EHA] is only going to be carried out where you've got a child in need. Where you've got a child in need, there's a legal duty to undertake a child in need assessment. So by having that in there, it's distracting for the social workers, or the people who are going to be carrying out the assessments from doing their jobs lawfully. Because they'll think it's an alternative and why would this be in there if we weren't expected to use it? It will see more people doing it.'*

Given the views expressed by the legal professionals, we queried why lead professionals should be thinking of undertaking an EHA in circumstances where potentially they should be making a referral to social care straight away. A solicitor's response to this was:

> *'It doesn't make sense because you can refer back out in the sense that if social workers do an assessment and they identify eligible needs, they identify that those needs are going to be best met by referring the child to another service like CAMHS, or a [VSO] that can provide support at a lower level, and that the child only needs that, then that's how you deal with that. You refer them back for the early help if you've done your assessment, and you've identified that nothing at a higher level is required.'*

29 Disabled children, for example, are automatically within the category of children in need

30 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p12 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

31 The definition of a child in need is provided under Children Act 1989, Section 17(10), as referred to in the legal foreword

We believe that the position is further confused by the wording which states that 'If at any time it is considered that the child may be a child in need as defined in the [CA] 1989 … a referral should be made immediately to local authority children's social care.'

Another issue is that no timeframe is stipulated in the *2013 WTSC* within which an EHA is required to be undertaken. This heightens our concern about the potential for drift and delay being caused to a child in need by an EHA. Solicitors with whom we discussed this shared our concern. One told us: '*Absolutely. This is all just a delaying tactic …*'

They added:

> *'I think a lot of well-meaning professionals who work with [children] will try and follow the guidance as they're supposed to, and try and do everything they can to do all this early help. They may not refer to social [care] because they won't want to bother it, or they're consulting with social [care] and social [care] are saying "oh, you should do this and you should do that before you refer to us."'*

In these circumstances, a child's needs could become more entrenched, and delay could add to their suffering. There is also of course the additional issue, raised above, of a number of local authorities requesting CAFs to be used as referrals. Solicitors raised the potential for abuse on the part of social care. This included, for example, through informal consultations without a referral being made, or '*social care actually receiving a referral and then making the decision that they do not need to do an assessment because they can refer back for an EHA to be undertaken, and no-one really knowing if the child in need threshold is crossed – and arguably that's not lawful.*' We were told that if the need is low enough they might be able to do a summary assessment which identifies the support that can be provided by someone else. The solicitor told us '*You can't really get around doing the assessment in the first place but people won't realise that.*' Those who have had specific training may well do, but there will be many who will not have. Another solicitor told us:

> *'I think a lot of professionals just don't have sufficient knowledge or training. Even with the old system a lot of them struggled with understanding the different assessments, and would just accept when they were being turned away.'*

We are also mindful, as highlighted in the previous chapters, of the serious pressures that many of those working in the agencies to which this section applies were already facing, even before the *2013 WTSC* came into force. We share the concerns voiced by various witnesses to our Review over the lack of feedback having been sought from the relevant agencies on the EHA – including it not being specific enough and potentially fuelling confusion and inconsistencies between local authorities.

The CEO of a VSO raised the importance of high quality professionals undertaking the lead professional role. They told us:

> *'What we saw almost immediately after Eileen Munro's Review was some local authorities coming to us saying "will you be the lead [professional] here?" And us saying*

"we are happy to do so, but we are not giving that to an NVQ Level 3 qualified member of staff," and we need to understand how that system is going to work. In many instances, we were unable to get the assurances we needed so did not take on the role. Now, if we were asked to do that, I suspect other VSOs were also asked to do it.'

We were told that if a VSO is big, it can afford to turn things down or to push quite hard because it has a degree of credibility and authority. However, it is considered to be much harder to do for very small VSOs, or if a VSO is very reliant on a '*smorgasboard of quite complex, fragile funding*.' We question whether some lead professionals are being placed in a precarious position.

'And who will take responsibility to be lead professional? Because more and more and more they are expecting head teachers to do it, and they just have not got the time. That's where there's a sticking point. No-one will take it on because of the work involved.'
SHS practitioner, in evidence to the CSJ

A GP told us:

'It is proving to be too big a burden … In General Practice most face-to-face care occurs in ten minute consultations … there are not many GPs who have the resources to do it … it's a definite barrier … on the whole it's being done by health visitors and school nurses …'

There are also significant issues, as discussed in Chapter Two, concerning barriers to many vulnerable children's (and young people's) access to primary care, and pressures and challenges faced by some GPs.

'In many areas the early help offer is not yet embedded and therefore families are offered a service only when their needs become acute and there is likely to be statutory intervention.'
VSO, in evidence to the CSJ

The *2013 WTSC* states that 'Local areas should have a range of effective, evidence-based services in place to address assessed needs early. The early help on offer should draw upon the local assessment of need and the latest evidence of the effectiveness of early help and early intervention programmes.'[32] However, there is a worrying lack of understanding and knowledge regarding the importance of using evidence-based early intervention on the part of some commissioners. In addition, we were told that the '*whole statutory system is imploding*,' with '*every service … haemorrhaging cases down to the next level*.' Some professionals are struggling to hold and support vulnerable children with severe and complex needs who are not able to gain access to statutory services, with adverse implications for those who would genuinely benefit from early intervention. Concerns exist over the lack of appropriate skill, training and experience of some of those working in early intervention services to address

32 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p13 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

their needs. Some well-meaning professionals may not be trained to recognise the needs that vulnerable children could potentially present with. Furthermore, our research has revealed that in some areas of the country there is now a reduced resource in preventative services.

An example of preventative services in decline

Parenting programmes at all levels that act as a preventative and reactive tool for vulnerable families have now ceased. None are running across the city in which our witness operates, and organisations such as Nacro Osmaston Family Project are seeking alternative funding, as yet without success.

The introduction of the council's Dynamic Purchasing System has resulted in funding for VSOs under the TFP only being available in small amounts for short-term work. This means VSOs having to employ staff on zero hour contracts. It does not allow for long-term planning and assessment of the children, young people and their families. For example, Enthusiasm Trust provides intensive mentoring to children and young people. This is usually a piece of work lasting up to one year due to the complex areas of their lives. However, currently, Enthusiasm Trust receives funding for blocks of six weeks at a time.

Cuts to drugs and alcohol prevention services in the city now means that the prevention work that Enthusiasm Trust was undertaking on an outreach basis using its community bus – in partnership with Breakout Drug and Alcohol Services – can no longer be delivered. This means that many children and young people will not receive vital information and awareness about these issues, leading to a lack of preventative work taking place.

Enthusiasm Trust works with a high number of children and young people who become at risk of sexual exploitation, and who run away from home. The VSO is now facing the prospect that services providing intervention and specialism for this in the area are going to face cuts in their local authority funding.

By nature of the work that Enthusiasm Trust undertakes, services are interdependent, and children and young people and their families need to access a wide range of services at different times of their lives. However, the VSO can no longer refer them to many of these.

It is felt that in using the CAF as a specific example of how to conduct an EHA assessment, there is a risk that it could be viewed as the only mechanism for assessment, to the exclusion of others. This is in the context of a number of difficulties clearly existing in relation to CAFs. As was the case in *No Excuses*, witnesses to our Review painted a very mixed picture in relation to the CAF's implementation and effectiveness.[33] Enthusiasm Trust told us '*At an operational level work loads are increasing due to us having to do things that were previously undertaken by social care.*' It went on to explain that, for example, in relation to multi-agency working, and the completion of CAFs:

> *'We are required to lead on undertaking CAFs on a regular basis. It is a universal integrating tool and beneficial to the families and wider team; however, it does take up huge amounts of time.'*

33 Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, September 2011, p73 and pp191–192

A GP told us: '[The] *CAF needs to be re-designed. Something needs to be done about it … I think the CAF form is a disaster … [It] is a bureaucrat's delight and a busy practitioner's nightmare … I know about the need to share information, but come on.*'

> *'The trouble is, the minute you instigate a CAF, you pick up the baby. That's why we haven't moved to a shared framework … the CAF just becomes an unwieldly document. The concept of it – being online based, that everyone can access, just doesn't work.'*
> **Head of a special school, in evidence to the CSJ**

> *'When the CAF first began … [it] was not about a form, it was about allocating resources … What has happened since then is that is has become more diverted into a procedure and an offloading exercise. There is a total lack of clarity about what is being requested. That needs to be revisited.'*
> **Professor Corinne May-Chahal, Lancaster University, in evidence to the CSJ**

A Senior Manager of a Children's Services Department told us that they had looked at the range of different types of early assessments, that they are not dissimilar, and that one could probably pull them together into a single assessment that could then continue if the child accessed social care services.

Threshold document to be published by LSCBs

The *2013 WTSC* states that 'the LSCB should publish a **threshold document** [its emphasis] that includes:

- The process for the [EHA] and the type and level of early help services to be provided; and
- The criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services under:
  - section 17 of the [CA] 1989 (children in need);
  - section 47 of the [CA] 1989 (reasonable cause to suspect children suffering or likely to suffer significant harm);
  - Section 31 (care orders);[34] and
  - Section 20 (duty to accommodate a child) of the [CA] 1989.'[35]

In order to be lawful, any threshold document would have to set 'threshold' at the same level as the statutory one. However, concern exists regarding some local authorities potentially seeking to impose a higher threshold for access to a child in need assessment. At the time we took evidence from legal professionals, in July 2013, none of them had seen a threshold document. This is despite there having been a 12-month lead in to the *2013 WTSC*, and the fact that the *2013 WTSC* was in force from 15 April 2013.

34 We were informed that Section 31 Care Orders are not relevant here, as they are not about need but a child's removal

35 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p14 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

A recent internet search by the CSJ has revealed that threshold documents are not available from a significant number of local authority websites across England.[36] From an initial review of a very small sample, we were alarmed to see the level of need that children are expected to reach, in a number of local authorities, before statutory intervention is sought. It appears that children with high/complex needs may be held at the early help level, and only those with acute needs, and/or who are suffering or at risk of suffering significant harm are referred to social care. A solicitor made the following comment on one of the threshold documents that they reviewed:

> *'It is very concerning to see that children listed as 'Level [x]'… are considered only eligible for early help. I would argue that many of those would meet the legal definition of a child in need and be eligible for support under S.17 … , and should not be limited to receiving just early help. If it has to reach the stage of 'Level [x]' before social [care] intervenes, then it may already be too late for them to provide effective interventions to promote the upbringing of children in need by their families.'*

The *2013 WTSC* states that LSCBs 'should' publish their threshold documents. We believe that the wording does not go far enough – there should be an express and absolute requirement. As one solicitor stated:

> *'They must publish, absolutely. "Should" must become a "must." What's the point in having these documents for people to rely on if you can't get access to them?'*

We highlight, in this context, concerns that have been expressed to us over the lack of transparency and unlawfulness of thresholds being used by some local authorities, and evidence regarding joint protocols. Again, for VSOs (amongst others) supporting vulnerable children, this is an extremely important document for them to be able to access.

> *'The people who these documents apply to are vulnerable children. Vulnerable children are not going to know to request it. It's almost that this must be provided to any person who makes a referral, so at least they should have been informed. They've been given the opportunity to be informed by this. No child in need is going to think "I must ask for this;" no parent of a child in need is going to think this document exists. If it's given to anybody to whom a referral is made about, I think that would be a start. Assuming it's a lawful document, that takes us back to the problem. What's the point in having these documents if they're totally unlawful and misleading?'*
>
> **Solicitor, in evidence to the CSJ**

There is almost an expectation on the part of some solicitors, given their experience of the practice of some local authorities, that some threshold documents will contain unlawful thresholds. One solicitor anticipated *'In due course, I'm sure we will be finding those sorts of threshold documents which set out completely unlawful thresholds, that have nothing to do with the legislation or the guidance, that we'll have to be challenging.'*

36 This does not of course mean that they do not exist, in fairness to any local authority which may have produced a threshold document

Some local authorities create their own internal eligibility criteria for which departments can deal with which cases internally. A solicitor stated that where that is done lawfully, they cannot see any objection to it. However, we heard about a case, in one local authority, where there was no department willing to provide the service that children in need required, so they had to get into another department which dealt with a particular cohort of vulnerable children. The eligibility criteria for getting a service from that department imposed additional thresholds over and above the fact that children were children in need. The same solicitor told us:

> *'They converted what was a departmental internal thing into an overall gate keeping exercise. Who knows how many local authorities have got some sort of internal policies going on about which department deals with which case which actually then is effectively operating as unlawful eligibility criteria …'*

The solicitor went on to explain:

> *'… you never know what internal policies are floating around the local authority unless you get your hands on them … pre the [2013 WTSC], the local authorities could have been operating internal thresholds for when or when not they would accept a referral and carry out a child in need assessment. The only reason you ever find out about those is if some social worker makes a foolish reference to the existence of one somewhere in correspondence which then enables you to ask for it. So the same will apply to [a threshold document required under the 2013 WTSC]. How will you know whether there is one? How will people who aren't lawyers know to ask? At least if it's in the guidance we know to ask for whether there is one but lots of people won't. Unless it's published there's no chance of ever identifying whether they're being used unlawfully or not.'*

In this context, a solicitor raised the example of joint protocols for housing (as discussed earlier), as a direct comparison document. They said:

> *'I think there's going to be such an inconsistency between documents from local authority to local authority. You'll have some which are good, some which are terrible, some which are in between, some which probably don't exist at all. Then … are social workers actually trained in what they should be doing, are they going to understand how they should be applying it, are they going to be following it? And just my experience of seeing how social workers in different local authorities should have been dealing with referrals in the past, and just the inconsistency that comes from what I don't think is a particularly complicated way of doing things – the more complicated you make it the more inconsistency I think you're going to see.'*

Another solicitor expressed their agreement with this. They said *'I don't know why any of it is really necessary when you can just go back to the core duty which is whether you have a duty to assess following the case law on S.17.'*

Decision within 24 hours of referral

Local authority social workers should make a decision – within 24 hours of receiving a referral – about the type of response that is required, and acknowledge receipt to the referrer.[37] However, a number of legal professionals shared their experience of decisions not being reached within this timeframe, and of having to chase for them. A solicitor stated:

> *'Under the old guidance, they were supposed to do the same, and I can probably count on one hand how many times in several years they've come back and said what they're going to do within 24 hours.'*

Another solicitor told us:

> *'We've got the same problem. They don't do it within 24 hours. It could be a week and you're still chasing a decision.'*

As at April 2014, both of these solicitors confirmed that this was still the case. Another reported that they are '*always*' experiencing failure by social care to comply – '*and generally challenging by starting [JR] protocol.*' As highlighted in Chapter Three, many of the VSOs that gave evidence to our Review are also having to pursue social care teams for a response to their referrals – whether within the 24 hour deadline or indeed at all. A solicitor told us:

> *'That is a major concern. I will put in my letters that we expect a decision within 24 hours. Now if they're not responding to lawyers requesting that, they're certainly not going to be doing that for parents, for schools, for voluntary sector workers.'*

The problem of local authorities having such different practices was raised by legal professionals. One solicitor referred to a practice operated by a local authority in the North of England which they told us seemed to work quite well – with a team comprising social workers, that deals with both child in need and child protection referrals. They said:

> *'If you ring them you speak to someone who knows what's going on and takes the referral from there straight away. They take the information and contact details and seem to be good at coming back to you about what's happening. I had updates in less than 24 hours.'*

However, worryingly, this seems to be somewhat of an exception in their experience. They added:

> *'But other local authorities, you ring up and you're not going to get through to anyone that's competent to deal with the referral. So you send it by a letter or fax, and then endless chasing to ensure it's even been received.'*

37 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p23 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

Some VSOs also work across local authorities, desperately trying to understand the different languages and processes that the authorities use, and often with limited time and resources. [38]

There is no requirement specified in the *2013 WTSC* for social care to acknowledge receipt of referrals in writing. When asked whether the guidance ought to contain an express provision requiring social care to do so, a solicitor highlighted the extent of challenge which exists even for legal professionals. They told us:

> *'I've lost faith in that sort of guidance. Just because it's in the guidance saying they've got to acknowledge it in writing, we'd still end up having to call them and say "have you got it? Can you send us a letter?" And by the time they've actually sent you a letter saying they've got it, they probably should have done an assessment, or confirmed whether or not they're going to do an assessment.'*

Another solicitor recognised an important distinction here, in that solicitors are able to take action, given that they know what the legal rights are – they can chase it up. They said:

> *'It's for the people who aren't legally qualified who don't know the law. They're the people who need to have this confirmation in writing telling them what's going to happen … If there's no confirmation that this has been received, and that something is being done about it – is anything going to be done about it? That would be my concern.'*

We believe that an express requirement would also benefit VSOs (amongst others), and help to hold local authorities more accountable, as written confirmation would form an important part of the paper trail regarding referrals.

45-day timeframe for assessments

The Munro Review recommended that the distinction between initial and core assessments should be removed, together with their associated timescales for completion. It recommended that these should be replaced 'with the decisions that are required to be made by qualified social workers when developing an understanding of children's needs and making and implementing a plan to safeguard and promote their welfare.'[39]

The *2013 WTSC* has removed the distinction between the assessments, and their associated timescales for completion.[40] However, it has retained a timeframe for the single assessment to be completed. Under the *2013 WTSC*:

- *'The maximum timeframe for the assessment to conclude, such that it is possible to reach a decision on next steps, should be no longer than 45 working days from the point of referral …*
- *Whatever the timescale for assessment, where particular needs are identified at any stage of the assessment, social workers should not wait until the assessment reaches a conclusion*

38 As discussed in Chapter Three

39 Munro E, *The Munro Review of Child Protection: Final Report: A child-centred system*, London: Department for Education, May 2011, p10

40 I.e. of ten and 35 working days respectively. This was the requirement under the *2000 Assessment Framework*, as explained in the legal foreword

before commissioning services to support the child and their family. In some cases the needs of the child will mean that a quick assessment will be required …

- *To facilitate the shift to an assessment process which brings continuity and consistency for children and families, there will no longer be a requirement to conduct separate initial and core assessments. Local authorities should determine their local assessment processes through a local protocol.'*[41]

Legal professionals voiced their concerns over the longer timeframe within which social care teams are required to provide an assessment under the *2013 WTSC*. These, in part, centre on identifying, and therefore addressing, any of the more immediate support needs of some children – for example, those at risk of gang violence, while the assessment is undertaken. This is notwithstanding the fact that in a number of places the *2013 WTSC* refers to the importance of the timeliness of an assessment. One solicitor said:

> *'They make a decision "yes, we're going to carry out the assessment," and then in theory they've got 45 working days to actually do anything about it.'*

Frustrations were expressed over the fact that many social workers did not comply with deadlines under the *2010 WTSC* in relation to assessments. Now that an initial assessment is no longer required to be undertaken by social care, lawyers have lost their chance to bite at seven days in relation to what action is being taken by them. They now have to wait until 45 days have passed. This is in circumstances where we heard from a barrister that '*very few local authorities complied with the 35 days any way, and normally started doing it after 35 days – I assume that they will just start doing it after 45 days now*.' Evidence has reportedly come to light that, 'Seven years after Baby P died, social workers in Haringey are still failing to assess vulnerable children quickly enough … Documents show that less than three quarters of children and their families were being assessed within Haringey council's 45-day time limit.'[42] A couple of solicitors have confirmed that they are experiencing a failure by social care to comply with the 45 day timeframe. One informed us that they have '*not received any on time as yet*;' another stated '*… I have never received an assessment within the timeframe*.'

A number of solicitors shared examples of some local authorities continuing to comply with the *2010 WTSC*, instead of the *2013 WTSC*. One told us:

> *'Even though this new guidance has come in, it's not being followed. Whether it's just not been filtered down, [or] whether there's internal training that needs to be put in to place. From our point of view, if they say they're going to do an initial assessment within ten working days it's not for us to criticise. Because we'd much rather have that.'*

Another solicitor added:

41 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, pp23–24 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

42 The article also states that 'In Haringey's monthly monitoring report of children and families, 74 per cent [of them] were assessed in time, missing the council's target of 85 per cent … ' London Evening Standard, "*Haringey 'still failing' vulnerable children after Baby P scandal*," 7 April 2014 [accessed via: http://www.standard.co.uk/news/crime/haringey-still-failing-vulnerable-children-after-baby-p-scandal-9243099.html (12.04.14)]

'We've had a similar experience of people just treating it like this guidance hasn't actually happened …'

As at April 2014, we received confirmation from the former solicitor, together with another solicitor, that this was still the case, and from the latter solicitor that they had not experienced this recently.

In his Ministerial Statement regarding the *2013 WTSC*, Edward Timpson, MP, stated that the Government proposed to continue work with the eight (which has since become six) local authorities that had been trialling more flexible assessment practices:

'… to analyse the impact of changes over a longer time period to decide whether the 45 days limit can ultimately be removed.'[43,44]

An evaluation of the pilot concluded that:

'Delay and drift is an ever present danger in the context of competing demands at the front door. In this context a notional upper time limit for initial visits to see the child and for the completion of single assessments was welcomed by professionals.'[45]

An extension of a further 12 months was granted to the trial local authorities from 15 April 2013.[46] As observed by a solicitor, the trial local authorities of course know that they are under the spotlight, and are more likely to ensure awareness and compliance amongst their staff.

Local protocol for assessments

The *2000 Assessment Framework* has been abolished in favour of local protocols for assessment. The *2013 WTSC* stipulates that:

- *'Local authorities, with their partners, should develop and publish local protocols for assessment. A local protocol should set out clear arrangements for how cases will be managed once a child is referred into local authority children's social care and be consistent with the requirements of this statutory guidance. The detail of each protocol will be led by the local authority in discussion with their partners and agreed with the relevant LSCB.*
- *The local authority is publicly accountable for this protocol and all organisations and agencies have a responsibility to understand their local protocol.'*[47]

43 The original local authorities were Westminster, Knowsley, Cumbria, Hackney, Kensington and Chelsea, Hammersmith and Fulham, Wandsworth and Islington. Cumbria and Islington subsequently decided not to continue with the trial following a decision to extend it beyond 15 April 2013

44 GOV.UK, Written statement to Parliament, *Working together to safeguard children*, by Edward Timpson MP, 21 March 2013 [accessed via: https://www.gov.uk/government/speeches/working-together-to-safeguard-children (08.04.14)]

45 The Department for Education commissioned the Childhood Wellbeing Research Centre to 'undertake a piece of rapid response work between April and July 2012 to independently evaluate the impact that the flexibilities granted to the trial authorities have had on practice and service responses to safeguard children from harm;' Childhood Wellbeing Research Centre, *The impact of more flexible assessment practices in response to the Munro Review of Child Protection: Emerging findings from the trials*, July 2012, p27 [accessed via: http://www.cambslscb.org.uk/files/Impact%20of%20more%20flexible%20assessment%20practices.pdf (16.04.14)]

46 GOV.UK, *Child protection trials: local authority direction letters*, published 16 January 2014 [accessed via: https://www.gov.uk/government/publications/child-protection-trials-local-authority-direction-letters (16.04.14)]

47 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p24 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

For a VSO and others to comply with the responsibility to understand the local protocol, and to know how a case will be managed, following social care's acceptance of a referral, then it will need to have a copy of the local protocol. A search on the internet by the CSJ has revealed that an extremely small number of local protocols appear to be available from local authority websites across England. Social workers are required to 'lead on an assessment and complete it in line with the locally agreed protocol according to the child's needs …'[48] Where the document is not publicly available, as it should be, what is the local agreed protocol in the relevant local authorities, and how do VSOs and others obtain a copy of it – assuming that it does in fact exist?[49] In parallel with threshold documents, we believe that there should be an express and absolute requirement on local authorities to publish their local protocol.

We question the extent to which local protocols vary in different local authorities. Again, these issues have the potential to cause further difficulties and confusion for professionals, particularly those in VSOs working across boroughs.

A further issue is that there is currently no national standard for conducting assessments. A barrister highlighted the ensuing difficulties that may arise in the context of JR proceedings. They told us that '*save for a few notable exceptions, the Judges in the Administrative Court have limited social care experience.*' The barrister explained that they need guidance by which to judge the assessment of a local authority against the standard of reasonableness. However, there is currently no standard against which they can benchmark assessments. The barrister suggested that the Health and Care Professions Council (HCPC) and the College of Social Work (CSW) ought to provide guidance which is flexible, and which could be helpful for those in practice – particularly newly qualified social workers. We understand that the aim is for professional guidance to be produced by NICE and the CSW. In the meantime, the methodology for assessment is set out in the *2013 WTSC*.[50] The same barrister commented:

> *' … the issue is how is it to be applied? Bringing into force statutory guidance that abolishes previous assessment protocol without replacing it with something new just leaves a void. The [HCPC] and [CSW] should have issued new guidance in March 2013 …'*

4.2.5 Legal aid proposals[51]

Key concerns raised regarding the Government's legal aid proposals, in the context of this report, included the following:

Criminal proposals

The Government's proposals to reduce the funding available for criminal defence solicitors is a concern. This is in light of the impact that they are anticipated to have on the nature and

48 Ibid, p30

49 This point is discussed further in The Voluntary Sector: A Poor Position for Exercising Influence, at Appendix 6

50 At paragraphs 32 to 35; HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, pp19–20 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

51 We recognise that some of the Government's proposals are in force, while others, such as the residence test (which we understand is awaiting JR), are not

quality of vulnerable children and young people's experience of legal advice, and of receiving a personal service which is sensitive to and understanding of their needs and the challenges that they face. This compounds concerns that have been raised throughout this report of the difficulties our vulnerable children and young people can experience in forming relationships with those who are responsible for or able to support them across numerous services – where there is mutual trust and respect, as well as consistency.

> *'It won't lend itself to local firms that clients get to know and trust. I think in order to make it viable you have to be able to take a fairly large number of cases … small high street firms with five or six solicitors just can't take the large number of cases. A lot of our clients come through walking in the front door, and word of mouth recommendation, and also knowing that when they come in to the office and say "can I speak to X?," X is there and they know who it is, and they'll talk to her and she will take the time to listen to them. I can't imagine them walking into a giant conglomerate office and saying "I want to speak to X," and them being there and that same person being there all the time.'*
>
> **Solicitor, in evidence to the CSJ**

Vulnerable children and young people may also find themselves without criminal solicitors in their community. Importantly, some of these offices are currently well placed to be able to serve those who are in need of their services, and given the practical difficulties that many can often face in terms of engaging with non-statutory, as well as statutory services.

> *'… the chances of there being one located locally. And for [children or] young people, they've lost their mobile phone, they haven't got any money. They can walk to the criminal solicitor's office … We spend so much time trying to get hold of clients, the amount of time we spend in terms of tracking them down, they've changed their mobile number … Criminal solicitors do not have that time to be able to do that degree of chasing; if they can't get hold of the client, they can't get hold of the client.'*[52]
>
> **Solicitor, in evidence to the CSJ**

Civil proposals

The residence test was raised as a particular area of concern. The way the residence test operates is that an individual will not be eligible for legal aid if they do not have a formal settled legal status here. In addition, they have to have been in the country lawfully for 12 months at some stage. Those who are most likely to be impacted by the test, in the context of our report are children and young people who are British but have no way of proving it.

> *'Because British nationality is often acquired by operation of law, not necessarily through a grant or proof through a certificate, there will be lots of [children and] young people who are British but have no way of proving it. And if the proposals go through as they currently are proposed, legal aid solicitors are not going to be taking cases where the [child or] young person can't provide some sort of decent documentary evidence to show that they meet the residence test. Because otherwise they'll be doing all the work, and they're not going to be getting paid for it at the end of the day. We know with the way the Legal Aid Agency already*

52 This comment was made by a solicitor who practices in civil law, not criminal law

operates with bank statements and things, it won't work. You get a child that's been born here, who is British but has never got a passport, or had any formal other documentation, and they're going to struggle more than others to get a legal aid solicitor to take their case.'

'And the vulnerable 16-year-olds we represent are the ones who have probably never left [their borough in London] in their entire life. Why would they need a passport? Why would they need something that shows where they come from? As a legal aid lawyer we cannot take the risk that we're not going to get paid for potentially hundreds of hours of work. We need to see something that proves that they've got status.'

Solicitors, in evidence to the CSJ

Judicial Review proposals

'Our advocates find that in many cases, [JR] is the only option for children and young people, particularly where no right to appeal exists or to seek appropriate remedies where policies have been breached by public bodies. We find that despite intense advocacy from our staff, in many cases the threat of legal action is required for public bodies to act lawfully, leading usually to a settlement in the young person's favour. This includes cases where children and young people are at risk of homelessness and where there are serious safeguarding concerns. Without [JR] many children and young people would become or remain homeless and at significant risk of exploitation and abuse.'

The Children's Society[53]

The Government held a third consultation on its proposals for further reform, which closed in November 2013 (the Consultation). It responded in February 2014 (Response).[54] Fundamental concerns exist in relation to the proposed changes to funding for JR proceedings, and their potential impact on vulnerable children and young people.

A main concern is that it is going to prevent their access to justice. The proposed reforms restrict the role of JR for individuals (and VSOs) wishing to bring a claim. On the basis of the evidence highlighted throughout this report, there can be no question as to the crucial importance of VSOs being able to continue to act as a claimant or to intervene in JRs. Over and over again, we have discovered cases of VSOs providing a lifeline to our vulnerable children and young people, and an effective means of support in terms of ensuring lawful action on the part of some local authorities. As argued by The Children's Society, in their response to the Consultation, the Government's proposals 'fail to recognise the particular vulnerabilities and barriers which children face in accessing justice and seeking redress and do not account for the vital role that [JR] can play … in holding the state to account for decisions that fundamentally affects [sic] children's lives … Without [JR] many children and young people would become or remain homeless and at significant risk of exploitation and abuse.'[55]

2013, pp 1-2 [accessed via: http://www.childrenssociety.org.uk/sites/default/files/tcs/the_childrens_society_response_to_judicial_review_proposals_for_further_reform_0.pdf (08.04.14)]

54 Ministry of Justice, *Judicial Review – proposals for further reform: the Government Response*, February 2014 [accessed via: https://www.gov.uk/government/publications/judicial-review-proposals-for-further-reform-the-government-response (11.05.14)]

55 The Children's Society, *The Children's Society response to the Ministry of Justice's consultation on '[JR]: Proposals for further reform*,' November 2013, pp1–2 [accessed via: http://www.childrenssociety.org.uk/sites/default/files/tcs/the_childrens_society_response_to_judicial_review_proposals_for_further_reform_0.pdf (08.04.14)]

Claimants are required to make an application for permission to apply for JR. A JR cannot proceed to a full hearing without permission being granted by the High Court. However, solicitors will often need to undertake a significant amount of work on a case after proceedings have been issued, before it reaches that stage. The Government originally proposed that solicitors would not be paid (with legal aid) for JR work unless the High Court granted them permission (normally, we understand, well into the case), and including cases which settle before that stage. However, the Government revised its position and proposed that the Legal Aid Agency (LAA) will have a discretion as to whether a solicitor will be paid in these circumstances:

> *'in certain cases … to enable payment in meritorious cases which settle prior to a permission and in which it is not possible to obtain costs from the defendant.'*[56]

The Government has since agreed, in its Response, 'to adjust the criteria – or factors – which will be in legislation and which the [LAA] will apply.'[57]

The Government's decision, which came into force on 22 April 2014, has attracted widespread condemnation. The Joint Committee on Human Rights report, *The implications for access to justice of the Government's proposals to reform [JR]*, stated:

'We do not consider that the proposal to make payment for pre-permission work in [JR] cases conditional on permission being granted, subject to a discretion in the [LAA], is justified by the evidence. In our view … it constitutes a potentially serious interference with access to justice and, as such, it requires weighty evidence in order to demonstrate the necessity for it – evidence which is currently lacking.'[58]

A solicitor shared their concerns over the fact that even if the LAA agrees to pay a proportion of solicitors, the proposal is still likely to lead to some firms going out of business. In addition, they stated that they do not have faith in the LAA to use their discretion appropriately, and that it would result in a vast number of cases where the LAA would exercise its discretion in favour of non payment. Chris Callender told us '*It's going to be a catastrophe, if … they're not going to pay the legal costs pre-permission, then we will be working at risk. You can't run a business on that basis.*' Another solicitor stated '*Margins are so tight already that even if one in ten cases resulted in no-payment, there would be a disastrous consequence for firms like ours.*'

> *'With the JR proposals … there may be firms that take a view immediately that it's just not viable to do the work anymore. I think what's more likely is that firms will continue to try and do the work, but that over the next few years you'll see a lot of the legal aid firms that do the work that we do going out of business. Ultimately what that means is that for the sorts of client that you're talking about in your report, there won't be legal aid. There won't be social welfare solicitors like us there able to do that work for them. That is a real*

56 Ministry of Justice, *Judicial Review – proposals for further reform: the Government Response*, February 2014, p12 [accessed via: https://www.gov.uk/government/publications/judicial-review-proposals-for-further-reform-the-government-response (11.05.14)]

57 The stated purpose of this is 'to reduce to a degree the risk that providers will be expected to take and will enable them to continue to be paid in cases which are meritorious at issue but which conclude prior to the permission decision;' ibid, p13

58 Joint Committee on Human Rights, *The implications for access to justice of the Government's proposals to reform judicial review*, April 2014, p26 [accessed via: http://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/publications (11.05.14)]

probability if these proposals go through as they are. There will not be specialist public law solicitors who bring JRs funded through legal aid to challenge unlawful decision making.'

'The margins on which we survive at the moment are so small. A lot of the work we do isn't profit making. We need to rely on getting costs in order to be able to stay in business in some of our cases. If we don't get a few cost orders a year, we can't carry on. That's as it is now. And if we're then going to lose potentially 25-30 per cent possibly of our certificated work, I think even firms like us who have a very good success rate, we can't continue.'

Solicitors, in evidence to the CSJ

Given that no payment will potentially be made for bringing JRs, it creates a perverse incentive for cases not to settle before the permission stage. Sometimes a local authority may only agree to settle a case with a favourable outcome for the child or young person on the basis that they agree not to pursue their costs against the local authority. A solicitor told us:

'And if that's in the best interests of your client, you would need to go ahead with that settlement. And you're effectively then putting the survival of that firm in conflict with what's in the best interests of the client. Because if that means that you're not going to get paid at all, are you going to accept that settlement on behalf of your client? And the firms that do will ultimately be penalised.'

The problem, according to another solicitor, is that the Government's argument is that solicitors should be able to judge whether a case is going to get permission or not, and that solicitors should not be bringing weak cases. They told us that in their practice, they never bring cases which they do not think are strong in terms of the merits they assess at the beginning. However, they said that it is very hard to predict in JR, which is so fast moving. The solicitor illustrated this in the context of challenging local authority decisions, where they challenge their failure to do an assessment, issue proceedings, and within a week the local authority has done their assessment:

'But it's unlawful. So you're then looking at can you amend your grounds to challenge that? The nature of the JR claim that you bring at the outset won't be the one that you're fighting if it ends up in a final hearing. Because there could have been two or three decisions in the meantime.'

Another important point raised is the extent to which JR cases settle. A solicitor told us:

'… the vast majority of our [JR] cases … settle. I very rarely end up in a final hearing … These cases a lot of the time are black and white. The local authority has acted unlawfully. We issue proceedings, they get a barrister on board and we've talked about cases where they don't follow advice but, in the vast majority of cases, somewhere along the line between first writing to them and a final hearing, they will eventually listen to advice and concede the case. They don't go all the way and a lot of the time they won't go up to permission, so we'll have a settlement with them.'

Another solicitor confirmed that their JR cases normally settle before permission is considered by the court. In fact, over 40 per cent of all applications lodged during 2012 – for permission to proceed to a full application – were withdrawn before a decision was reached on them. Evidence indicates that many of these cases may be settled on favourable terms to the claimant.[59] This further evidences how essential JR is in achieving justice for vulnerable children and young people; however, the proposals place solicitors at cost risk. Solicitors could fight a JR case that they feel is strong in terms of the merits, and to serve the best interests of their vulnerable clients by doing so – only to then not be paid for that work. As mentioned above, it could be in their clients' best interests to reach settlement, but why should the few legal firms across the country, with specialist legal knowledge and vast experience, who represent our vulnerable children and young people, be penalised in the process?

> *'I'm supposed to be in court [later this week] on a case and we've settled today. This is a case where we've had permission refused, because the local authority wrote to the court saying "we are doing what they're saying we need to be doing." They weren't at all. So we renewed permission and they've now caved less than a week before the permission hearing. We've said they should pay our costs, they've said that they shouldn't, so it's going to be going on written submissions to a Judge to make a decision on whether or not they should be paying our costs. I'd like to think the Judge will see sense, but I've had many decisions from Judges where they haven't. They're often very defendant friendly, they're local authority friendly. They don't like to take money out of one part of the public purse to put into another.'*
> **Solicitor, in evidence to the CSJ**

Never mind about not wanting to remove money from one part of the public purse to another – what about the potential impact of such practice on our vulnerable children and young people – many of whom are suffering grotesque injustice at the hands of those who are statutorily responsible for caring for, protecting and/or supporting them? An irony here of course, as we have heard from countless witnesses to our Review, is that by virtue of one statutory service failing a vulnerable child or young person, this can result in the costs of addressing their needs being borne by another statutory service further on down the line – at a significantly higher level and cost to the public purse.

One would have thought that the efforts of those who fight for justice for these vulnerable children and young people would at least receive fair and appropriate financial payment for doing so. Instead, we face the risk of failing to prevent the closure of specialist providers. A solicitor commented '*What you can't say is that we can guarantee with immediate effect that definitely firms will close, and there won't be legal aid available. It's just very likely because of these cost factors that over a period of a few years there won't be the specialist firms doing this work.*'

> *'The cases that we take on – where we actually see a client, we get them signed up – it's very rare, if ever, that we don't make a positive difference to some aspect of their life. It*

59 Bondy V, and Sunkin M, *The Dynamics of Judicial Review Litigation: The resolution of public law challenges before final hearing*, 2009; cited in The Children's Society, *The Children's Society response to the Ministry of Justice's consultation on '[JR]: Proposals for further reform,'* November 2013, pp6–7 [accessed via: http://www.childrenssociety.org.uk/sites/default/files/tcs/the_childrens_society_response_to_judicial_review_proposals_for_further_reform_0.pdf (08.04.14)]

may be a life changing difference, or it may just be a small difference that helps them move forward with their life. But well over 95 per cent of our cases that we take on, we make a difference to certain aspects of their life for the better.'
Solicitor, in evidence to the CSJ

The potential impact on vulnerable children and young people of specialist firms ceasing to exist could be devastating. We have consistently seen the positive impact that solicitors from these firms have on their lives and the challenges that they face. In its response to the Government's first consultation on its JR proposals, Kids Company stated 'We have had to initiate a number [sic] pre-action letters and [JRs], every single one of which has been actioned or ruled in favour of the children so that we could be sure that they were cared for and protected.'[60]

'We all know that behind the scenes the local authorities are doing all of the gate keeping, all of the things that we've talked about, and the [children,] young people or the parents of whoever it is at the receiving end of the decision, don't know it's unlawful, don't know to challenge it. And that will be more widespread. Local authorities will just get away with all of the decisions that we currently challenge.'

'I think it will go further than that. There will not be the safeguard of lawyers in the background to help these people to bring these challenges. If that's taken away, then local authorities, and I don't like to use the phrase "get away with" because, as I said earlier, I don't think that's what they set out to do, but that's what is happening – they will end up getting away with avoiding their statutory duties to the detriment of vulnerable [children and] young people.'
Solicitors, in evidence to the CSJ

We argue that the potential for the decisions of those in the public sector to be subject to JR is a critical component of a just society – and what was described to us as '*the judge over your shoulder*.' A wealth of evidence contained in this report clearly demonstrates the need for this to be protected to the fullest degree possible. If the JR proposals go ahead, this begs a deeply uncomfortable question: given the failings and unlawful practices of some local authorities that already exist, what hope will our vulnerable children and young people have?

'It's a recognised feature of public decision making that the knowledge of those public decision makers that potentially their decisions could be subject to JR … and scrutinised by the court, has an effect on their decision making. And obviously we don't know to what extent it does and doesn't but … advocates saying "I'm going to refer this to a lawyer unless you do this, this week …" that in itself we know has an effect. Often advocates are able to achieve something just by the threat of "I'm going to send this kid to [law firm] if you don't do it." And if that threat is no longer there, and the local authority knows that in reality that's very unlikely, then clearly it will have an overall effect on the quality of the decision making. I don't think there can be any question of that.'
Solicitor, in evidence to the CSJ

60 Kids Company, *Response: 'Judicial Review: Proposal for reform,'* Submission by Kids Company, January 2013, p2

We believe that JR performs an essential role in democracy, and that the evidence contained in our report, including that provided by various members of the legal profession, robustly demonstrates the critical need for vulnerable children and young people to have access to high quality legal advice and to JR. Something that puts this issue into sharp focus is the small number of specialist legal professionals who are currently able to advise and support them.

> *'We are only scratching the surface. We're dealing with a very small number of [local] authorities where there happen to be solicitors that know what they're doing … There are whole parts of the country where there are none. Literally none … In total I would say you're looking at 25 lawyers, solicitors and barristers combined … nationally. Maybe 30 at a push. If any of those … solicitors fall away then there really is big trouble. The momentum of the legal challenges and the possibilities will be virtually nil. There's whole parts of the country, like the North East, where there's absolutely nobody doing it, [and with] massive areas of deprivation and so on.'*
>
> **Barrister, in evidence to the CSJ**

As highlighted by multiple examples throughout this report, it is not just the cases that are known to VSOs and legal professionals which cause them and us profound concern, it is also the cases we do not know about. A study conducted by the University of Essex has mapped where JRs are used to challenge local authorities in England and Wales. It showed that 'while for a few [local] authorities [JR] challenge is a regular event, for most it remains a rarity.'[61] It also revealed that:

> *'60 per cent of all local authority challenges were to decisions of London Boroughs … By contrast County Councils only attracted 7 per cent … the degree to which [JR] activity is concentrated in the London Boroughs is remarkable …'*[62]

Furthermore, the study found that:

> *'The top 20 challenged [local] authorities are all London Boroughs …,' and that beyond the Greater London area "hotspots" of [JR] activity … are Merseyside, Greater Manchester, West Yorkshire and the West Midlands.'*[63,64]

The authors observed that:

> *'… the virtual absence of [JR] activity across most of the country, including many areas that are heavily populated and urbanised.'*[65]

We asked what various legal professionals' concerns would be for vulnerable children and young people in light of this. A barrister replied '*They're not being represented.*' A solicitor added '*The local authorities are getting away with murder.*'

61 Sunkin M et al, *Mapping the Use of Judicial Review to Challenge Local Authorities in England and Wales*, Public Law, 2007, p546
62 London Boroughs were recorded as constituting '14 per cent of the population of England and Wales,' as opposed to County Councils 'covering 44 per cent …'; ibid, p549
63 Ibid, p550
64 Ibid, p552
65 Ibid

A barrister told us '… *what happens of course is, you get something like Rochdale and Oxford and everybody says "Oh God, it's terrible what's happening." It's always after the event isn't it?*' The barrister then referred to the case of a girl whose mother was living with a paedophile. The case went all the way to the Court of Appeal. The paedophile went into custody for indecent assault during the proceedings. The barrister said '*These kids had been living with a paedophile … By the time we got to the Court of Appeal he was out of prison, and the mother was with a different paedophile … we were just trying to look after these children … fighting to ensure the local authority recognised that there was a risk to these children, and took appropriate measures to protect them from those risks. They fought it all the way to the Court of Appeal, it must have cost them about £100,000 and they lost. It's unbelievable.*'

Chris Callender, a solicitor, referred to having listened to an interview of one of the girls from the Rochdale case on Women's Hour: *'She said live "And now I cannot get any support from social [care]." It's jaw dropping. As a result of that radio broadcast, the Director of Children's Services was alerted and rang in and said he wasn't aware of this …'*

Solicitors from specialist firms constitute another critical means of support for vulnerable children and young people, and can help prevent their difficulties and needs from escalating to a point where they become more costly to address – from a human and financial perspective. Some are helping to stem the tide of a lack of preventative action and early intervention being taken by some social care teams. A solicitor told us:

> *'The vast majority of the clients we see, in terms of the teenage clients, there are issues that should have been dealt with long before …'*

As if the justice and democracy factors do not weigh heavily enough, there are also the cost implications of what is being proposed.

Dr Nick Armstrong, a barrister from Matrix Chambers, has attempted 'to cost some of the civil aspects of the *Transforming Legal Aid* proposals.'[66] Dr Armstrong focussed on 'a small number of specific impacts,' which he concluded 'show that the £6 [million] projected savings of these civil legal aid proposals will be dwarfed by on-costs of nearly £30 [million].'[67] This figure in itself is huge. However, Dr Armstrong goes on to highlight 'the more general effects' that need to be added to this figure including, for example, an increase in litigants in person.[68] However, we believe yet further costs are likely to be incurred to the public purse by, for example, social care, health and the criminal justice system. We should also factor in the lack of contribution to the economy which is likely to ultimately be made by many vulnerable children and young people impacted by the legal aid proposals.

4.2.6 Ofsted

Ofsted's first stand-alone *Social Care Annual Report*, published in October 2013, revealed that in July 2012, only four out of 10 local authorities were judged good or better for safeguarding

66 We understand that this document was submitted to the Commons debate in the summer of 2013; Dr Nick Armstrong, Matrix Chambers, *Costing The Transforming Legal Aid Proposals*, 2013 [accessed via: http://legalaidchanges.files.wordpress.com/2013/06/nick-armstrong-costing-the-civil-legal-aid-proposals-1306242.pdf (12.04.14)]

67 Ibid, p5

68 Ibid

children.[69] Ofsted also judged 17 local authorities inadequate. After then reinspecting 50 of the weakest, 'focussing on child protection as the area of highest risk,' the figure of local authorities judged as inadequate increased to 20.[70] In addition, inspectors found that 'a persistent absence of stable leadership was a feature of most "inadequate" local authorities.' Ofsted reported that 'In these weakest places:

- The most basic acceptable practice was not in place;
- Supervision, management oversight, purposeful work with families and decisive action where children were at risk from harm were ineffective;
- The views of children and families were rarely considered;
- Support from key statutory partners – health, police, schools – was weak and poorly coordinated; and
- In some inadequate authorities, managers did not appear to have a firm understanding of what constituted good practice – making the management of risk and support for staff at the frontline almost impossible.'[71]

The report did find that some local authorities had:

> *'… worked hard to ensure their services are more effective and better able to meet the needs of children and families in their areas. In these areas, leaders and managers had a clear understanding of what was going on at the front-line and had coherent and urgent plans in place to address identified areas of need.'*[72]

However, Ofsted concluded that:

> *'Services to protect children need to improve. Too few are good or better and too many are inadequate. It is not clear, however, whether this is a picture that is getting better or worse. More inspections will be needed to provide a conclusive answer because the current picture is complex … The inspection results of the past 12 months arise from a system where many [local] authorities are finding improvement difficult. Almost half of the inspections did not result in a changed judgement.'*[73]

Ofsted has since published the results of its second tranche of inspections under the new inspection regime. Three of the six councils – East Sussex, Essex and Staffordshire – were rated as good, Coventry as inadequate, and Bolton and Hounslow requiring improvement.[74] More recently, Ofsted has judged Birmingham City Council's Children's Services to be inadequate. Its

69 This was the outcome of the first full three-year cycle of safeguarding and looked after children inspections; Ofsted, *Social Care Annual Report 2012/2013*, 15 October 2013, p18 [accessed via: http://www.ofsted.gov.uk/resources/social-care-annual-report-201213 (16.01.14)]

70 Ofsted found that 'The group of [local] authorities currently judged inadequate is different to the group with an inadequate judgement last July. Additionally, four local authorities have improved convincingly … '; Ibid, p7 and p18

71 Ofsted, *Press Release: First Social Care Report puts spotlight on leadership*, 15 October 2013 [accessed via: http://www.ofsted.gov.uk/news/first-social-care-report-puts-spotlight-leadership?news=21735 (16.01.14)]

72 Ibid

73 Ofsted, *Social Care Annual Report 2012/2013*, 15 October 2013, p18 [accessed via: http://www.ofsted.gov.uk/resources/social-care-annual-report-201213 (16.01.14)]

74 Community Care, *Ofsted publishes latest wave of new-style children's social care inspections*, 21 March 2014 [accessed via: http://www.communitycare.co.uk/2014/03/21/ofsted-publishes-first-wave-new-style-childrens-social-care-inspections/#.U3FOvMZ4Xnc (12.05.14)]

inspection report "reveals that the cases of more than 400 children, which had been referred more than two months previously, had not been risk assessed with a 'significant number' receiving no intervention at all because their cases were closed due to insufficient staff numbers."[75]

A Senior Manager in a Children's Services Department explained:

> *'The world of children's services … is massively complicated. Ofsted try and sum it up in one word. That's bonkers. Actually, what they should do is a narrative judgment. That would mean that people wouldn't be teaching to the test. We wouldn't feel we had to tick all the process boxes, but what we actually want is proper constructive feedback and we will listen to that … We need a proper grown up conversation.'*

They raised the example of one local authority, outside of London, which they understood was doing a decent job, and got '*slaughtered*' in their Ofsted inspection. They explained that the local authority had a problem in one of its teams, in respect of which the Assistant Director was aware and taking action. Our witness made the case that a narrative judgment would have provided a proper reflection of what was happening – that most of the services were doing well, but there was an area which was a bit of a problem. They added:

> *'That is the sort of thing that Ofsted need to take on board and get to grips with. The one word judgments are much too much of a blunt instrument to help services. Ofsted are supposed to be helping services improve and they're not. At the moment they are devastating services.'*

Andrew Webb, President of ADCS, has publicly called for narrative judgments to improve inspections – on the basis that the current inspection regime urgently needs reform because it does not reflect the complexity of safeguarding systems.[76,77] He has also said that there is a lot of concern that the current system is calibrated in the wrong way – the chances of being found inadequate are greater than they should be. Mr Webb explained to us that looking at the current protection of children inspections, and using Sir Michael Wilshaw's judgment that only good or outstanding are good enough, and that everything else is not good enough, then about 60 per cent of local authority safeguarding systems, using their final judgment, will be not good enough.

Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, explained to us that the impact of an Ofsted judgement being worse than expected:

> *'is always deterioration – people leave, including some of the best people who can find other jobs … potentially you've got quite a long time to just recover before you*

75 Children and Young People Now, *Child protection cases closed without review as Ofsted rates Birmingham services 'inadequate'*, 23 May 2014 [accessed via: http://www.cypnow.co.uk/cyp/news/1144254/birmingham-child-protection-closed-assessment-ofsted-rates-childrens-social-care-inadequate (04.06.14)]

76 Community Care, *One word Ofsted judgements 'ludicrous,' says top children's director,* 5 July 2013[accessed via: http://www.communitycare.co.uk/2013/07/05/one-word-ofsted-judgements-ludicrous-says-top-childrens-director/ (15.04.14)]; Community Care, *Ofsted damaging morale and performance with 'futile' judgements, says ADCS*, 18 October 2013 [accessed via: http://www.communitycare.co.uk/2013/10/18/ofsted-damaging-morale-and-performance-with-futile-judgements-says-adcs/ (15.04.14)]

77 At the time of publication, Andrew Webb is no longer the President of ADCS

start the improvement journey. There's not enough attention to how do departments, for example, improve.'

We strongly believe that a change in Ofsted's approach to inspection is needed – to one which focuses on how to support social care teams to improve. This is particularly in the context of the low morale and instability which already exists in some (but by no means all) of them. This could lead to greater effective and positive change, not just on the part of those working in the teams, but more importantly for vulnerable children and young people.

'If you assume at the outset that everybody needs to go on an improvement journey, and the point of the inspection is to improve things, instead of saying you pass or fail, the assumption is that you make an improvement plan. Ofsted may or may not have confidence in you to deliver it, so they decide to come back sooner rather than later, but you end up with a slight continuous improvement if you do that.'

Andrew Webb, President of ADCS, in evidence to the CSJ

Conversely, several legal professionals and social workers expressed their shock at the higher gradings that have been awarded by Ofsted to a number of local authorities, given the cases that they are dealing with, and practice known to them, in those local authorities.

'… I'd be lying if I said I wasn't extremely surprised by some of the … outstanding ratings that have been coming through … shocking … It's a million miles from what we're actually seeing on the ground.'

'It just ultimately undermines the whole Ofsted system …'

Solicitors, in evidence to the CSJ

A solicitor told us '*It's just mad … It just doesn't make sense*.' Another commented:

'It's worrying because … most of the London Boroughs are dreadful. There are certain local authorities that come up time and time again among [VSOs] that we speak to and other welfare solicitors. We all know which are the ones that just cause endless problems. And if they're then getting really good ratings from Ofsted there's something wrong, because it's not even just from our own individual limited practices, we're hearing it from other solicitors and [VSOs].'

What we do know from the legal professionals and other witnesses who gave evidence to our Review – about the practice of some local authorities in London and other areas of the country – is profoundly concerning enough. We are aware of some of the vulnerable children who are being denied access to social care services, or who are being provided with inadequate support. However, there are swathes of the country where there is no specialist solicitor provision, no JRs being submitted against local authorities, and/or no VSOs holding local authorities to account. This reinforces the vitally important role that Ofsted has to play – in securing an understanding of the reality of the experiences of vulnerable children and young people across the country. However, Ofsted came under significant criticism by various witnesses to our Review in relation to how it conducts its assessments of services and reaches its conclusions.

'Before Ofsted arrived, we had a meeting and were primed. We were told not to discuss with them any concerns or issues that we had, and that if we had any issues, we should discuss them with management. We were told to be very careful because the Ofsted people are "very friendly." It was put to us this way: "because they are friendly, don't be lulled into a false sense of security and divulge anything to them." Everyone was whipped into shape … We were all told what to do. There was an element of "you put a foot wrong and you'll be for the chop. Don't mess this up for us." I felt it was immoral to be spoken to in that way. It was like "if there are any problems, they will be swept under the carpet." If only they had got to me. They do talk to members informally, but I think certain people were chosen to be part of a discussion group. I can only imagine that those people were spoken to again. The whole system is not conducive to people being able to say how they feel. You're made to feel like you're betraying the whole organisation and if they find out it was you, then you pay.'

Social worker, in evidence to the CSJ

Ofsted introduced a new single inspection framework for vulnerable children and young people, with effect from November 2013, with a focus on their experiences and progress.[78] Ofsted now assesses Children's Services 'on the difference professional practice is making to the child, young person or family,' with inspectors evaluating 'the performance of local authorities end to end: from first contact to leaving care and everything in between.'[79] It is hoped that by focussing more on the quality of practice under the new inspection regime, this will lead to better outcomes for vulnerable children and young people. It is also hoped that people 'teaching to the test' and focussing on timescales will become more difficult in the new environment. As discussed in Chapter One, it has been suggested that Ofsted should help enable local authorities to improve by explaining what 'good' and 'outstanding' looks like.

'The biggest issue I have with Ofsted – and in many ways I'm very pleased they're moving on to looking at practice – is actually regarding the quality and consistency of their inspections. Perhaps because they haven't got enough people who have done the job recently. We should have a system where people move in and out of inspections because you learn a lot by being an inspector. Doing should always be valued above inspection.'

Dame Moira Gibb, Chair of Social Work Taskforce and Reform Board, in evidence to the CSJ

However, it strikes us that serious challenges exist to Ofsted gaining an informed understanding of the reality of the experience of many vulnerable children and young people. For example, as shown by our research, the language used by some social workers on their system, regarding action taken by them or the outcome for a vulnerable child, may be perfectly acceptable on the surface. However, it could mask a dark truth. What about the reality of 'did not engage' for many vulnerable children and young people? And what about all of those who we have highlighted in this report, who cannot gain access to social care services, who are entitled to

78 This combines into one inspection: local authority services for children in need of help and protection, children who are looked-after and care leavers (up to the age of 25). This includes local authority fostering services and adoption agencies

79 Ofsted, *Press Release: First Social Care Report puts spotlight on leadership*, 15 October 2013 [accessed via: http://www.ofsted.gov.uk/news/first-social-care-report-puts-spotlight-leadership?news=21735 (16.04.14)]

support and in desperate need of it? As demonstrated by our report, numerous VSOs across the country could certainly provide Ofsted with an invaluable insight.

Our attention was drawn to the fact that if one compares the decisions reached by the LGO regarding some local authorities against how Ofsted have graded those same local authorities, they can be in direct contradiction. It has been suggested to us that Ofsted should take legal decisions, settlements, and LGO decisions into account, amongst other issues, as part of their inspection process.

It is also felt that Ofsted could perform a valuable role with respect to commissioning practice.

> *'I think there is a lot that Ofsted could add … If Ofsted were to develop a regime that had the capability, and capacity to comment on the extent to which commissioning practice, and a whole system approach by a local authority to its commissioning and its provision of services, is either positive, or not positive, for a child, that would be brilliant. At the moment Ofsted are clearly and rightly highlighting when more needs to be done to reach the hardest to reach children, without then going on to say what the problems are and how these could be overcome. In some instances the data is not there. In others the contract price is insufficient to cover the work needed to engage with the most difficult to reach families. It would be brilliant if they could step into that strategic space.'*
>
> **CEO, VSO, in evidence to the CSJ**

4.3 Mental health

> *'We don't even know what the hell CAMHS are … they are the secret services that speak their own language. They keep themselves very close to the medical profession, and stay away from identifying with social care when we are meant to all be working together. There is no joint working with us … there are so many children who don't meet their … thresholds and we have the same problem.'*
>
> **Social worker, in evidence to the CSJ**

'[Children] … presenting serious risk of harm to others in a variety of settings and those in contact with the [YJS], have high rates of mental health problems and learning difficulties and have traditionally not accessed core [CAMHS] …'[80]

80 Dent M et al, *Community Forensic Child and Adolescent Mental Health Services (FCAMHS): a map of current national provision and a proposed service model for the future, Final Report for the Department of Health*, Solutions for Public Health, NHS, January 2013, p23 [accessed via: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CC4QFjAA&url=http%3A%2F%2Fwww.chimat.org.uk%2Fresource%2Fview.aspx%3FRID%3D151814&ei=vAIlU87HKOSg0QXpvIGYCQ&usg=AFQjCNEhCAzuWqAOe2dAWdZajcibogLDzA&bvm=bv.64542518,d.d2k (11.04.14)]

As raised earlier, during our review of Kids Company cases, we repeatedly found:

- A failure to produce a health assessment; and
- A lack of coordinated holistic support for the vulnerable child/young person.

4.3.1 Weak legal position[81]

A solicitor explained that we are blighted by the lack of mental health legislation, and fact that the basis of the NHS, from a legal position, has always been '*hands off*'. It appears that vulnerable children and young people are afforded little, if any, legislative assistance with respect to the mental health services that they are offered or receive. One of the difficulties regarding mental health, in terms of ensuring that vulnerable children and young people are provided with appropriate support, is the law. Statutory mental health services operate within a looser framework than social care. Statutory duties tend to be very general in their nature, and much seems to be subject to guidance, and local interpretation and negotiation. This adds to the complexity of the problem. CAMHS does not have its own statutory framework, and is shaped by government policy. Furthermore, *The National Service Framework* is practice guidance, and does not need to be followed if there are good reasons to depart from it.

Our evidence reveals that thresholds have become higher and eligibility criteria tighter in some CAMHS. There appears to be broad agreement about thresholds for access to CAMHS but they seem to differ on a local basis. We understand that national guidance does not exist with respect to the use of eligibility criteria by CAMHS, but that they may be applied on a local basis. It appears that there is also an issue regarding the 'exclusion criteria' which are being used by some CAMHS. We heard of some such services not accepting referrals for a particular service on the basis that the child or young person in question is not stable, or should receive therapeutic provision for another issue before receiving their particular service. We have been advised that there would be a number of difficulties in challenging such an approach because there are only very limited circumstances in which a health service can, in any event, be compelled to provide services, and the courts are very likely to defer to specialists in the field. This is unless it could be explained that no-one in their right mind could have excluded the child or young person from receiving the relevant service.

There is no specific provision in the NHS Act 2006 requiring the assessment of a child or young person's health care needs, although it can be argued that such a duty exists.[82] A senior CAMHS clinician pointed out that it is as important for other professionals working with a high risk child to know that they are not dealing with a case that requires mental health intervention, as it is for them to know that they are. Such knowledge can be helpful to the child and family as well as to other professionals who can then be reassured that they can proceed with their work with the child. The clinician pointed out that, in multi-agency, high risk, complex cases, the ability for a CAMHS clinician to advise colleagues from other agencies in this way necessarily requires a credible baseline assessment to have been undertaken. We were told that:

81 The legal framework relating to statutory mental health provision is set out in the legal foreword
82 For reasons explained in the legal foreword

'Often with complex cases, where there are going to be repeated questions asked about mental health needs over a period of months or years in relation to a given child, it can be very helpful to provide an initial assessment so that it is done, and all involved know that it has been done.'

A S.17 assessment can be used as a means of mobilising mental health support for children. However, we repeatedly heard, across our evidence, of cases where S.17 assessments were not conducted, in circumstances where the needs of the children were considered to warrant this. Furthermore, we have seen from various cases that even where such an assessment is undertaken, it does not necessarily lead to a vulnerable child receiving timely or appropriate support with their mental health problems, nor indeed with their social care needs. Our concerns over opportunities being missed to try to secure the necessary mental health support for vulnerable children by means of a S.17 assessment are fuelled by those raised earlier on the EHA and threshold documents.

Daniel

It appears that Daniel's anti-social behaviour and criminal activities offered up the one glimmer of hope for him receiving multi-disciplinary support. His six-month YOT Referral Order led to a referral to CAMHS, which is understood to have conducted a mental health assessment, although this was not shared with his mother (which is a concern in itself). He received four months of counselling but his mother understood that he was assessed as displaying paranoid and depressive behaviour and possibly psychosis. However, CAMHS' involvement fell away after Daniel's YOT Referral Order ended.

This clearly shows a lack of coordination between services. It is likely that the fact that there was no-one to take the lead in coordinating services once the YOT Referral Order ended, meant that the opportunity to provide Daniel with the much needed therapeutic intervention, structure and stability was lost. Therefore, although Daniel's need for support continued, his services stopped. If there was an expectation that the vulnerability that Daniel was displaying meant that he should have continued to receive support after his YOT Referral Order ended, the gap in the system caused by the loss of a lead agency, without specifying who should have taken over, would have resulted in Daniel falling within that gap.

Whilst Daniel is understood to have had a mental health assessment, he was not afforded support from social care, which potentially could have enabled him to secure further mental health support. It was never clear to Kids Company whether Daniel's social worker (based in a multi-disciplinary team within the local authority) and their line manager were actually attached to the local authority's Children's Services. The social worker undertook an assessment, which Daniel's key worker believed related to his respite placement. However, we have been advised that, even if a social worker was conducting an assessment for his respite, what else could that assessment have been, on the facts, but a S.17 assessment (assuming they were attached to Children's Services and conducting this for the local authority)? The solicitor told us '*When people start making up other assessments you know it's because they don't want to do what they know they are supposed to do.*'

In addition, there is no evidence of the social worker having made a referral to CAMHS for Daniel, or of a core assessment having been undertaken – through which further mental health support may have been mobilised for him. Furthermore, the social worker went on to make the unlawful decision that even though Daniel was homeless, fleeing from violence (gangs) and could not go back home due to family breakdown, he did not meet the criteria for S.20 and should be passed to Housing. He was

then placed in B&B accommodation – placing him at significant risk. At the time of the CSJ's review of Daniel's case, Kids Company believed that until Daniel's mental health concerns were addressed, and he was in consistent supported accommodation, there was every likelihood that he would commit further crimes.[83]

4.3.2 Lack of cooperation between statutory services

Section 10 of the CA 2004

'Section 10 … requires each local authority to make arrangements to promote cooperation between the authority, each of the authority's relevant partners and such other persons or bodies working with children in the local authority's area as the authority considers appropriate.'[84]

The arrangements are to be made with a view to improving the well-being of children in the authority's area, which includes physical and mental health and emotional well-being, protection from harm and neglect, and education, training and recreation.[85]

There is a clear recognition that health and social care should cooperate with each other, and that health bodies and local authorities must cooperate with each other.[86] Argument exists that local authorities have a clear responsibility to take the lead role in assessing and ensuring that a child's needs are met in accordance with an assessment under S.17; similarly, a CCG may act as the lead agency where a child is considered to have needs that are sufficiently severe and complex so leading to the conclusion that they are eligible for continuing health care needs. However, there is no statutory duty on the local authority or health to act as the lead agency, thereby significantly increasing the chance of a vulnerable child slipping between the gaps in the services.

A lack of cooperation and coordination between statutory services featured in a number of cases across our evidence. The solicitor told us that they do not think that the CA 2004 has helped with respect to its promotion. They explained that, in practice, there are cases where social care and health services will not cooperate, and '*will try to pass responsibility for the support of a child on to the other.*' In their view, it is down to finances. They said it is very difficult to bind health as it can take its finances into consideration.

Claire[87]

In Claire's case, the social worker effectively stepped away from the process. Social care, education, CAMHS, the police and Kids Company had all been involved in the case. The role of the local authority would have been important here with respect to the core assessment, because it would have been the lead coordinator. Without anyone taking on the role of lead coordinator in the multi-disciplinary management of Claire's needs, her chances of receiving a structured, well-coordinated and holistic

83 Daniel's case summary (Case Two) can be found on page 32

84 Children Act 2004, Section 10(1), cited in HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p11 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]. The local authority's relevant partners are stated as being listed in Table A in Appendix B of the *2013 WTSC*

85 It also includes their contribution to society, and social and economic well-being; Children Act 2004, Section 10(2)

86 Children Act 2004, Section 10; and NHS Act 2006, Section 82

87 Claire's case summary (Case One) can be found on page 30

package were dealt a serious blow. There are several references to social care claiming that it had no involvement in Claire's matter, although she was clearly vulnerable and in need/at risk of significant harm. Similarly, there are references to social care being absent at two professionals' meetings. Social care could not take on the role of lead coordinator if it would not involve itself in Claire's case.

The solicitor told us that there is a real imbalance in how a child's mental health problems are dealt with, because of a reluctance on the part of some social care teams to get involved in mental health issues. In addition, appointments were made with CAMHS and not kept. While it might be the case that Claire was reluctant to attend, it seems rational to think that given her age at that time (approximately ten), her non-attendance would have raised concerns about the role of parent/family members. This may be an indication of a lack of coordination between social care and CAMHS, because Claire's non-attendance could have resulted in a plan being put in place to try and ensure Claire's attendance.

Having been diagnosed with PTSD and depression, it is not clear what support Claire received for the PTSD. For instance, what consideration was given to the issue of PTSD when the local authority took the decision to place Claire with a relative who resided in the building in which she had initially suffered sexual abuse, as to whether this was acceptable for someone with PTSD? This may demonstrate a lack of holistic understanding of Claire's needs.

Where a child's needs are predominantly mental health orientated but they also have social care needs, we were told that it is often the case that no professional steps forward to take the lead in planning and coordinating services. This will only ever be to the detriment of the vulnerable child requiring clear, structured and consistent support, as demonstrated by several cases across our report. A vulnerable child who needs therapeutic input might be given six sessions of, for example, counselling, following which no further support may be given – the box has been ticked. A solicitor told us:

> *'What you rarely get is an agency offering someone more sessions once the allocated number has been reached even though it is clear that further therapeutic input is required.'*

Again, in parallel with social care, our research reveals that the focus of CAMHS services, in some areas, is on those with acute needs. We have heard that a particular cohort of vulnerable children is not gaining timely or appropriate care and support from some CAMHS – in particular, those with emotional and behavioural problems, and conduct disorder.[88] If we do not address this issue and ensure that their needs are met, a significant proportion can expect their lives to be filled with even greater suffering. In addition, society can expect the associated crime and financial cost that evidence indicates may ultimately result.

We shared various concerns with a senior CAMHS clinician over the impact on some social workers and VSO practitioners, for example, of being left to hold and manage vulnerable children and young people with complex and serious needs, where they do not have mental health training, and of the escalation of their needs. The clinician responded that there have been developments in service provision over recent years which have not helped the longer-term management of complex cases:

> *'… frequently now in local CAMHS teams there is pressure to open and close cases a lot, and so longitudinal perspectives on children sometimes are not maintained. In long-term*

88 As discussed in Chapter Two

complex cases where much of the management is being undertaken within social care or education, it does not appear to be within accepted current CAMHS practice that a clinician may nevertheless keep a case open to allow on-going support for other agencies, and to ensure continuity of clinical involvement.'

The clinician explained that sometimes CAMHS do not appear to realise that, even if they conclude that they cannot provide an intervention, they can still be very helpful to other agencies in thinking about the case. This could involve contributing to a supportive plan, providing guidance on interventions, and advising on what agencies the professionals should be working with.

Some vulnerable children and young people with mental health problems also have SEN.[89] We have seen from various cases during our Review, the severe impact on the children where they have also faced difficulties gaining support through the SEN statutory assessment process.

'I have been thinking recently, there might be a pattern with what is happening with all these SEN cases. Effectively, it is a very long-winded process to:

a. convince the [local] authority a child needs a statement
b. collect the reports for the above
c. ask for and implement amendments of the initial draft
d. lodge an appeal if the [local] authority does not accept certain amendments
e. find an appropriate school
f. go to a tribunal hearing

What is effectively happening is that, as time goes by, without an adequate resolution due to the above process, these kids are more likely to enter the criminal justice system, making the progress of finding a suitable school near to impossible. The outcome of such a situation is probably that, after a while, the whole thing becomes someone else's problem, if not the problem of a different department within the same local authority, that might, however, be oblivious to the events preceding. Surely, it is all done with the "public purse" in mind; however, the final bill might be equal, if not higher, to a residential therapeutic placement, for example, assuming the situation is still reversible. One would have to compare the short-term investment in these kids (with all associated benefits) versus the total, long-term cost for society. Of course, the latter could be fragmented among different government departments, and over a longer period of time, encouraging further a false economy.

It would be really interesting to find out what the outcomes of SEN services following a kid through are. Is there a correlation between how long it took for their needs to be truly recognised and the outcome?'

Witness, in evidence to the CSJ

We heard about the battles that are waged between departments in some local authorities over the provision of funding and services that are desperately needed by some vulnerable children and young people.

89 Please note that SEN and disability can include children and young people who have SLCN depending on its severity. It is possible for a child or young person to have SEN (as defined under the Education Act 1996) or a disability (as defined under the Equality Act 2010). Some children and young people may have SEN because of a medical condition or a disability; others may have SEN without a diagnosis or a disability – Contact a family, *Which children have special educational needs?* [accessed via: http://www.cafamily.org.uk/advice-and-support/sen-national-advice-service/which-children-have-special-educational-needs/ (16.04.14)]

'You get ridiculous funding disputes going on with these kind of residential placements, where they are … there to meet someone's educational needs and … to meet their social care needs, and disputes between the education bit of the same local authority and the children's services bit, and fights over who should fund that – one saying "it's not us, its education," and the other one saying "no, it's social care." It's unbelievable.'

Solicitor, in evidence to the CSJ

The Headteacher of a Special School in London told us about the experience of a senior officer who, until recently, worked in the education department of a local authority:

'When [the local authority] started applying the brakes in terms of placements, and saying no to moving kids into good independent special schools, [the senior officer's] view was that if you have really complex kids, who are massively expensive and difficult to place, they were beginning to stay at home. Then you have the next group of kids who are going to become that complex, because they aren't getting anything. Everything is going to move up a gear because the local authority can't afford to spend on that group. So you've got a larger group of complex kids totally out of the habit of coming to school … In terms of creating perfect storms, if you're also cutting funding for police and social [care] …'

A solicitor told us:

'It comes out of the education department's budget, therefore down the line it's not going to be their problem, it's going to be someone else's problem. If they've gone seven or eight years without having to provide … £20,000 pounds a year, possibly with a special school, you could be looking at £100,000 pounds a year, they've saved £800,000 pounds by not doing this for the child. If he's in the criminal justice system in the future, if he ends up killing somebody – well, it's not their problem.'

Another issue raised was the failure of an holistic approach being taken, and of a lack of CAMHS and social care input. A solicitor explained:

'They should be looking at whether CAMHS are involved, or should be involved, and getting a report from CAMHS, or an assessment from CAMHS, social [care] as well. And so rarely do you actually see a CAMHS report or social [care] support where they're involved, gathered up as part of the evidence for the statement. And for me it's such a critical part, especially if you're looking at residential placements, to make sure it is a suitable residential placement. Because invariably the local authority's education department is going to go for a local authority maintained residential placement which is far cheaper than perhaps a specialist placement that might actually be able to make a difference to the child's needs.'

Some vulnerable children and young people's needs are complex, and their lives chaotic. It is imperative that an informed and holistic understanding is gained of their needs and circumstances – with CAMHS' and social care's input. Without this, vulnerable children and young people are placed in a deeply unjust position. We were told that the new EHC plan

'*sounds great*,' but concerns were raised over the fact that, in practice, the SEN Tribunal will still not be able to make decisions about health and care.[90] The point was made as to whether the most appropriate outcome for a child or young person will necessarily be secured through a SEN Tribunal – for example, it could be a suitable holistic placement which would not be within the SEN Tribunal's remit to be able to provide. It seems that there is the potential for the situation to become more complex again – for those whose needs may not meet the criteria for an EHC plan.

Adam[91]

In Adam's case, CAMHS Consultant Psychiatrist (CCP) apologised to Kids Company for their delay in producing a report on Adam for the SEN Tribunal. They explained that having looked extensively around their services, CAMHS had very little to offer him. They added that amongst competing priorities, and dealing with constant crises, it had not been possible for them to make time to complete the report. The Kids Company lead staff member on Adam's case (staff member) responded that there had been a deterioration of the professional network around Adam closer to the time that they had been asking for professional contributions, leaving the staff member to carry the case alone. At this stage, they remained unclear on what the CCP's position on Adam's needs was, and on how they could be met. The staff member also explained that the Ed Psych report that the CCP had referred to in previous correspondence, had devoted a section on behaviour that contained a number of behaviourist strategies but failed to address Adam's trauma of physical abuse and emotional neglect. In addition, the report suggested that there would need to be a continuing involvement of other agencies, such as social care and CAMHS. The staff member also stated that Kids Company would not expect any single service to provide them with the answer – 'It is my conclusion, after working with these kids for sometime, that only the systems around them…can make a difference; my championing work is of little value without your input, and, I suspect, vice versa.' The staff member added:

> *'I think it is very honest of you to indicate that there are no services to cater for kids like [Adam], but it would appear this is not widely known. As a result, schools, social [care], educational psychologists…will continue to refer kids to services that have a different remit, placing you, I am sure, in a very difficult position; at the same time, valuable time is lost. It has been a year since [Adam's] referral to CAMHS, when, I am sure you are aware…that every day 'lost' in these kids' life [sic], is a day closer to prison, or their immature death. Although [Adam] has not been convicted of any offenses yet, his trajectory indicates that he will, and, I am sure, you will agree that prevention is much better than treatment. I think you will agree with the need to develop new structures in order to meet the needs of young people in psychological distress originating from trauma rather than a medical condition.'*

The CCP informed the staff member, a month later, that they recognised that CAMHS have a gap in services for this group of children, and that an integrated systems approach would certainly be helpful at an earlier stage, if resources could be found for this. They felt that the key hub would probably be education, with an increased focus on working with families and moving away from a culture of excluding children from school. On the same day, the staff member informed the CCP that the situation had got worse – Adam had been seen carrying a knife, and had been issued with a six month YOT Referral Order, with additional intelligence indicating that he was more involved in gang activity, amongst other things. They stated 'All of the examples…indicate that it is impossible to expect one service to contain this situation. It is also indicative that there was a window of opportunity to

90 Reforms to the special educational needs and disabilities system are being introduced by the Children and Families Act 2014. New legislative duties will take effect from September 2014

91 A snapshot of Adam's case can be found on page 210

intervene and effect change, before the young person loses confidence in us, and stops caring, as it is simply too painful; it could be that he is dead before September.' The CCP subsequently met with Adam, after which the staff member recorded that CAMHS had confirmed that they would close Adam's case, that he did not meet their threshold, and that they did not recognise a mental health problem in him from a medical point of view. The CCP was also recorded by the staff member as having told them that they recognised that Adam was at risk, but that there was nothing they could do.

The CCP provided their report approximately nine months after confirming their agreement to do so. The opinion contained within the report referred to Adam's '…increasingly high risk, conduct disordered behaviour including interpersonal violence and carrying weapons.' It stated that Adam did not present with a mental disorder – 'such as depression, anxiety, psychosis, [PTSD], ADHD or autism.' It also stated that Adam had declined further CAMHS' support – contrary to Kids Company's understanding which was that CAMHS' involvement ceased because they felt there was nothing they could offer Adam. The CCP referred to their concern over Adam's risk of violence to others escalating – 'although this appears to be driven by peer and social factors rather than a mental disorder. He has recently expressed thoughts of harming or even killing others, and is currently deemed to be at risk of becoming a victim of serious violence himself.' A list of interventions likely to reduce risk were included in the report, as well as confirmation that Adam's case had now been closed at CAMHS.

We note that Adam's specific designated school was still not finalised in his SEN statement over a year after the local authority agreed to conduct a statutory assessment of his SEN, whilst it continued to also refuse the inclusion of speech and language provision. In the former case, Kids Company has informed us that this was because an educational tribunal had to be adjourned in the absence of any therapeutic residential schools being available to accept Adam on their roll due to his increasing violence. We were also informed that, meanwhile, the local education authority was still suggesting local BESD schools, in the absence of any other statutory body (i.e. social care and CAMHS) clearly recognising the imminent need for Adam to leave London and receive education in a residential therapeutic provision.

In response to this, Camila Batmanghelidjh, CEO of Kids Company, explained to the CSJ:

> *'Conduct disorder in these children emanates from severe emotional and psychological difficulties. It is a manifestation of mental health difficulties and is recognised as such in [DSM]. The problem with conduct disorder is that it has been misinterpreted as a deficit in understanding morality, whereas it is predominantly a deficit in being able to regulate emotion, with the child having impaired mentalisation capacities, and therefore in response to stress, exhibiting defensive anti-social responses. These children exhibit structurally and functionally damaged brain activity. Therefore it is a mental health issue.'*

Time for a child is very different than time for adults, which is why children will become disaffected with a situation quickly. As demonstrated by examples in this chapter, of which there will be countless others, there can be a small window of opportunity to help vulnerable children. They need timely and effective support. However, as discussed in Chapter Two, all too often, from the cases across our evidence, this is absent. A solicitor told us that there is often a race between getting a child into a specialist residential care placement, before they enter the criminal justice system. The same solicitor also reported to us, anecdotally and based on their case law experience, that it is quite common to find that children who are suffering from undiagnosed or untreated mental health problems will self-medicate with drugs. For instance, when they state that they use amphetamines in order to calm themselves down, this immediately raises 'alarm bells.'

A senior CAMHS clinician highlighted '*a conceptual problem*' that can exist in highly complex cases, where vulnerable children are presenting with high risk behaviours:

> *'The other thing is that the interface … between therapeutic involvement and risk management is not very well understood. It seems to me that often in these highly complex cases where there are high risk behaviours going on, people tend to focus on whether there is any therapeutic provision and that's fair enough, but actually there is a spectrum … between being able to provide really meaningful, supportive, containing therapeutic provision, and ensuring good management of risk.'*

They went on to explain that if a child is in a position where they are not going to accept, or want, or be able to engage with therapeutic provision, then all agencies need to place greater emphasis on aspects of risk management ('*rather than persisting in search of "therapeutic magic*'"). This is because:

> *'the situation needs to be contained, and other people need to be protected, and the child in question needs to be protected from their own behaviours. In such cases, the best possible risk management plan then needs to be in place.'*

We were told that once such a plan is in place, and the situation is better contained, it may then be possible to start thinking about doing some therapeutic work with the child.

In addition, we heard how professionals often consider that an 'out of county' placement is needed before a clearly organised joint care-or risk-management plan is in place. The reality of such a placement for a child could, for example, involve indeterminate 'therapeutic' input, and a less concerted general approach than may have been available locally if agencies had been better coordinated. However, our witness added that sometimes, if a service is available to local agencies that is experienced in thinking about risk, risk management and the extent to which 'therapeutic' intervention is feasible, this can help with the containment of professional anxiety and enhance the possibility of local support for a child. It is likely that such a service could meaningfully be part of overall CAMHS provision but is likely to be highly specialist rather than part of locality CAMHS teams.

A senior forensic CAMHS clinician informed us that specialist local health provision for children with learning disability (LD), or neurodevelopmental difficulties such as autism, is patchy. However, due to the area in which our witness works (i.e. with high risk, high concern cases), they do not make any distinction between concerns about LD and concerns about mental health, because they feel that the tools they have are the same for whether children have either. Our witness thinks it is a group that gets neglected. They explained:

> *'They often get good support or little support in school, but when they get to 16, very frequently there is very little available for them – particularly if they are involved in a range of risky behaviours and not in a specialist placement … They are a special group who really do need thinking about, but I would suggest people think about them within the overall remit of mental health rather than separating it off – certainly at the high risk end.'*

'I had a client who I picked up because he was excluded from school for an incident that happened outside of school … which wasn't actually pursued by the police in any way but the school nevertheless excluded him. When I met him, I immediately picked up that he had a learning difficulty, and I was pretty sure that it was something along the lines of ASD. But I'm not an expert in that area; he had a diagnosis of ADHD. He had been trying to access CAMHS or an educational psychologist to access a diagnosis but the school failed to refer him, and CAMHS were refusing to do a further diagnosis unless they had an educational psychologist report. As a result of him being excluded, he went to the PRU. One of the traits of his autistic behaviour would be that he would become obsessive about certain things, and could be easily influenced by certain people. He met somebody who was involved in criminal activity … [and] started imitating his behaviours. In the space of a month, he racked up multiple criminal charges. In the course of one of those proceedings, his solicitors raised fitness to plead concerns. An expert report obtained by solicitors confirmed that he did have ASD. It was only because of that, that we managed to get confirmation of the ASD, and at that point we requested a statutory assessment of his needs as well. Even with the report saying he had ASD, the local authority refused to do a statutory assessment, so we also had to challenge that at the Tribunal. The local authority strongly contested the appeal. Only at the Tribunal hearing did we manage to get an Order saying that he needed a statutory assessment. Now he's got a statement, he's got 20 hours of support, and he's in school, and he's not offending and he's doing fine.'

Solicitor, in evidence to the CSJ

With respect to the needs of children with LD in youth justice settings, a senior forensic CAMHS psychiatrist commented that LD is an issue that is so often unrecognised – and by that they mean global learning difficulty with clearly impaired IQ levels.[92] The issues of fitness to be interviewed, fitness to appear, fitness to understand what is going on in court, and fitness to plead, are frequently not adequately considered or recognised within the pre-court and court processes. This can then result in these children ending up in custody, or receiving community sentences with which they may not be able to comply. We were informed that these children, and indeed those with other significant neurodevelopmental disorders, need to be thought of as a special group with special needs – whose suitability for diversion from the Youth Justice System (YJS) should be a paramount professional priority.

A senior CAMHS clinician raised an issue regarding the provision of information to the youth justice or family law systems:

'A major difficulty for the courts stems from the fact that many children's local CAMHS services are not commissioned to provide court reports or advice to the youth justice or family law systems. This means that frequently, if court reports or advice on mental health matters are sought by the courts, a clinician who is not linked with the local services is engaged who frequently has no knowledge of local services available for the child, and who has no obligatory mandate to ensure that, if mental health difficulties are identified, appropriate intervention is arranged.'

92 Our witness confirmed that neuro-developmental difficulty covers the group to which they are referring – e.g. those with LD, ASD or acquired brain injury

The clinician pointed out that this was an issue previously identified within the Bradley Report, which they stated has continued not to be adequately addressed.[93]

We were told that YOT are an '*opportunity*' for a child to gain access to support that they might not otherwise be given by social care or CAMHS. *Rules of Engagement: Changing the heart of youth justice* stated that:

> *'An overwhelming number of YOTs reported to the CSJ that they constantly struggle to access support from [Children's Services] for the children under their supervision – both for those at risk and those already in the [YJS]. We were informed of a number of examples where YOTs are exclusively addressing the welfare needs of children.'*[94]

It is abhorrent, and another serious indictment on our society, that some vulnerable children's needs are being left unaddressed to the point where one of the only remaining options for them to gain support is once they have become at risk of or involved in offending behaviour. The CSJ has contested that YOTs were not designed for the purpose of exclusively addressing the problems of children at risk or offenders, and has made recommendations to rectify this, and help ensure that 'prevention is understood as a multi-agency responsibility.'[95]

Good Practice Example: The Thames Valley Forensic CAMHS Team (FCAMHS Team)

Established in 2004, the FCAMHS Team functions as part of CAMHS but is commissioned on a regional, as opposed to a local basis, due to its level of specialism, having initially received development funding from the Department of Health. The service covers the Thames Valley area (Oxfordshire, Buckinghamshire, Berkshire and Milton Keynes), which has a total population of 2.5 million, and includes nine local authorities.

The FCAMHS Team is small, experienced and multidisciplinary. It provides specialist child and adolescent mental health expertise on several levels and in all environments, for professionals working with high risk children. It has experience across the board – including with education, social care, YOT, solicitors, courts and prisons. The FCAMHS Team understands social care and youth justice legislation and practice, and their interface with relevant mental health legislation.

93 Department of Health, *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, April 2009 [accessed via: http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf (30.04.14)]. The Centre for Mental Health established a new independent Commission to conduct a five year review of the Bradley Report, to review progress made in achieving the recommendations made by it. The Commission will publish its final report in 2014. Further details can be found at: http://www.centreformentalhealth.org.uk/criminal_justice/bradley_commission.aspx

94 Centre for Social Justice, *Rules of engagement: Changing the heart of youth justice*, London: Centre for Social Justice, 2012, p39. The report referred to the high thresholds adopted by social care – with 'only the most acute cases' being referred for support, and delays to core assessments (pre the *2013 WTSC*) where thresholds were met – as featured in Matrix Evidence, *A Review of YOTs and Children's Services' Interaction with Young Offenders and Young People at Risk of Offending*, London: Youth Justice Board, 2010, p42

95 Centre for Social Justice, *Rules of engagement: Changing the heart of youth justice*, London: Centre for Social Justice, 2012, pp13–14, and pp50–52

The FCAMHS Team spreads its net wide at the point of referral, with a very broad initial description of who can contact its service. Professionals can call for advice on cases 'as opposed to having to fill out long referral forms.' The FCAMHS Team stipulates that professionals simply need to have concerns that a child may have a mental health disorder or learning difficulty problems, as opposed to them needing to have a proven history in either case. In addition, the child must present a high risk of harm to others, and/or be in contact with the YJS. The children supported by the FCAMHS Team are 'often those who fall through the net of statutory services – because they do not attend routine services; in addition professionals tend to focus on their behaviours as opposed to their mental health profiles or learning difficulties.'

The FCAMHS Team is not just a directive service; it also provides professional support in the context of its general functions. It offers, for example, advice, formal consultation, and specialist assessments and interventions in identified complex cases – 'so that we ensure we're really seeing the cases we need to see, and that other professionals get appropriate advice and support on the cases that we don't need to see. The last thing one needs is multiple assessments on a lot of these cases, and professional networks involving multiple individuals and several agencies, none of which are taking a clear lead in case management. On the other hand, it is crucial that the highest risk, most complex cases are seen by those specifically trained in assessment and intervention.'

One of the FCAMHS Team's specific functions includes liaising with locality specialist CAMHS and YOTs, to ensure that YOTs are not isolated from CAMHS services. It has helped CAMHS services across its region to develop CAMHS/Youth Offending Service (YOS) linkworker roles, and maintains close links with those undertaking such roles which are usually managed by local CAMHS teams. The FCAMHS Team trains CAMHS/YOS link workers in structured risk assessment and supports them in quarterly network meetings so that if, in the interim, they come across a particularly concerning case and are unsure what to do about it, they have access to specialist advice and, if necessary, direct clinical support.

Another of the FCAMHS Team's specific functions includes the development of related services where the team identifies gaps in existing provision. Within this context the Team has been involved in developing a service for children with sexually harmful behaviour (jointly commissioned with local authorities in Oxfordshire and Buckinghamshire), and more recently a police/youth justice point of contact liaison and diversion service for children (commissioned by NHS England (health and justice)).[96]

An evaluation of the FCAMHS Team considered the impact of its loss – 'Respondents highlighted the loss of important clinical advice in relation to the management of complex cases, the loss of in [sic] important co-ordinating service, and the likelihood of resultant gaps in service provision and the increased potential for vulnerable [children] to fall through the gaps in services.'[97] The successful evaluation led to the establishment of the FCAMHS Team's regional specialist commissioning funding, and to securing funding for a pilot service replication for Hampshire and the Isle of Wight (HIoW).[98, 99]

'Mental health provision for [children] about whom there are mental health concerns, who present a high risk of harm to others and/or are in contact with the [YJS] is heterogeneous and patchy in terms of existing national provision. A small number of areas benefit from

96 CAHBS operates across Oxfordshire and Buckinghamshire, and offers consultation, advice and clinical assessment/intervention where there are professional or family concerns about a child's sexualised behaviours. CAHBS sits within the FCAMHS Team but operates solely on the basis of referrals received in relation to concerns about sexually harmful behaviour, as opposed to mental health concerns. A recent Department of Health funded external evaluation of the CAHBS service has recently been completed: http://www.sph.nhs.uk/what-we-do/resources/shp-viewpoint/SPH_CAHBS%20Evaluation%20Report_final_4.11.13.pdf

specialist community FCAMHS provision whilst many others do not. There is now a clear body of evidence relating to validated service models and functions for community FCAMHS.' [100,101]

It strikes us that in numerous cases across our evidence, local CAMHS and a whole host of other professionals across the relevant agencies, as well as vulnerable children and their families, could have benefited enormously from the specialist and authoritative support provided by a community FCAMH team, such as that profiled above. We believe that they could perform a pivotal role in helping to address a series of concerns highlighted throughout our report concerning the provision of statutory mental health services for vulnerable children, including – crucially – with respect to early intervention. However, a Department of Health national mapping exercise has found that:

'… commissioning arrangements for community-based FCAMH services vary considerably across the country. [Their] development … has been largely ad hoc and different parts of the country have … varying levels and types of provision.'[102]

The changes in commissioning structures in England are considered 'to offer an opportunity to ensure more equitable commissioning of FCAMH services.'[103]

A recommendation has been made for the gaps in provision to be addressed:

'… to ensure that children … with complex forensic mental health needs have access to appropriate community based services, in addition to the existing network of medium secure in-patient units, local tier 3 CAMHS and other therapeutic services. There should be agreed national minimum standards for community FCAMH services and a standard commissioning framework to provide a level of national consistency in provision.'[104]

97 Public Health Resource Unit, NHS, *The Provision of Forensic Child and Adolescent Mental Health Services in the Thames Valley*, October 2006, p16 [accessed via:http://www.sph.nhs.uk/what-we-do/resources/sph-viewpoint/the-provision-of-fcamhs-in-thames-valley/?searchterm=Public%20Health%20Resource%20Unit,%20NHS,%20The%20Provision%20of%20Forensic%20Child%20and%20-Adolescent%20Mental%20Health%20Services%20in%20the%20Thames%20Valley,%20October%202006 (11.04.14)]

98 Solutions for Public Health, NHS, *Evaluation of a Pilot Community Forensic Child and Adolescent Mental Health Service (FCAMHS) for Hampshire and the Isle of Wight (HIoW)*, p2 [accessed via: http://www.sph.nhs.uk/what-we-do/resources/sph-viewpoint/evaluation-of-a-forensic-camhs-service/?searchterm=Public%20Health%20Resource%20Unit,%20NHS,%20The%20Provision%20of%20Forensic%20Child%20and%20Adolescent%20Mental%20Health%20Services%20in%20the%20Thames%20Valley,%20October%202006 (11.04.14)]

99 The pilot ran from April 2010 to March 2012 and was funded by the Department of Health. An evaluation of the pilot found that '… the [HIoW] FCAMH service was generally highly valued … [and] valued as a source of expertise and advice for the management of complex presentations that could be considered as high risk by the locality CAMHS and YOT teams. The additional insight that the [HIoW] FCAMH team could provide around risk assessments and … the management of children … with sexually harmful behaviours was also particularly valued. The [HIoW] FCAMH team's ability to signpost to other services and arrange for other types of specialist assessments was also valued by a number of interviewees; ibid, p3

100 Dent M et al, *Community Forensic Child and Adolescent Mental Health Services (FCAMHS): a map of current national provision and a proposed service model for the future, Final Report for the Department of Health*, Solutions for Public Health, NHS, January 2013, p4 [accessed via: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CC4QFjAA&url=http%3A%2F%2Fwww.chimat.org.uk%2Fresource%2Fview.aspx%3FRID%3D151814&ei=vAIlU87HKOSg0QXpvIGYCQ&usg=AFQjCNEhCAzuWqAOe2dAWdZajcibogLDzA&bvm=bv.64542518,d.d2k (11.04.14)]

101 Indeed, external evaluations funded by the Department of Health, of the Thames Valley FCAMHS and HIoW FCAMH service (as referenced above), resulted in 'recurrent regional specialist commissioning for both;' ibid, p5

102 Ibid

103 Ibid, p22

104 Ibid, p4

The Department of Health determined to provide 'a recommended set of functions and service standards to inform the commissioning of comprehensive and high quality community FCAMH services.[105] Currently, NHS England, via its relevant clinical advisory groups, is deliberating the need to consider such specialist services as part of a specialist pathway for children with high risk behaviours about whom there are mental health concerns.

4.4 Conclusion

> *'… we only really know what's going on in those areas where there are solicitors who are actively involved in children's cases. So God only knows what's going on in areas where there isn't access to legal support that are bringing these cases forward. And the areas we do know about, like [specified local authorities in London], it's absolutely horrendous. It's like war. The children's services routinely see their role as stopping services being provided for children.'*
>
> **Barrister, in evidence to the CSJ**

> *'They're just lost. There are so many gaps in the system a kid can fall down. There are lots and lots, at lots of different points. We're supposed to have lots of systems in place but, again, if the social worker is in the lead and … is anti the child so to speak, everyone can just follow suit and just say "I don't have a leg to stand on, the local authority doesn't agree with [it]." Again, we're put in this position of being a power person. We've got power but again, we're just people, just playing along …'*[106]
>
> **Social worker, in evidence to the CSJ**

This chapter further exposes the inexcusable and profound injustice that many vulnerable children and young people are enduring at the hands of some statutory services. It also illustrates further, the extent of challenge faced by some VSOs at the interface. Unlawful practices on the part of some local authorities – including, for example, placing vulnerable older children in B&B accommodation, can place them at greater risk and distress, and present a VSO that is trying to support them with even greater issues to contend with.

Furthermore, our research reveals the disturbing lack of accountability on the part of social care and mental health services. Some VSOs, which can provide vulnerable children and young people with their only place of sanctuary, are expending precious resources – holding social care services to account, and helping to obtain the care, protection and/or support that some should have been entitled, by law, to receive from the outset. What is even more unjust is the fact that some VSOs are compelled to do so having met barriers themselves to sharing valuable information and insight with social care. As demonstrated by our analysis of local authority duties towards VSOs in the context of conducting assessments, the membership of core group meetings and attendance at CPCs, VSOs are in a weak position

105 Ibid, p5

106 Our witness added that '*The social worker does not always have the answer and relies on those in the network to help in the decision making process. However, some social workers find it difficult to say "I don't know*'"

in being able to exercise their influence.[107] In addition, we heard from a Senior Manager in a Children's Services Department that '*It is quite tricky for local authorities to hold CAMHS to account.*' Given the challenges that some VSOs and vulnerable children and young people have in holding local authorities to account, what hope do they have of holding CAMHS to account?

A solicitor provided an example of a JR case against a local authority, in which they obtained an injunction. The Director of Children's Services knew the CEO of the organisation providing advocacy for the child, and contacted them to remind them that they had a contract to provide advocacy for the local authority's looked after children, which would be in jeopardy if there were any further JRs, or legal actions or referrals. The solicitor added:

> *'That's just the tip of the anecdotal evidence I can give you. I've had YOT officers on the phone in tears, because they have referred a case of a child who needed support. The Director of Children Services came down and said "I will discipline any member of staff who has referred that child to the [VSO] or to lawyers …"'*

Legal challenge brought against local authorities is also incurring potentially vast costs to the public purse, as illustrated by solicitors who commented that they know of those that have incurred legal bills in excess of £1M, with some being known to have numerous costs orders against them after they have resisted JRs – either up to or until just before the final hearing. Our witnesses discussed that it would be very interesting to submit Freedom of Information requests, specifying the category of cases, to find out what local authorities are paying out in costs orders, as well as what the local authorities pay their own solicitors and the barristers they instruct.

The lack of knowledge and correct application of the law by some social workers, as well as those in more senior positions, and even some local authority lawyers, is of extreme concern. Rather than address the difficulties faced by some vulnerable children, it can intensify and prolong them. This is contrary to preventative action and an early intervention approach, which may have avoided the need for children to be removed from their homes, or them reaching the child protection threshold. Our concerns about the needs of vulnerable children being promptly and appropriately met are heightened by the fact that aspects of the *2013 WTSC* are considered likely to increase inconsistency, confusion, delay and potentially unlawful practice.[108]

Our evidence powerfully demonstrates the critical role that some legal professionals are also performing in holding some local authorities to account. We share the grave concerns expressed by many people across society over the Government's changes to JR, and their implications for vulnerable children and young people gaining access to justice. We believe that the potential impact on them of specialist legal firms ceasing to exist (as feared) could be devastating.

107 The analysis can be found at Appendix 6
108 Particularly in the context of early help and threshold documents

In light of the unscrupulous and illegal practices which have come to light on the part of some local authorities during our Review, we question what is happening for many vulnerable children and young people, for whom no VSO and/or legal support is available in their community.

We do not believe that legislation is the only answer to finding solutions to the existing challenges presenting to vulnerable children and young people. However, the weak law that exists regarding mental health may well help to explain, in part, why many vulnerable children and young people with mental health problems are being failed to the extent indicated by our Review. Although there are clearly serious problems with some local authorities failing to comply with the law, at least when legal professionals are involved, it appears that positive outcomes are secured for vulnerable children and young people more often than not.

We have repeatedly seen how the pre-existing difficulties of some can be compounded by the lack of cooperation between some statutory services, and lack of coordinated holistic and structured support. Some of those with both social care needs, and mental health problems, are being catastrophically failed by services in both systems. In these circumstances vulnerable children and young people can fall through the gaps created by those services, lose hope and relinquish the fight for support from them. Daniel's and Adam's cases provide powerful examples of the extent to which some vulnerable children are being failed, and the challenges a VSO can face in trying to contain and support them – particularly, we have noted, where they are exposed to street gang violence.[109] In a number of the Kids Company cases we reviewed, we were braced to ultimately discover that some of the vulnerable children and young people had died or been killed. Had it not been for the support provided by Kids Company, we believe this may well have been their tragic fate.

Child X

Child X had spent time on the streets from when they were a young child. Concerns began to surface over the injuries they first presented with at primary school, and their suspected street gang involvement. Kids Company consistently strove for Child X to receive appropriate support – including at their primary and secondary school and PRU, and from social care. Although glimpses of partnership working featured in this extremely complex case, the potential for securing positive outcomes for Child X appears to have been constantly frustrated by (amongst other issues) the relevant agencies failing to work collaboratively, by one local authority seemingly passing the buck to another – and then another – with respect to the family, and of Child X and their primary carer failing to engage with CAMHS. In the meantime, Child X became exposed to continued risk of significant harm, and concerns over their safety and welfare escalated. The missed opportunities in this case were staggering. With chilling predictability, Kids Company forewarned social care that Child X was 'at very high risk of being stabbed or shot, or very badly wounded.' Within six days, and when Child X was in their early teens, they were indeed stabbed – something they went on to experience on several separate occasions. They then attended a secure unit for a period, having been charged with possession of Class A drugs.

109 Daniel's case summary (Case Two) can be found on page 32, and a snap shot of Adam's case can be found on page 210

A solicitor told us that, with respect to those with complex needs:

> *'If their needs do not fit neatly into boxes, or are not very cheap to deal with, social care will often avoid or be resistant to putting in place vital support.'*

They referred to having had a number of cases where it has been a race against time to obtain a S.17 assessment of a child's needs, rather than them entering the criminal justice system.

We were also informed that mental health legal cases are '*few and far between*' – and that this is an area that does not get opened up.[110] They believe that this is because '*practitioners steer them away*,' due to diagnosis difficulties, and because of the lack of specific enforceable legal duties that are in place for children and young people with mental health needs. However, they felt that there were questions to ask as to why this is the case. The solicitor has asked a barrister specialising in mental health over the last ten to 15 years whether they receive cases brought in relation to vulnerable children and young people with mental health problems in the community. The answer was '*very rarely*.' The solicitor thinks that this is not because those cases do not exist, '*but they can be more easily hidden*.' The consequence of this lack of support reveals itself in the very high proportion of children and young people with mental health problems who can be found in the criminal justice system. We hope that this report will help to shine a light on this issue.

> *'… in the system, at some point, somebody has to step in and take responsibility – whether it's health, social care, or the criminal justice system. It shouldn't be the criminal justice system. It shouldn't be that the criminal justice system is having to compensate for the fact that we have let children down in care, for instance. But it is.'*
>
> **CEO, VSO, in evidence to the CSJ**

It is arguable that because Daniel came to the attention of the authorities through his involvement with the criminal justice system, he was viewed as someone whose own challenging behaviour had brought him in conflict with the law, rather than a vulnerable child whose difficult upbringing and mental health concerns had resulted in him coming within the criminal justice system and meant that he was in need of support. The UNCRC expressed its concern at the intolerance and inappropriate characterisation of children within society, in its concluding observations to the UK's third and fourth periodic report.[111]

110 This is notwithstanding the fact that complaints can be made about the services received from NHS bodies, or JR proceedings brought, as explained in the legal foreword

111 CRC/C/GBR/CO/4, 20 October 2008

'A summary of the major health issues for [children and] young people in contact with the [YJS] …' [112]

- *Over three quarters*
  - *have a history of temporary or permanent school exclusion (custody)*
  - *have serious difficulties with literacy and numeracy (custody)*
- *Over half*
  - *have difficulties with speech, language and communications (custody)*
  - *have problems with peer and family relationships (community & custody)*
  - *of [those] who commit an offence have been a victim of crime – twice the rate for non-offenders*
- *Over a third*
  - *have a diagnosed mental health disorder (custody)*
  - *of those accessing substance misuse services are from the YJS (community and custody)*
  - *have been looked after (custody)*
  - *have experienced homelessness (custody)*
- *Over a quarter*
  - *of young men in custody (and a third of young women) report a long-standing physical complaint*
  - *have a [LD] (community and custody)*
- *A high proportion*
  - *of children from black and minority ethnic (BME) groups, compared with others, have [PTSD] (community and custody)*
  - *have experienced bereavement and loss through death and family breakdown (community and custody)'*

The CSJ has previously identified that the YJS is 'operating as a dumping ground,' and 'sweeping up the problem cases that other services have failed, or been unable, to address.' Its report, *Rules of Engagement: Changing the heart of youth justice*, revealed that the YJS often failed to provide an holistic, family-based approach to youth offending.[113] The CSJ considers that the establishment of a connection between the youth court and the family proceedings court is essential for the prevention of youth crime, and made recommendations in this respect.[114] These could offer many vulnerable children, some of whom – as exposed by this report – are likely to have already been failed by social care and/or statutory mental health

112 Department of Health, *Healthy Children, Safer Communities – A strategy to promote the health and well-being of children and young people in contact with the youth justice system*, Department of Health, 2009; with an update on the evidence of needs provided in 2012, in Ryan M, and Tunnard J, *Evidence about the health and well-being needs of children and young people in contact with the youth justice system*, Department of Health, London, 2012 – both cited in Dent M et al, *Community Forensic Child and Adolescent Mental Health Services (FCAMHS): a map of current national provision and a proposed service model for the future, Final Report for the Department of Health*, Solutions for Public Health, NHS, January 2013, pp6–7 [accessed via: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CC4QFjAA&url=http%3A%2F%2Fwww.chimat.org.uk%2Fresource%2Fview.aspx%3FRID%3D151814&ei=vAIlU87HKOSg0QXpvIGYCQ&usg=AFQjCNEhCAzuWqAOe2dAWdZajcibogLDzA&bvm=bv.64542518,d.d2k (11.04.14)]

113 Centre for Social Justice, *Rules of engagement: Changing the heart of youth justice*, London: Centre for Social Justice, 2012, pp 11-13. We note that a Parliamentary Inquiry was launched on 23 September 2013, into the operation and effectiveness of the YJS, chaired by Lord Carlile, which is due to report in June 2014

114 Ibid, p212

services (amongst others), a critical opportunity to secure desperately needed and long overdue support.

A witness from one VSO highlighted the appalling individual and societal cost of mental health services failing to appropriately address mental health problems:

> *'A lot of it … anecdotally … will get picked up by the criminal justice system … we see it. What will happen is the young person will leave, after say 12 weeks with us, and they will just … languish, particularly if they are between 18 and 25. There will be nobody willing to want to pick them up, and this is true even in [AMHS]. We've had 18- and 19-year-olds who … we have been extremely concerned … concerned [about as being] an imminent suicide risk, and we have referred them to the crisis teams in [AMHS] who have literally … referred them to a CBT course … there is just this batting away of responsibility for some of these really vulnerable people. And of course, they don't go to that referral, and then what happens to them? They either show up in some other part of the system, or another department and … it's not even cost effective, which is the ironic thing. It's the most expensive way to treat people.'*

Far from caring for, protecting and/or supporting vulnerable children and young people, our evidence clearly demonstrates that the treatment many receive from some social care services completely undermines the spirit and intention of the CA 1989 (amongst other legislation), and in some cases, contravenes it. We also recall the general duties on the Secretary of State for Health, under the NHS Act 2006, to provide health care for individuals.[115] We question where that leaves, for example, many vulnerable children with conduct disorder, in light of our evidence. What will be done to address that apparent gap in some CAMHS services? Furthermore, on the basis of our findings, we cannot see how any legitimate argument could be made that the aspiration of Standard 9 of *The National Service Framework* has been realised.[116] In addition, evidence contained within our report demonstrates that England is failing to comply with the requirements of Article 19 of the UNCRC.[117]

115 National Health Service Act 2006, Section 1(1) and 3, as referred to in the legal foreword

116 Again, as referred to in the legal foreword

117 In terms of mental health provision in the UNCRC, the relevant Article is Article 23. We have been advised that Article 23 is to be achieved in accordance with available resources. The position is unclear to us in terms of England's compliance with it

Main conclusion

'Alarm bells? They weren't alarm bells; they were like St Paul's Cathedral in your front room.'

Chris Callender, solicitor, in evidence to the CSJ

'… It's … like constantly fighting fires without investing in safe environments and smoke alarms.'

Public Health Manager, BSMHFT, in evidence to the CSJ[1]

'We have all these conflicting needs, and part of the problem is no-one really puts the kids at the centre of the debate. Who advocates for a seven-year-old who needs to go into care? We've got some kids here who are six or seven, who have had ten different foster placements … Why is it we can't put the child at the centre of that decision making? It's because we don't have a joined up framework, although you'll find examples of good multi-working practice. We actually need to perpetuate our own resources but we don't have a shared understanding … We haven't developed a framework that says let's put children at the forefront of all the decision-making and strip out the vested interest.'

John d'Abbro OBE, Head of the New Rush Hall School, in evidence to the CSJ

The case summaries and snapshots contained within this report provide a mere glimpse into the devastating experiences endured by many vulnerable children and young people. Some have lost their childhoods and are courageously surviving experiences which are full of pain and horror.

Examples of the type of maltreatment that some of these children and young people have suffered – without receiving adequate support from social care are as follows:

- A seven-year-old boy feeling forced by his mother to steal milk for his baby sibling, and abandoned by social care following his arrest – left to live with his mother (addicted to crack cocaine) for a decade in conditions of extreme neglect, and in a chronically chaotic and violent environment, while his younger siblings continue to live with her to date. He developed anger and substance misuse (cannabis) difficulties.

1 It should be noted that the views expressed by the Public Health Manager, BSMHFT throughout this report are their individual views, and may not represent those of BSMHFT

'Dad used to fight with [my mum's partner] a lot. My mum used to hit dad all the time, with severe blows. She stabbed him, put a cup in his face, dashed him in the skull with rollerblades. But daddy was an angel. He never used to…hit my mum back…It was very bad because I used to go to school and when I came back I always used to see blood – on the wall or on my dad's face.'

- A teenage girl, sexually abused from when she was a young child – left to experience serious physical, emotional and sexual abuse over years, and for periods living with her father who introduced her to each of the men who sexually abused her; she self-harmed, made a number of suicide attempts, and was hospitalised in an Adolescent Psychiatric Unit – before finally being placed in care at the age of 14.

  'I want to be a little girl. I did not have the chance as I had to grow up and look after myself…'

- A six-year-old boy, found by Camila in his underpants in the snow – left living with his mother (addicted to crack cocaine), losing his father to an alcohol overdose at the age of eight, suffering severe neglect – without food, with rotting teeth, and surviving off the food and shelter provided by neighbours; he witnessed a violent incident in his home between drug dealers, before being rendered homeless at the age of 17 after his mother reportedly set fire to the home.[2] Now, at 23, he is recognised as having developed OCD, high levels of anxiety and delayed emotional development.

  'There was no fun in my childhood. To be honest, there was no childhood…I literally feel like I was born an adult, just…smaller.'

- A young girl – severely neglected and physically abused by her mother, repeatedly seen with her siblings searching for food in rubbish bins, raped in her early teens by a man in her community, and encouraged by her mother to find money to help feed her mother's drug addiction – *'even if she had to sell herself'* – until finally being placed in care at the age of 14, after repeatedly attempting suicide.

Our evidence paints a scandalous picture in terms of the lack of care and support and, in some cases, protection that many receive from statutory services. Countless numbers of abused, neglected, despairing, and traumatised children and young people are being spectacularly failed by some statutory services. Some are being abandoned to the problems they face. Encouraging and best practice examples do exist. However, they appear to be somewhat of an exception to the rule. Our report demonstrates that child protection systems and statutory mental health services in some parts of England are a far cry from being child/young person-centred. They are, in fact, in crisis and not fit for purpose. Many vulnerable children and young people are experiencing a profound injustice as a result.

Worse still, we appear to have a bigger child protection problem, and greater prevalence of mental health problems in children and young people, than the available statistics indicate.

2 He disclosed that his mother set fire to the home

> *'[We] find an incidence rate for child abuse and neglect that is about 10 times as high as the incidence rate for all forms of cancer … [T]here is a multi-billion-dollar research base reliably renewed on an annual basis for cancer treatment and prevention. Nothing remotely similar to this exists for child abuse and neglect.'*[3]

There is an absence of comprehensive and up-to-date data, and many unknowns in terms of the risk factors to which children are being exposed.[4] This is in circumstances where some social care and statutory mental health services are already overwhelmed. Put simply, we are blind to the extent of challenge that we face as a society.

> *'Too often social workers told us about how they endeavour to practise effectively despite, not because, of the system in which they operate.'*
>
> **APPG on Social Work, 2013, *Inquiry into the State of Social Work report*[5]**

The valiant efforts, commitment and perseverance of the vast majority of professionals, day in, day out, across the social care and statutory mental health sectors, are remarkable. They are desperately trying to deliver a quality service to our vulnerable children and young people, under intense pressure, in some areas. However, our research has uncovered multiple and, in some cases, persistent challenges to effective frontline child protection practice in some areas. We have also found that many vulnerable children and young people with mental health problems continue to face significant barriers in accessing, engaging with and obtaining appropriate care and support from primary and secondary care services. Several parallel issues have emerged from our evidence between frontline child protection practice and statutory mental health provision – presenting a 'double whammy' of challenges to some vulnerable children and young people whose needs require support from both. It is clear that the budget cuts are presenting additional challenges in some parts of England, which are inevitably having an adverse knock on effect on vulnerable children and young people. However, our evidence shows that the financial pressures constitute part of the lens through which the immense difficulties in various areas need to be viewed and understood.

Issues of concern exist regarding the early identification of social care needs (for example, neglect and those who are most vulnerable – where they are not one and the same), and mental health needs. Critical opportunities to intervene early and stem the tide of acute cases are being missed. Early intervention – the subject of much bold and ambitious rhetoric – is lacking and in dire need of prioritisation and investment in some areas of the country. Where such services do exist, some are experiencing serious pressures as a result of cases being pushed down from statutory services. This can impact on the extent to which they are able

3 Putnam F, *Why is it so difficult for the epidemic of child abuse to be taken seriously?*, Handout: The Costs and Consequences of Child Abuse; cited on The Leadership Council, *The Economic Cost of Child Abuse To Society* [accessed via: http://www.leadershipcouncil.org/1/res/costs.html (01.05.2014)]

4 Jütte et al, *How Safe Are Our Children? 2014*, March 2014, p14 [accessed via: www.nspcc.org.uk/howsafe (24.04.14)], and Action for Children, *Child Neglect: The Scandal That Never Breaks*, March 2014, p7 and p22 [accessed via: http://www.actionforchildren.org.uk/media/8678791/child-neglect-the-scandal-that-never-breaks.pdf (07.05.14)]

5 All Party Parliamentary Group on Social Work, *Inquiry into the State of Social Work report*, The British Association of Social Workers on behalf of the All Party Parliamentary Group on Social Work, 3 December 2013, p7 [accessed via: http://www.basw.co.uk/appg/ (11.01.14)]

to provide sufficient help to those who genuinely require early intervention. Anxiety levels are running high amongst staff in some such services, due to their lack of appropriate skills, training or experience to address the needs of the vulnerable children and young people they are left holding. Nor are they being given adequate support. The fact that many professionals – including social workers – are feeling powerless to intervene in suspected cases of neglect is an absolute disgrace. So too is the fact that a lack of intervention and support continues to exist for many children and young people with emerging mental health problems.

Gatekeeping and higher thresholds in some areas mean that some vulnerable children and young people are not gaining access to the care, protection and/or support that they are considered eligible to receive from social care and/or CAMHS. We have been stunned by the severity and complexity of need on the part of some of those who have not been able to secure support. We have heard about resource as opposed to needs led support, and resource-led diagnosis – with some social care teams and CAMHS services operating a crisis response, and a focus on acute needs. A toxic mix of higher thresholds and lack of other resources (for example, provided by VSOs) in some areas, is also presenting a serious challenge to some GPs, schools, and VSOs – as well as social workers and clinicians, where support cannot be accessed from the other's service. Some are being left to hold children and young people with serious and complex needs, and with high risk levels and vulnerability.

Even where vulnerable children and young people do gain access to statutory services, some are not receiving timely or appropriate care and support to meet their needs. Some are not being provided with adequate protection. Our evidence has revealed multiple challenges to some social workers and medical practitioners developing an informed understanding of vulnerable children and young people's circumstances and needs. Although there have been some positive developments following the Munro Review, some social care teams are still struggling to break free from the old model, and process-, incident-driven culture. A powerful way to achieve positive transformation in the lives of vulnerable children and young people is through relationship. However, bureaucracy and prescription continue to win over the importance of relationship in frontline child protection practice in some local authorities. Traditional practice models can result in some vulnerable children and young people with mental health problems (also) experiencing a lack of continuity of care and consistency of relationship in primary and/or secondary care services.

Various issues of concern have emerged with respect to the approach of some statutory professionals towards vulnerable parents, children and young people, which can compound their pre-existing barriers to engagement, and the ability of statutory professionals to get to the root of their difficulties. Of particular concern is the ease with which vulnerable voices can be silenced by, for example, being recorded as 'has shown no insight,' 'did not engage,' or 'did not attend,' where this may not in fact present a fair or accurate reflection of the reality. We question how many are losing out on much needed support as a result.

> *'… it's important to stress that the frontline social worker is simply a cog in a machine that is very badly resourced, and continues to have to excessively audit its work to meet Ofsted's demands.'*
>
> **Witness, in evidence to the CSJ**

With many social workers weighed down by excessive caseloads and bureaucracy, their capacity to carry out direct work is restricted. Many CAMHS clinicians are also struggling under the strain of high caseloads, which is impacting on the quality of care they are able to offer. A lack of preventative work is being undertaken in some social care and CAMHS services. Children in need services are not sufficiently resourced in some local authorities. The pressures faced by some CAMHS services can mean long waiting lists – particularly, it seems, for children with behavioural problems. Certain cohorts of vulnerable children and young people are being particularly failed.[6] Some are being exposed to continuing or greater risk, distress and/or harm. The lessons captured in Every Child Matters are in danger of being forgotten as more of a focus is being placed in some areas on short-term as opposed to longer-term and holistic interventions, where the latter may be required to secure the most effective outcomes for vulnerable children and young people. This is contrary to the importance placed on treatment being tailored to meet individual needs.

During our Review a lack of confidence, skills, training and support of social workers has surfaced repeatedly. Given the extent to which attachment problems are experienced by vulnerable children and young people, it is surely a matter of common sense to ensure that all professionals who work with vulnerable children and young people are equipped with the requisite knowledge to better understand them, and to inform their approach to working with them. Professionals also need the requisite skills and support to identify, understand and address the harrowing and severe challenges that they can face.[7] In addition, as one witness described, there are the 'complex new social issues.' So too must sufficient resources be available for them to secure specialist intervention where that is required. Many social workers and CAMHS clinicians are understandably feeling demoralised given the pressures and challenges that they face. They need to feel valued, safe and supported in their roles.

It is imperative that we retain the commitment, knowledge and experience of the many high quality staff within the workforce. Furthermore, we need to ensure that the right calibre of people are being recruited to train as social workers – those who possess fundamentally important personal qualities, as well as the necessary academic capability.

> *'In my opinion, frontline staff need more training and support, and effective, flexible services available to manage and assess cases appropriately … Unfortunately families under pressure often "fail to engage," or are labeled "hard to reach" by statutory services, and then become "heartsick cases" in General Practice. In recent years I have found that many enlightened practitioners working within statutory services have decided to leave psychiatry, psychology and IAPT NHS services, in order to have the freedom to continue to work individually with patients according to their needs. They value being able to apply their professional judgement, rather than have to stick to over prescriptive guidance that needs to be tailored to fit with complex reality. All too frequently nowadays, statutory services try to pigeon hole patients to fit the guidance and negotiated pathway, and then get frustrated when patients decide it's not for them and opt out.'*
>
> **Dr Zoe Cameron, RCGP representative, in evidence to the CSJ**

6 Including, for example, in the context of social care: children in need and children at risk of or suffering street gang violence, older children and care leavers, and in the context of CAMHS: children with emotional and behavioural problems, children with conduct disorder, and children and young people who are exposed to street gang violence and those with dual diagnosis. It must be noted that the circumstances and needs of some children and young people may be such that they are considered to be within a number of the aforementioned categories

7 I.e. pastoral and therapeutic, and with their professional development

Concerns have been expressed repeatedly over how some social care and statutory mental health services are marshalling their resources – particularly with respect to early intervention, and failing to secure the best possible outcomes for vulnerable children and young people. Whilst the needs of some can develop and escalate, yet further pressures are caused within and outside of child protection and statutory mental health systems, and on the professionals within them. This is at a time when we can least afford it, and when some services are already overwhelmed.

> *'If you look at the total amount of funding per child, it is not too bad compared to the rest of the world, but how it is being used, and how accounts are being held in different services is an area of challenge. A lot of money is being used in very inefficient ways – inefficient services, inefficient managing of it, and lack of communication between various agencies. I do not believe for a moment that this country does not have the resources to look after its children … It is about how the resources are being used. That is something we have to set right, with some root and shoot changes.'*
>
> **Dr KAH Mirza, a senior CAMHS clinician and academic, working at the Maudsley NHS Trust, in evidence to the CSJ[8]**

A number of false divides that exist within and between some secondary care and social care services call into question whether the services are operating as effectively and efficiently as they should. This also raises the paramount importance of social care and statutory mental health services working in partnership and collaboratively – as well as with other agencies. Despite S.10 of the CA 2004, and a stream of recommendations – including from the 2008 CAMHS Review, reviews undertaken by Lord Laming, Professor Sir Ian Kennedy, and Professor Munro, and the *2013 WTSC* – multiple and significant barriers clearly remain to cooperation and effective partnerships across agencies in some areas.[9]

8 It should be noted that the views expressed by Dr Mirza throughout this report are his individual views, and do not represent those of South London and Maudsley NHS Trust, or any other organisation that he works for

9 *CAMHS Review – Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families and Department of Health, November 2008 [accessed via http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399 (25.04.14)]

Laming Lord, *The Protection of Children in England: A Progress Report*, London: The Stationery Office, March 2009

Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, September 2010, [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (25.04.14)]

Munro E, *The Munro Review of Child Protection: Final Report: A child-centred system*, London: Department for Education, May 2011

HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (25.04.14)]

Completing the Revolution described 'the remarkable unanimity of the findings and recommendations of the various reviews published in the last ten years, and especially among those published shortly before and since the current Government took office. For example, all of these reports stress the need for the integration of services and for a commitment to working across professional boundaries to ensure that all children get services and support tailored to their needs;' *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p106

As stated by Professor Sir Ian Kennedy, 'Sharing information is a prime example of collaborative working between organisations.'[10, 11, 12] However, our evidence has revealed numerous barriers to this in practice.[13]

> *'We do have gang specialists and YOT have intelligence – but even…working with our YOT, they don't necessarily share the information. It's like pulling teeth…They've got a wealth of information on young people, and their associations and their gang ties. But because we are on different systems, they can't access our information and we can't access theirs. It is all covered by Data Protection. They do reports, but we can't necessarily get those and they are very insightful and useful for our work. They look at us like we are dealing with the looked after children stuff, and they are dealing with the crime, but we don't always work together.'*
>
> **Social worker, in evidence to the CSJ**

> *'…other organisations know what has worked or what hasn't worked by way of interventions and what are the risks and…that impacts on all sorts of safeguarding issues that…all the services we work with are aware of. But that's where it falls down; we have lots and lots of incidents where it was because the right information about a particular risk wasn't shared or wasn't known…one organisation held it and another one didn't know.'*
>
> **Service Development Manager, BSMHFT, in evidence to the CSJ[14]**

Our report highlights the invaluable offer and support that some VSOs are providing vulnerable parents, children and young people. However, it also shows the severe challenges that some VSOs are facing at the interface with statutory services. Some are struggling to work in partnership and collaboration with social care and CAMHS services. They are experiencing multiple barriers to sharing vital information and insight, and to contributing their skills and experience in helping to care for, protect and/or support vulnerable children and young people. Vital opportunities are being lost to enhance the quality of assessments undertaken by social care and statutory mental health services, and the efficacy of their

10 How this works in practice constituted 'a major theme' throughout Professor Sir Ian Kennedy's review. Kennedy I (Professor Sir), *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, September 2010, p25 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf (25.04.14)]

11 Issues regarding information sharing between agencies had previously been raised by Lord Laming; Laming Lord, *The Protection of Children in England: A Progress Report*, London: The Stationery Office, March 2009, pp40–41

12 The *WTSC 2013* refers to the 'strong role' that every LSCB 'should play…in supporting information sharing between and within organisations and addressing any barriers to information sharing.' It states that 'This should include ensuring that a culture of information sharing is developed and supported as necessary by multi-agency training; HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p64 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (25.04.14)]

13 We welcome the Child Protection – Information Sharing (CP-IS) project, an NHS initiative which 'focuses on improving the protection of children who have previously been identified as vulnerable by social [care],' when they visit NHS unscheduled care settings. It is intended that information can be shared about three specific categories of child: those with a child protection plan, those classed as looked after, and any pregnant woman whose unborn child has a prebirth protection plan. However, in light of our findings in this Review, we emphasise that a degree of caution should be exercised by clinicians with respect to the information shared by social care. The fact that a child is not on a child protection plan, or is not looked-after, will not necessarily mean that they are not being maltreated or at risk of significant harm. According to our evidence, they could be designated as a child in need or, in some cases, not even have gained access to support from social care. Further information on the initiative can be found at: http://systems.hscic.gov.uk/cpis/needed

14 It should be noted that the views expressed by the Service Development Manager, BSMHFT throughout this report are their individual views, and may not represent those of BSMHFT

support, interventions and outcomes. We have seen just how grave the consequences of this can be across various cases.

We appreciate the Catch 22 position that local authorities and statutory mental health services are in, with less funding and – in some cases – increasing demand on their services, whilst being subject to continuing and increasing legal duties and responsibilities. However, the uncomfortable truth, that has often surfaced across our findings, is that some local authorities are circumventing and contravening the very law that is in place to safeguard and promote the welfare of vulnerable children, and to support young people. As a result, some are being exposed to continuing, or heightened, risk, distress and/or harm. Unscrupulous and unlawful practice has reared its ugly head repeatedly throughout our Review. We have been astounded by the number and nature of legal failings and missed opportunities which were identified by the legal professionals' review of Kids Company cases.[15] More worrying again is the fact that these occurred in circumstances where a VSO was fighting on behalf of these children for their rights to be met. Our concerns about the needs of vulnerable children being promptly and appropriately addressed are exacerbated by the fact that aspects of the 2013 WTSC are considered likely to increase inconsistency, confusion, delay and potentially unlawful practice.[16] Furthermore, evidence contained within our report demonstrates that England is failing to comply with the requirements of Article 19 of the UNCRC.[17]

Our findings also demonstrate a staggering lack of accountability by local authorities with respect to vulnerable children and young people. In light of the deeply concerning practices exposed by our report, we have concerns over greater autonomy being granted to them.[18] Whilst some may well thrive with the greater freedom that this affords, we are confronted with the knowledge of the injustices suffered by many vulnerable children and young people in others. Some VSOs and legal professionals are performing a crucial role in holding some local authorities to account. We share the fundamental concerns of others over the potential impact of the Government's proposals for reforming JR. We believe that JR performs an essential role in democracy, and that evidence contained in our report robustly demonstrates the critical need for vulnerable children and young people to have access to high quality legal advice, and to JR. We also fear for the multitude of vulnerable children and young people who have no Kids Company or equivalent voluntary sector support, or specialist legal advice available to them. This reinforces the vitally important role that Ofsted has to play – in securing an informed understanding of the reality of experiences of vulnerable children and young people across the country. Steps must be taken to address the significant criticism raised by various witnesses to our Review over how Ofsted conducts its assessments of services and reaches its conclusions. Greater transparency is required. The position of the voluntary sector must also be strengthened so that effective VSOs can form part of the solution, and help statutory services to address the problems faced by vulnerable children and young people.

15 I.e. those of Claire, Daniel, Michael, David and Callie – which can be found above

16 Particularly in the context of early help and threshold documents

17 In terms of mental health provision in the UNCRC, the relevant Article is Article 23. We have been advised that Article 23 is to be achieved in accordance with available resources. The position is unclear to us in terms of England's compliance with it

18 We raised similar concerns in *No Excuses* regarding greater autonomy and freedom being granted to schools, in circumstances where our evidence revealed some schools contravening the law, and seemingly without consequence; Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, September 2011, p164

We have discovered that the legislation regarding mental health is surprisingly weak, and seems to be increasing the vulnerability of some children and young people, who are not being given timely or appropriate care and support to meet their mental health needs. The lack of cooperation between social care and statutory mental health services, and lack of coordinated holistic support is presenting some vulnerable children and young people with additional challenges, as well as VSOs and other agencies that are trying to support them. How can it be remotely acceptable for the mental health problems of some of our vulnerable children and young people to remain undiagnosed, until they reach a fitness to plead stage of criminal justice proceedings? Even then, some continue to slip through the net of appropriate care and support.

Our findings suggest that for all of the supposed focus on saving money, and reducing current and forecast future costs, we are in fact likely to incur greater costs in the longer-term. We are creating potentially crippling difficulties within and outside of child protection and statutory mental health systems in the immediate and longer-term. We recall the concern expressed by one witness of us potentially entering a perverse cycle. There is also the additional pain, despair and heartache endured by the vulnerable children or young people, as well as those who may be impacted by the offending behaviour of some.

Several issues of serious concern have emerged from our evidence regarding commissioning. The lack of prioritisation, identification and understanding of vulnerable children and young people's social care and mental health needs must (where this exists) be addressed as a matter of urgency. Where JSNAs do not accurately identify such needs, JHWSs will be hindered from effectively meeting them, and sufficient services are unlikely to be commissioned. There is clearly a need for stronger and more visionary leadership and innovative commissioning in some areas of the country. We need better informed commissioners – drawing on the expertise of relevant professionals, to maximise on the opportunities offered by the current landscape. This should include promoting partnerships between statutory services and VSOs. It is essential that commissioners understand the different cultures and competing agendas of the voluntary and statutory sectors. Furthermore, they must ensure that priority is given to considering how to best protect vulnerable children and young people when commissioning services. It is also important that the Government's rhetoric on integrating care is applied in practice by HWBs and commissioners.

> *'The traditional way of commissioning is around assessing need and then building specification – building in contract management, building in performance management, building in financial management and it doesn't work. I think the more sophisticated commissioning processes are looking at projecting need. It is difficult, but it is not impossible.'*
>
> **Angela Gascoigne, Management Consultant, in evidence to the CSJ**

Numerous fundamental flaws continue to exist in child protection and statutory mental health systems. We have seen across our evidence how some statutory provision can be confused or, worse still, chaotic – with vulnerable children and young people falling through the gaps. It can lack consistency of practice, approach and – in the case of statutory mental health provision – no consensus about service delivery design for vulnerable children and

young people. We have met statutory professionals who are up in arms about the current situation. They are desperate to do a good job. However, many continue to be constrained by the systems in which they are forced to operate. Our report does not provide a wholesale review and analysis of child protection and statutory mental health provision across the country. Nonetheless, we believe that our evidence presents the tip of the iceberg. Many of the issues raised are too long-standing, complex and wide-ranging to justify a 'tinkering around the edges' response. We call for a wholesale re-design of our services for vulnerable children and young people. They deserve nothing less.

Careful consideration must be given to how we offer services to vulnerable children and young people, and how we can best engage them. A particular focus should be paid, in this respect, to lone children and (where they are not one and the same) vulnerable teenagers. We need a sensitive, thoughtful and compassionate approach, keeping vulnerable children and young people in mind, and working with a sense of integrity to do the best for each one of them. They must be firmly placed at the forefront of decision making, and their voices must be heard and listened to – appropriately. So too must those of their parents. Furthermore, they must be given a greater chance of continuity of support.

We believe that fundamental action is required to prioritise and achieve the critical need for partnership and collaboration – within and across all relevant statutory and non-statutory agencies. Schools must take their crucial place alongside others, in ensuring that a collective responsibility is taken towards all vulnerable children and young people across every community.[19] It is imperative that effective VSOs are also brought fully into the fold.

As highlighted by the Munro Review, Article 19 of the UNCRC 'particularly requires action to prevent the abuse or neglect of children … as well as to deal with its incidence. In March 2011, a "General Comment" on this article was made by the Committee supporting the [UNCRC]. One observation underpinning the Article is that responsibility for the primary prevention of violence against children … lies with public health, education, social and other services.'[25]

'The trouble with partnerships though is that nobody can stand up and say "I am against partnership." Like collaboration, nobody will say "I am against collaboration." So it is difficult to argue against it, but it is difficult to know exactly what it means. I think a better question is "what are the factors that lead people to operate within their own frameworks?"… What needs to be done is an analysis as to what it is structurally which leads to those partnerships being difficult…One of the ingredients of that is trust. There is structure

19 In *No Excuses*, we emphasised that partnership and collaboration across the community is integral to tackling exclusion and disengagement from education – the underlying causes of which are often rooted in the family environment. Our recommendations for reform included the valuable contribution that BESD schools, PRUs and other alternative education providers, as well as effective VSOs and community sector organisations, can make in this regard. We profiled a number of exemplars of best practice; Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, September 2011, pp198–206

20 The report also states that "'In the General Comment," violence is defined as all forms of harm to children …, including physical and mental violence, injury or abuse, neglect or negligent treatment or exploitation, including sexual abuse;' General Comment No.13, *Article 19: The right of the child to freedom from all forms of violence*, New York, United Nations, 2011, cited in Munro E, *The Munro Review of Child Protection: Final Report: A child-centred system*, London: Department for Education, May 2011, p70

and relationships, and you have to build relationships… It is completely consistent with attachment theory…It is all good and well saying it here, but it is very tough.'

Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, in evidence to the CSJ[21]

A renewed and concerted effort must be made to create and build relationships across the board – amongst professionals, and between professionals and vulnerable children, young people and parents. And it must start from the top. We need quality, strength, stability and integrity of leadership. Shared understanding and meaningful working relationships can help to generate mutual trust and professional respect. This would hopefully help to overcome many of the issues which have been identified by our Review.

Services need to be coordinated, with a system designed to identify, prioritise and address the vulnerabilities and needs of children and young people. A genuinely child/young person and family – centred approach must be taken. Every effort must be made to engender the faith, trust and confidence of vulnerable parents, children and young people in the system. Roles, duties, responsibilities and limitations need to be clearly defined, understood and recognised. Professionals need to be encouraged to contribute their skills and experience, and utilise and complement one another's expertise, as part of a dedicated partnership and collaboration.

In the immediate term, we call for an open and honest conversation regarding the true scale of the problem, and reality of what is being experienced by all relevant agencies. We must turn the tide on the grotesque injustice that so many of our vulnerable children and young people are suffering and, with them, establish the most effective way forward – together. We must also, as a society, recognise that what so many of them are crying out for, through their pain and often troubled behaviours, is love.

'… This is a kid who has been through social care so many times – he has been subjected to an horrific childhood, marred by drug and alcohol abuse in parents, neglect, abuse and domestic violence – the whole works. I usually work with kids by inviting them to "live in the future" – a strategy based on appreciative inquiry practice. I asked him what his hopes and dreams are in 20 years … He said "I see myself working as a carer for kids who are getting into trouble." I said "why do you want to do that?" He said "the people who are doing that job at the moment don't know how to do it, and I don't want to be one of them." I asked "what are the qualities that you have that would allow you to become a good carer for the kids you are working with?" He said "I want them to listen to me and to respect me." I asked "how would you do it?" … .He said "I will show them that I care through my body and my words. I will show them that I care about them." I said "it must be really difficult for you, these kids must come from really difficult families and have lots of bad experiences." He said "yes, they will have lots of problems, but they can deal with them as long as somebody respects them and cares about them." There are four key things: listen, respect, care and provide hope. This is coming from a 15- to 16-year-old boy who the major discourses in society might think of as a lost kid … a criminal …'

Dr Mirza, senior CAMHS clinician and academic, in evidence to the CSJ

21 It should be noted that the views expressed by Dr Fuggle throughout this report are his individual views, and not those of Islington CAMHS

Recommendations

Overarching recommendation

Our overarching recommendation is that a Royal Commission be established in the next Parliament to radically re-think and advise on the wholesale re-design of social care and statutory mental health services for vulnerable children and young people. Reporting by 2017, this Commission should decide how society can best re-create the parental experience for them in the public space.

> *'The number of children in care each year does not even scratch the surface of the problem. There is an assumption that children are either in care or with their biological parents who are functioning. But in the middle there are the "lone children" – who are not in foster care or with functioning parent(s) …'*[1]
>
> **Camila Batmanghelidjh, CEO, Kids Company, in evidence to the CSJ**

We need an innovative, whole system approach to be taken towards vulnerable children and young people. It has become all too evident that the existence of lone children is a reality that must be addressed. We believe that consistent care provided by relevant statutory and non-statutory agencies working together to function like substitute parents for vulnerable children and young people is key.[2]

The Royal Commission will need to consider a wide range of data, including the findings of the Inquiry into 'children's and adolescent mental health and CAMHS' which is currently being undertaken by the Health Committee.[3] The Royal Commission should establish the extent of vulnerability that the system needs to address, and identify and build on existing best and innovative practice.

In addition, the Royal Commission should be informed, and its considerations shaped, by the Taskforce which we understand is due to be launched by Kids Company in the interim.

1 The full quote provided by Camila Batmanghelidjh can be found in the main introduction
2 Where it is not possible to also work with their parents
3 Further details of which can be found at: http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/14-02-14-cmh-tor

We view it as essential that the Royal Commission, in deliberating the re-design of services, considers how to create:

- A stronger and more important role for advocacy;
- Local and national representative boards of children and young people who have been through care systems, with peer support, who sit alongside and feed into local and national HWBs and partnership working boards, and policy making;[4]
- Genuinely child/young person- and family- centred services;
- Effective evidence-based early intervention;
- Services in which all professionals working with vulnerable children and young people are equipped with knowledge and understanding of infant and child development, and attachment;[5, 6]
- Holistic, coordinated, agile and flexible services;
- Appropriate outreach services;
- A relationship-based approach to service provision;
- Carefully considered and designed settings;[7]
- Co-located, integrated multi-disciplinary teams;
- Continuity of care and support;
- Individual and personalised care, support and treatment, that is longer-term and/or intensive where necessary, and which is focussed on achieving optimum outcomes.

4 The merit has also been suggested of a representative (supported) youth board of children and young people who have been through care alongside children and young people who have not – working together as an advisory group

5 In *No Excuses*, we recommended that training should be given for teachers in pastoral and therapeutic support – including on attachment theory, child development and emotional health; Centre for Social Justice, *No Excuses: A Review of Educational Exclusion*, London: Centre for Social Justice, September 2011, p201 and p124

6 The CSJ has since reiterated, in *Completing the Revolution*, that 'An awareness of child development is an essential component of an early intervention approach.' The Review found that 'within the wider children's workforce, there is a lack of knowledge and understanding of child development, of the causes of mental ill health and of ways in which children of all ages can be supported so as to maximise their resilience.' It recommended that '… infant and child development (including basic developmental neuroscience) be part of the training courses of all who work with children, as well as part of parenting courses,' and that 'joint training from the beginning of clinical and other professionals' careers aids understanding and integration …'; Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, pp121–122

7 I.e. where distressed parents, children and young people can feel safe, and taking into account the importance of attachment to physical settings. Vulnerable parents, children and young people should be consulted on the design and arrangement of these settings

> *'My view was that child protection should always be done by a co-located disciplinary team – you should have a mental health specialist, a child care specialist, a youth worker. Social workers play a vital role but practice can be enhanced through co-located multi-disciplinary teams.'*
>
> **Dr Karen Broadhurst, in evidence to the CSJ**

One of the key principles for mental health policy solutions for children and young people, as the CSJ emphasised in *Completing the Revolution*, is:

> *'The importance of services being joined up, integrated and co-located with other aspects of the lives of children and families: this means they will take the whole family into account, provide continuity of care and be less fixated on boundaries of age (thus dealing better with transitions from adolescence to adulthood) and profession (i.e., creating joint solutions to replace silo working and the passing around of children and families from one service to another).'*[8, 9, 10]

We contest that the problems exposed by our report demand a huge step change – to reduce the vulnerability of many children and young people in England, and the failure they experience at the hands of social care and statutory mental health services – over the long-term.

In pursuing its work the Royal Commission should consider:

- How the role of social workers should be defined (what exactly do we, as a society, want social workers to do?);[11]
- Whether adults' and children's social care services are constructed in the right way;
- How to improve the integration of child and adult mental health services;[12]
- How to create a joined-up financial strategy across the board – money should not be in separate pots but in an 'ever moving' pot, with clear and joint accountability;
- How to promote a more effective and intelligent use of data on vulnerable children and young people being exercised by all relevant statutory and non-statutory agencies, and their maximising the data to help secure optimal outcomes for them.

8 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p106

9 It is recognised that this approach 'will also require the development of imaginative protocols around the issues of confidentiality and consent;' ibid, p108

10 The report also recommends that 'multi-agency interventions involving complex families include mental health assessments of both parents and children; these are crucial to ensuring families receive the right help. They should also include evidence-based programmes or approaches that build on families' existing strengths to create a more nurturing environment, in which children's behaviour problems can be managed in a calm and non-punitive manner;' ibid, p119

11 We note the point raised by Sir Martin Narey in his recent report to the lack of 'a satisfactory definition of children's social work,' and the recommendation he makes for such a definition to be drafted; Narey M (Sir), *Making the education of social workers consistently effective, Report of Sir Martin Narey's independent review of the education of children's social workers*, February 2014, p13 and p43 [accessed via: https://www.gov.uk/government/publications/making-the-education-of-social-workers-consistently-effective (27.05.14)]

12 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p116–118

'I think within a neighbourhood setting, we need to be looking together, across agencies, at what is working and what isn't. One of the things that is getting in the way of that is data sharing and information sharing … I think there is a professional preciousness. It is almost this "badge of the expert," and "I have this data and I am not giving it to you because you're not one of me." For me, it goes back to the relationships again. It is that trust. We have created organisations which are very low trust organisations, so they have low trust with other organisations. Quite often, that's within the same organisations.'

Angela Gascoigne, Management Consultant, in evidence to the CSJ

'There is still a lot of jumping for inspection, and it was a shame that some of the weight of Ofsted could not have been pulled back a bit. You do have to keep a record of what you're doing, and you do need to be able to audit to develop intelligence for your service. But I still think there is not enough good use of data to answer really key questions. There is too much gathering of data that just then goes somewhere else … There is all this intelligence at people's fingertips, but they are not using it … These environments are rich with data … It is not just sharing information about cases; it is about sharing their analysis of what is going on in their local community. Their analysis of what works.'[13, 14]

Dr Karen Broadhurst, in evidence to the CSJ

Additional recommendations

In addition we recommend that the following immediate steps are taken to improve services for vulnerable children and young people:

1. Further research and work should be undertaken on providing an accurate and helpful prediction of the most vulnerable children, and provision of tools for early identification of those who are most at risk. The interventions also need to be informed by what we know about early social and environmental experiences.[15]

   One or more of the large funding bodies such as the Economic and Social Research Council (ESRC) should be encouraged to commission a well-funded research stream focussed on evaluating universal and targeted aspects of emotional health and well-being in school settings.

   Adoption of current NICE guidance on emotional health and well-being in school settings, and a consideration by Ofsted of reinstating a focus on core elements of health and emotional well-being in school assessments (originally based on Every Child Matters, 2003) would appear appropriate.

13 Dr Karen Broadhurst added that this administrative data is under researched for research purposes

14 The importance of this was emphasised by an expert adviser to our Review – and where introducing more robust applied research with researcher/practitioners who are encouraged to produce local and joined up national knowledge exchange, and dissemination driven by key questions that are raised by those working at the frontline

15 As referred to in Chapter One

In addition, it has been suggested to us that possibly Public Health England, working with the Department of Health and Department for Education would appear a natural champion for promoting the emotional well-being and resilience agenda in education and community settings.

2. Early intervention should be prioritised and evidence-based.[16]

> *'The thing about the group you are talking about – they're impulsive, poor regulation, aggressive, poor relationships. They are not an education problem. We need to persuade education to share the problem. They keep saying "we can sort it out; we are going to make a really good PRU." But you're not. It has got to be a joint social care, education, and health input. That would be a target group for me for early intervention.'*
> **Dr Peter Fuggle, Consultant Clinical Psychologist, Islington CAMHS, in evidence to the CSJ**[17]

One of the key principles for mental health policy solutions for children and young people, in *Completing the Revolution,* included:

> *'The need for early intervention policy given the role that the early years of a child's life plays in the aetiology of mental illness and given our growing ability to identify those children and young people whose early symptoms, when combined with risk factors described [in the report], are likely to lead to poor outcomes.'*[18]

3. The Government, local authorities and other commissioners should prioritise investment in preventative and early intervention services. More funding should be made available for children in need, in order for local authorities to provide or commission more services for them.

4. The Government, NHS, local authorities and other commissioners should prioritise investment in preventative, early intervention and targeted services.[19] A dual approach should be taken, which would require double funding – for preventative and early intervention services, alongside targeted intervention for those cases of emerging mental health problems.

5. The Government should consult on aspects of the *2013 WTSC* which were introduced without prior consultation, and revise the *2013 WTSC* to address relevant concerns, some of which have been highlighted in our report.[20]

16 We have been informed that any evidence-based applied research needs to operate in iterative cycles, with robust applied real-time evaluation and academic rigour. It has been suggested to us that Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) could be consulted and possibly commissioned to work on this in key locations nationally, and rapidly disseminate the findings/evidence to enable regional and national roll-out (perhaps through academic health science networks (AHSNs))

17 It should be noted that the views expressed by Dr Fuggle throughout this report are his individual views, and not those of Islington CAMHS

18 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p106

19 We have been advised that this should be done in tandem with real-time active applied research, to evaluate what is working and rapidly disseminate and drive best practice. It has been suggested that CLAHRCs and AHSNs could be very relevant here

20 Aspects introduced without prior consultation include, for example, amending, in the *2013 WTSC,* the guidance under Section 11 of the Children Act 2004, and introducing two new concepts of early help assessments and threshold documents

6. The Government should take appropriate action to ensure that each child in need has a comprehensive assessment and a structured care plan, setting out what needs are to be met, by whom and when. For children with multi-disciplinary needs, it is imperative that there is a professional who has the clearly defined role of coordinating the package, and ensuring that other agencies cooperate in the provision of a clear and structured package.

7. The Government should ensure that a national standard is introduced for assessments conducted by social care, following their acceptance of a referral. The HCPC, and the CSW should provide guidance which is flexible, and which could be helpful for those in practice – particularly newly qualified social workers. The reintroduction of a national standard will also assist applicants and Judges in the Administrative Court.

8. Prioritisation should be given to the need to improve pastoral and therapeutic support for professionals who work with vulnerable children and young people – in statutory and non-statutory agencies. It is vital that support is given to build their resilience.[21]

9. Accountability:

   (A) Vulnerable children and young people:

   'Children and young people have no power to command the system. A competent adult is out of the equation and the child or young person's right for help is completely compromised [when it comes] to accessing service delivery. If a vulnerable child or young person's needs are not being met properly then there needs to be an accessible capacity for them to alert provisions. Children and young people with Kids Company's support are lucky in that we become the pushy parent but who knows if we'll survive …'
   Camila Batmanghelidjh, CEO, Kids Company

A structure should be put in place to enable vulnerable children and young people to legitimately raise the alarm where they have concerns over failure by social care and statutory mental health services to provide them with appropriate care, protection and/or support, so that they do not have to submit a document to the LGO.[22]

   (B) VSOs: the lacuna in child protection should be addressed. The Government should introduce a mandatory requirement for VSOs that are providing services for, and are in regular contact with, vulnerable children to be consulted by social care as part of their assessment process, and invited to any CPC and to join the core group.

   (C) Ofsted: appropriate steps should be taken to ensure that Ofsted is gaining an informed understanding of the reality of what is being experienced by vulnerable children and young people – both, in the case of children, at the front door of social care services and following acceptance by social care of referrals. Ofsted should also

21 We have been informed that Psychologically Informed Environments (PIE) could be very effective here. Further information on PIE can be found at: http://www.rjaconsultancy.org.uk/6454%20clg%20pie%20operational%20document%20aw-1.pdf

22 It has been suggested that a representative youth board (with members from both vulnerable and generic youth) sit on local Health Watch panels, where issues could be supported through HWBs

take legal decisions, settlements and LGO decisions into account as part of their inspection process.

10. Commissioning:

- While evidence suggests that mental health problems are increasing in children and young people, the Government does not spend money on impression – its spending decisions must be based on fact. We argue that the Government must arm itself with the relevant facts, as must local authorities and HWBs:

    - The Government should commission national surveys to establish up-to-date statistics on the prevalence of mental health problems in those up to the age of 25; and on risk factors to which children and young people are exposed – including, for example, parental substance misuse and parental ill-health.[23] With these surveys in place a higher priority is likely to be allocated to identifying and addressing the needs of vulnerable children and young people.[24]

    - Robust local data is also essential.[25] To ensure that local authorities and HWBs are fully aware of the need in their area, they need to have better data. Appropriate action should to be taken by HWBs (as relevant) to address the issues of concern raised by this Review, regarding the lack of identification and prioritisation of children and young people's social care and mental health needs.

- All local authorities should ensure that there is a senior representative from CAMHS and AMHS on their HWBs, together with a child and young person, supported to be a child/youth ambassador.

- HWBs should work with their local population, and consult with vulnerable children, young people and their parents, to address their needs.

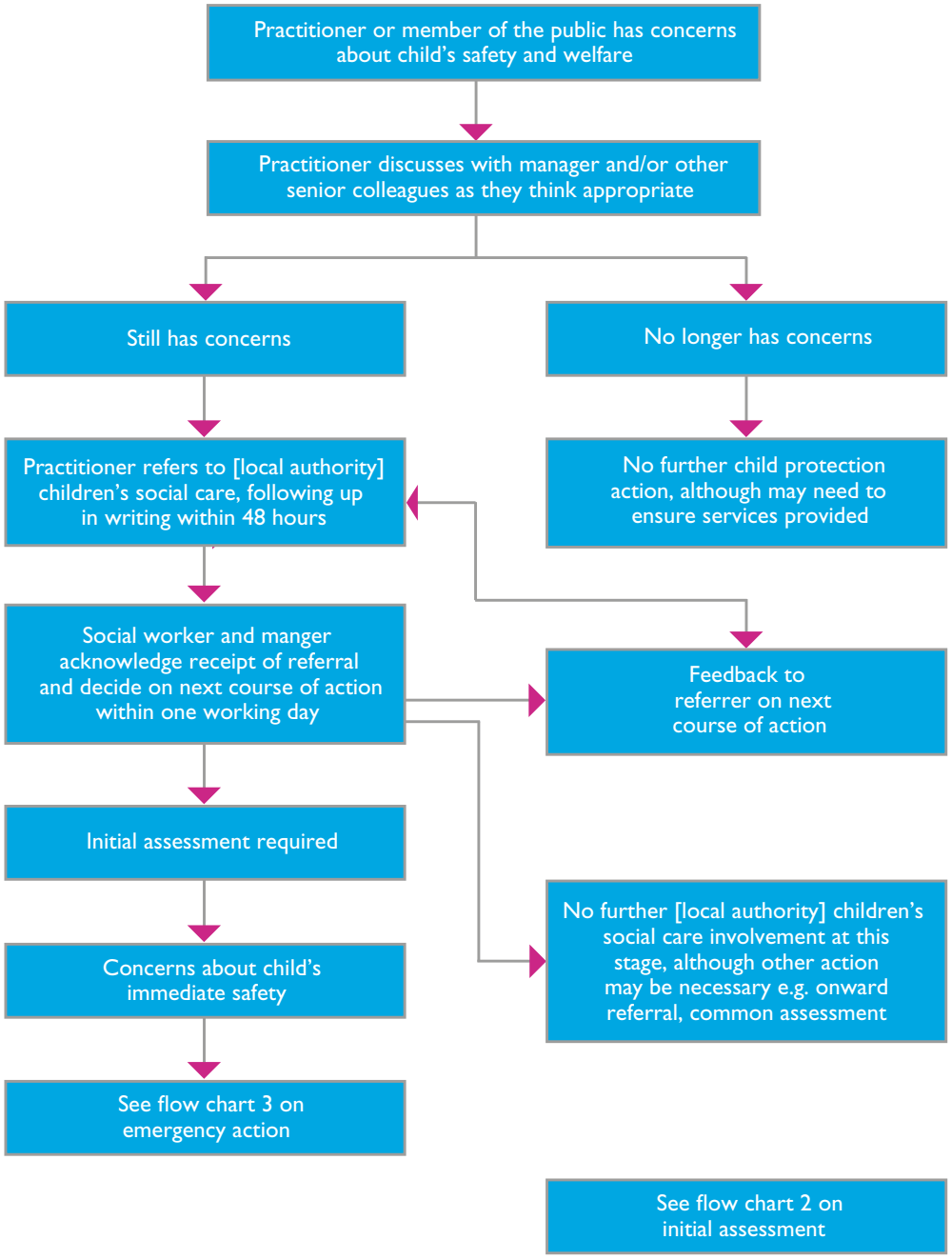
Completing the Revolution referred to the important role that HWBs have to play 'in ensuring that adequate resources are provided by local commissioners of services, and in recognising the strong role to be played by the voluntary sector and harnessing the potential of the wider community to provide social support through the facilitation of local community programmes.'[26]

> *'We need to be more transparent with the local population about some fundamental issues. We should be able to say, "so how much money is available for working with the children and young people in our Borough?" And explore with them how much more we need to raise to provide them with a good service. How much money can we use for education? How much … for social care? And how much … is going to CAMHS? And how do we work together for the needs of these children and young people? We could use existing epidemiological data from experts to map the needs and provide evidence-*

23 This should include, in respect of mental health problems, children under the age of five if assessment instruments are robust enough
24 A potential role for CLAHRCs, working with JSNA and regional health observatories, has been identified here
25 Again, the potential for CLAHRCs to be commissioned has been suggested
26 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, p113

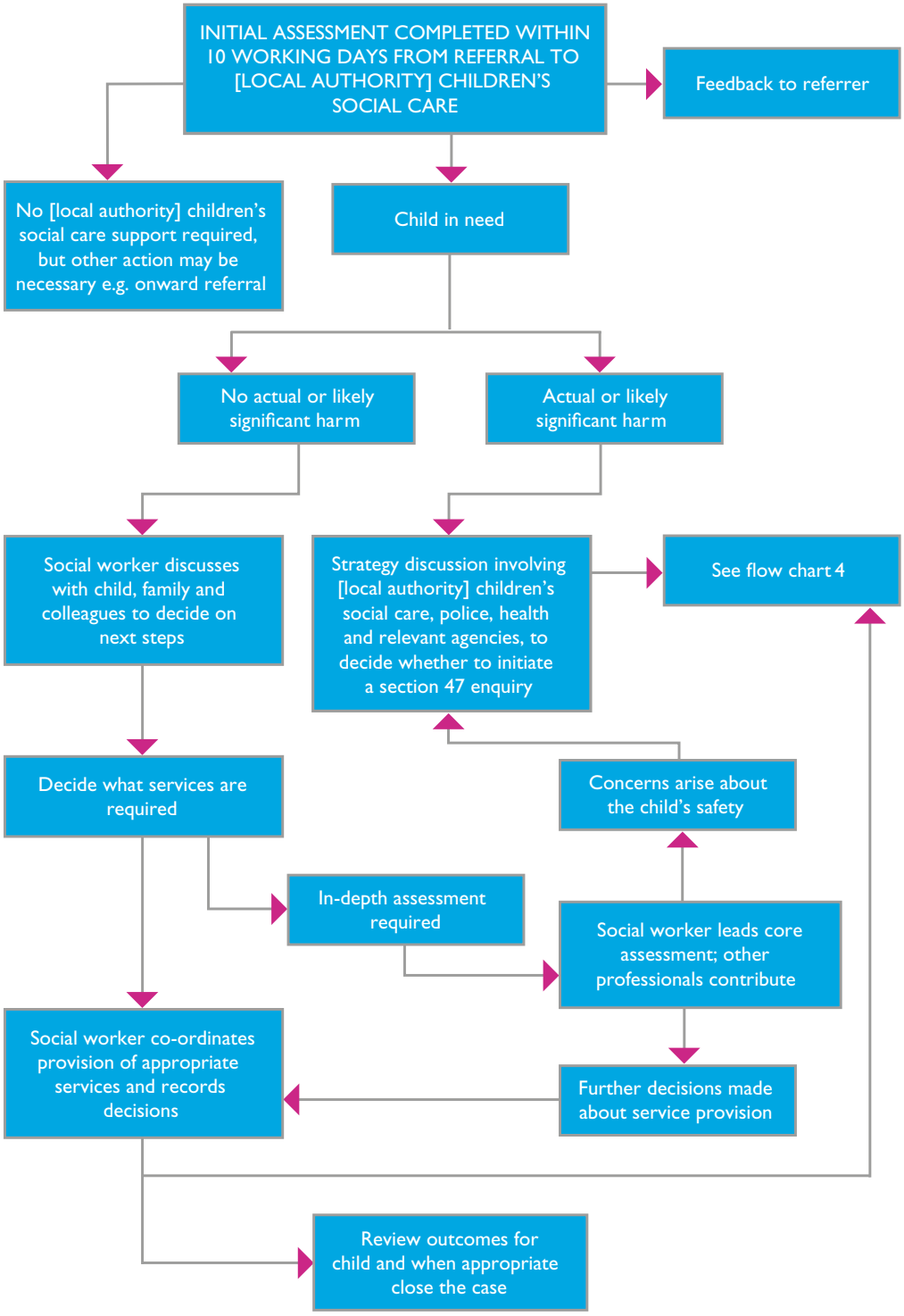
appendix 1:
Flowcharts from *2010 WTSC*

Flow chart 1: Referral[1]



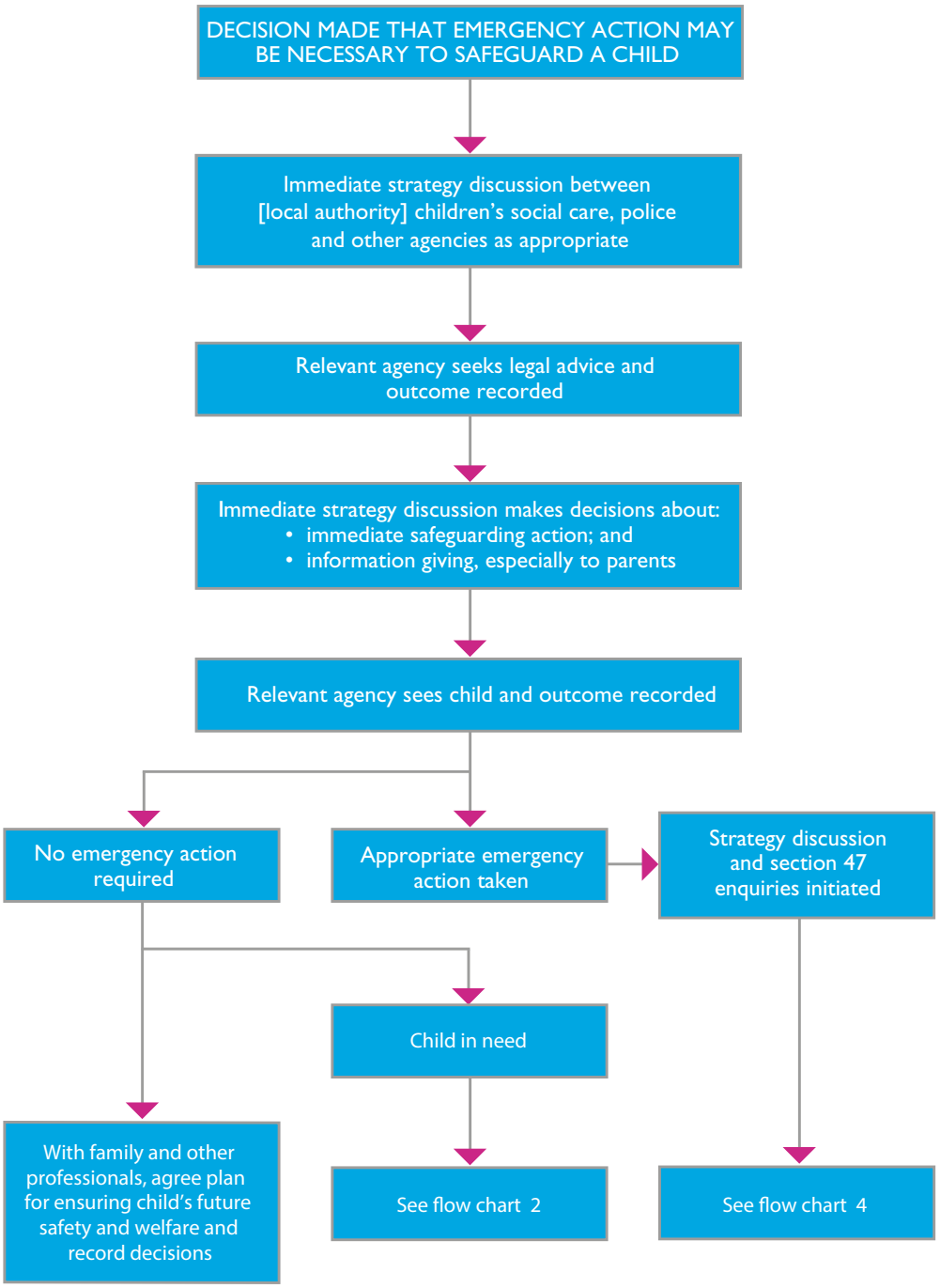
1 Department for Children, Schools and Families, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Nottingham: Department for Children, Schools and Families, issued March 2010, p186*

Flow chart 2: What happens following initial assessment?[2]



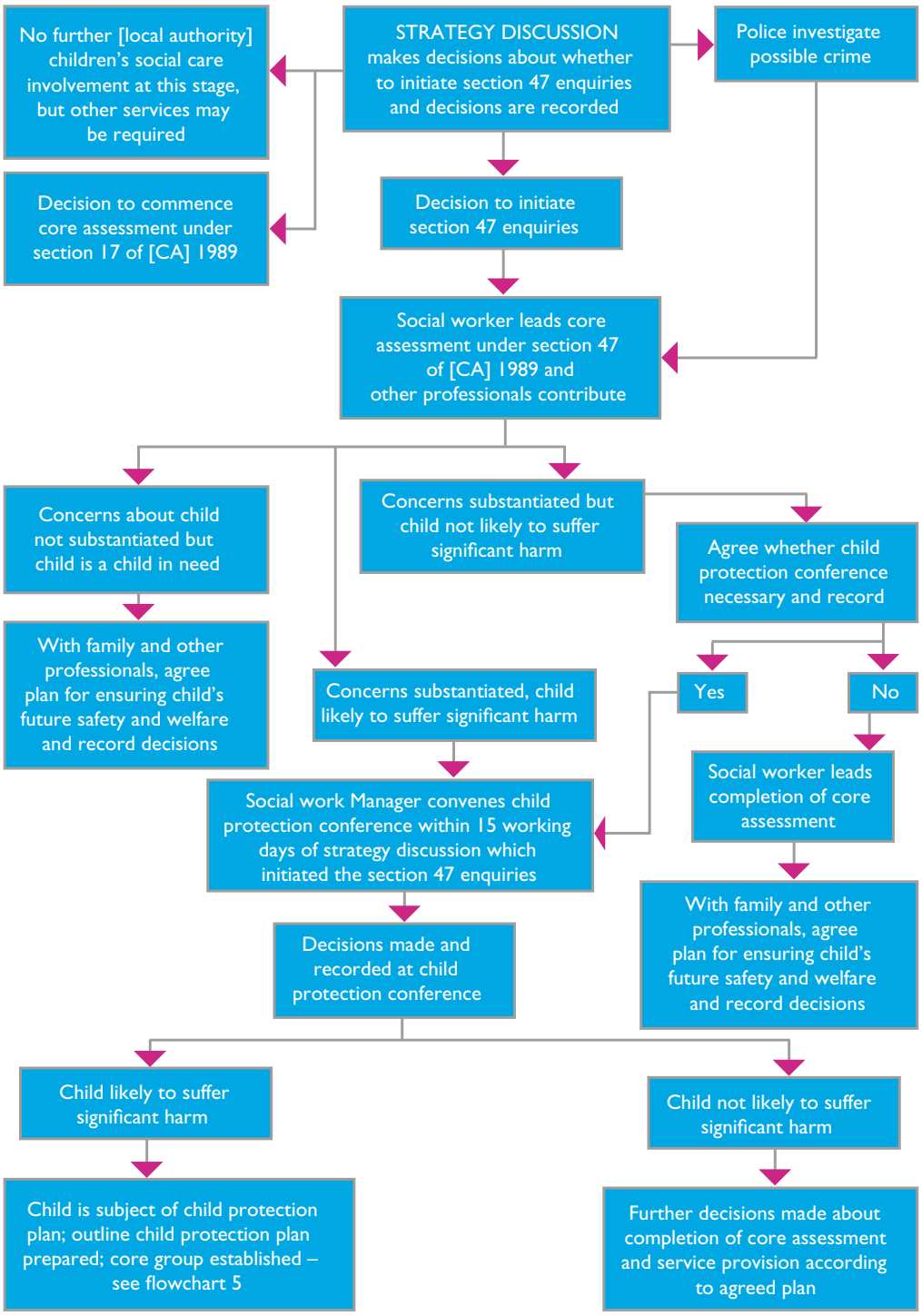
2 Ibid, p187

Flow chart 3: Urgent action to safeguard children[3]



3 Ibid, p188

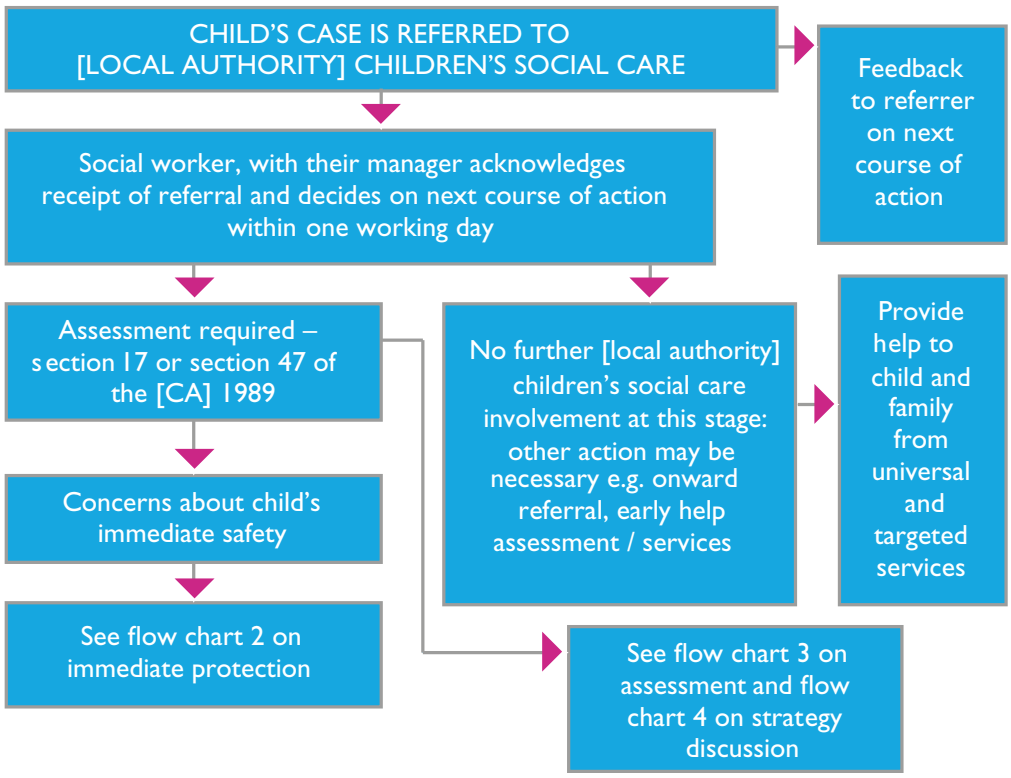
Flow chart 4: What happens after the strategy discussion?[4]



4 Ibid p189

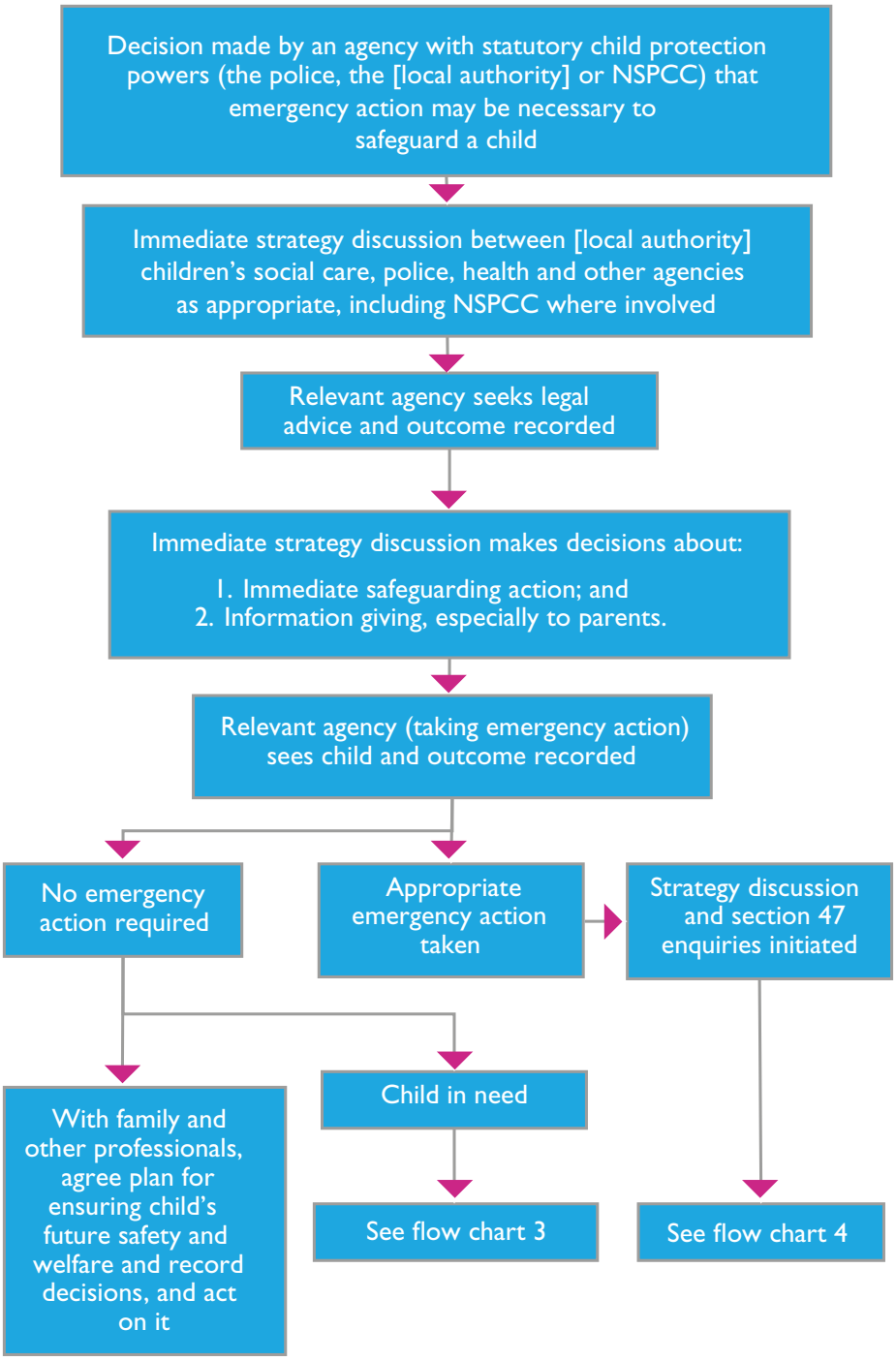
appendix 2: Flowcharts from *2013 WTSC*

Flow chart 1: Action taken when a child is referred to local authority children's social care services[5]



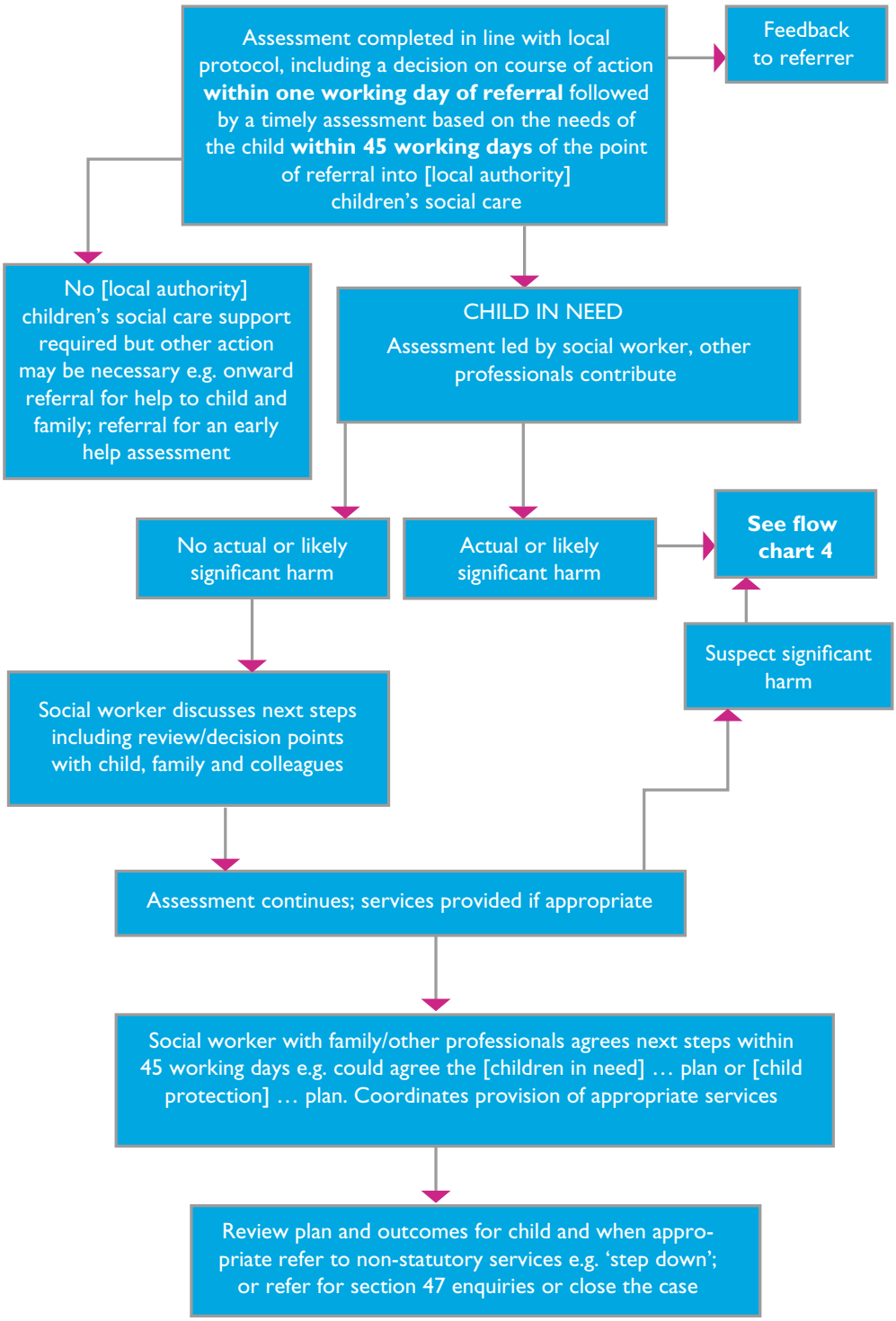
5 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, March 2013*, p27 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (25.06.14)]

Flow chart 2: Immediate protection[6]



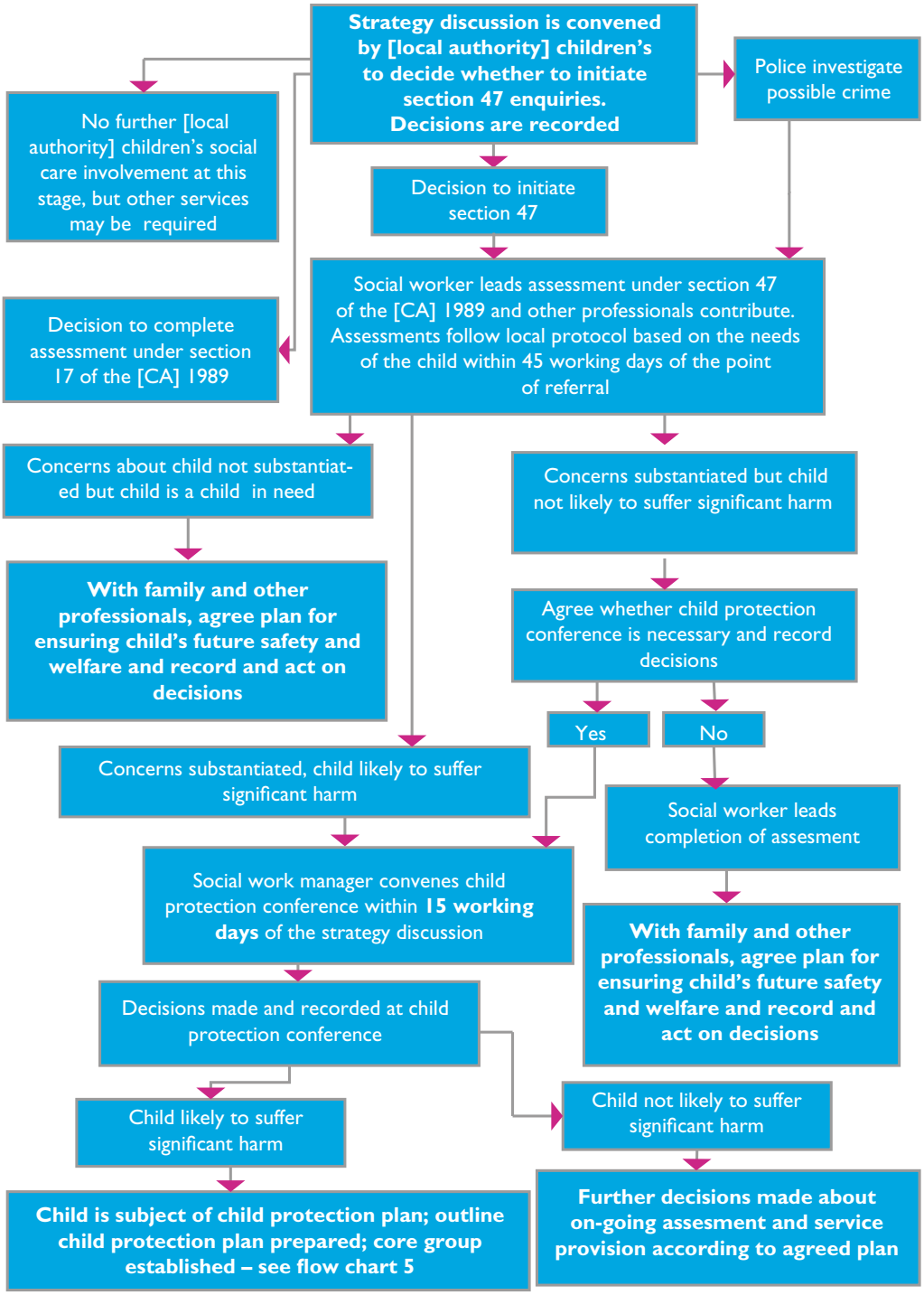
6 Ibid, p29

Flow chart 3: Action taken for an assessment of a child under the [CA] 1989[7]



7 Ibid, p32

Flow chart 4: Action following a strategy discussion[8]



8 Ibid, p35

appendix 3: Kids Company definitions of risk levels[1]

High risk young people present a risk to themselves or to others, can be identified as such by one or more of the following modes and criteria:

- Serious gang activity with access to weapons
- Evidence either described by them or others of their having in the past significantly harmed another individual through battery or the use of weapons
- Individuals who have in the past tortured or harmed animals or who own violent dogs which they use in a predatory way
- Individuals with convictions for Grievous Bodily Harm or acquisitions of goods using violence with a weapon
- Individuals who present with evidence of sexually predatory behaviours either having entrapped, harmed others in a sexualised way or having powerful fantasies or perverse norms in relation to sexualised abuse
- Individuals who may harm themselves, i.e. with the capacity to cause significant harm directed towards the self more than others. They could, for example, be self- harming through cutting or burning themselves or they may have had attempted suicides
- Individuals with psychosis or vulnerabilities towards psychosis where their grasp on reality is tenuous and where there is potentially risk of self-harm episodes as well as and/or harm to others
- Individuals who may be in situations where their life or personal safety may be seriously compromised, e.g. young girls or boys who are being run by drug dealers with access to weapons
- Individuals who may be living in circumstances where they are currently being exposed to sexual and significant physical abuse
- Individuals using Class A drugs: safety is compromised in accessing drugs, and mental wellbeing put at risk
- Individuals who are involved in high-risk prostitution, i.e. working in dangerous locations
- Young people exposed to significant domestic violence

1 Kids Company, *Kids Company Report for Government March 2011 – 2013*, London: Kids Company, 2013, pp202–203

Medium-risk young people can be identified as such by one or more of the following modes and criteria:

- Young people with unsatisfactory care circumstances, i.e. the absence of a functioning adult in their lives as a result of which the young person is exposed to unacceptable levels of risk
- Young people with identifiable mental illnesses according to the [DSM]
- Young people with developmental difficulties which remain unidentified or poorly contained, e.g. [ASD] or ADHD
- Young people with specific learning difficulties that may have led to failures in attainment and created barriers to employment
- Young people subject to frequent exclusions from school due to behavioural difficulties
- Young people who are not stable in the family home or may be living in high-risk hostels, where they are not appropriately engaged in education and employment
- Young people with perverse or anti-social strategies and communications, e.g. those who are engaged in accessing excessive pornography or inappropriate internet activities
- Young people with history of criminal activity
- Young people who have suffered a loss and become stuck in a state of bereavement which creates a failure to engage
- Disengaged, detached young people who are not part of the community experience of participation in education, employment or meaningful activities
- Young people with eating disorders, or whose substance misuse is having a detrimental impact on their wellbeing
- Young people whose lives are impacted detrimentally by their parents' substance abuse
- Young people with poor sexual health due to promiscuity or sexual exploitation
- Teenage parents whose ability to care for their children is compromised

appendix 4: Michael's summary (24-years-old)

'She can't love me. Do you think she loves me if she goes to stab me?'

Background

Michael has never seen or spoken to his father. Michael's mother, Diane, has a history of emotional and mental health problems, and a crack cocaine addiction. Michael has lived in extreme conditions of poverty and neglect, in a chronically chaotic and violent environment. Michael and his siblings were on the CPR from their birth for several years, in the previous borough in which the family lived. Michael and a sibling were placed under the category of neglect, and another sibling under the category of physical abuse. They experienced episodes of being placed in care, and the family continued to receive infrequent support for approximately another ten years after the children were removed from the CPR.

Michael was arrested for the first time as a young child, for stealing milk for his baby sibling. He explained:

> *'From that point, they made me hate the system because they made me a criminal … The baby was crying and my mum told me to get some [baby milk], but she told me in a way that I felt I had to rob it … She didn't give me any money … I felt alone … I asked myself "How come social [care] don't help me?"'*

When Michael was 12, a referral was made to social care by a health visitor, after Diane told her that she was struggling to cope with the eldest children's behaviour. Michael was truanting from school, involved in offending behaviour and had a YOT worker.

Key features of the case

- When Michael was 13, YOT was advised by the police not to visit Michael's home for safety reasons, as it was 'too dangerous to attend.' A decision was made to convene a CPC but

this did not take place until seven weeks later. The social worker prepared a report for the initial CPC that provided evidence of domestic violence, chaotic lifestyle and a poor home environment.

- Prior to the initial CPC, the CEO of Kids Company (CEO) reported her concerns to social care. These included the children's disclosures regarding incidents of significant violence between Donald and Francis – the two men living in the house, and involving Diane. The children had described horrific scenes with injuries which resulted in significant bleeding by one of the adults. Michael regarded Francis, the father of one of his siblings, as his father. He told the CSJ:

  > *'Dad used to fight with [Donald] a lot. My mum used to hit dad all the time, with severe blows. She stabbed him, put a cup in his face, dashed him in the skull with rollerblades. But daddy was an angel. He never used to … hit my mum back … It was very bad because I used to go to school and when I came back I always used to see blood – on the wall or on my dad's face …'*

- At the initial CPC, Diane reported that Francis was her current partner, and denied being married to Donald. This was contrary to what Francis and the children had told social care. The Chair of the child protection panel confirmed that 'in order for the core assessment to be completed … the inconsistencies need to be clarified.' Identified risks included Donald being regarded as 'an issue.' The children were placed on the CPR under the category of neglect. Diane subsequently confirmed that she was married to Donald, with whom she was having a relationship, and that Francis was her previous partner.

- The CEO wrote to the Director of Children's Services, raising her concerns that the first Review CPC had become a critique of Kids Company, which she felt had enabled Diane and Francis to divert the problem from their shortcomings. The CEO reported that Donald was a drug dealer and provided drugs to the whole household. She also reported that Francis and Donald often fought and stabbed each other, making the children very disturbed.

- Three adults were living in the home. However, YOT undertook a parenting program with just two of the adults, and failed to act on the high levels of violence within the home. Francis was arrested after an argument involving himself, Donald and Diane. The second Review CPC, one month later, referred to there having been no fights, and that the parenting program was complete 'with positive outcomes for the family.' The police did not attend this CPC, and the police report that social care had received following the last CPC, which contained new information, was due to be raised at the next CPC.

- Prior to the third Review CPC, the social workers stated, in their report, that 'We have not been able to meet with [Donald] for any length of time as yet as he tends not to be in the house when we visit in order to avoid tension between himself and [Francis].' The Chair hoped that the tension would recede once Francis moved out of the home. Social care continued to propose to complete a core assessment. This was to include an assessment of Donald. However, it appears never to have been done. At the third Review CPC, Diane

stated that Francis and Donald were constantly arguing, and that their arguments had recently started to become physical. Michael told the CSJ:

> *'S*** didn't change for a long time. It escalated from there. I tried to make a deal with my parents. "If you don't fight, I'll go to school." But how could I go to school when I was worried about my dad? Then I decided "f*** it, I'm not going to school anymore" and I stopped going because they carried on fighting. Once I made that decision, that was the time I started to smoke weed and I started to get involved in the fights – I'd pick up a knife and stab someone or pick up a chair and hit Donald.'*

- Michael and his siblings were removed from the CPR after just over a year (except for one sibling who was removed earlier). The CEO had advised that the children should remain on the CPR. A couple of months after this, Michael was rendered homeless, at the age of 14, after Diane threw him out. He stayed with squatters nearby. Kids Company subsequently advised that a child protection investigation should be reinstated under the category of emotional abuse for the younger siblings. However, social care declined to do so and determined to continue to work with the children on a child in need basis. At some point after this (it is unclear when), they were no longer regarded by social care as children in need.

- When Michael was 15, the CEO submitted a further referral to social care. The CEO reported that she had become aware of Diane's suspected crack cocaine use and disappearance for days, and that Donald had had a number of physical fights with Michael and a sibling, and frequently with Diane. The CEO also reported Diane's alleged attempt to stab Michael, and advised that this required further investigation. The CEO again expressed her additional concern for the younger children. Michael informed the CSJ that social care never spoke to him about the incident with Diane and never investigated it; he did not think they even knew about it.

- Michael informed the CSJ that he only went to school 'a few times a year' from the age of 12. He used to travel outside of London with his siblings and others. He explained:

> *'We … had to get away, we needed space. It was hard, mad – we became the street and got caught up in a life full of crime which we shouldn't have. I used to be so kind and good. I used to think I was a really good guy … But the pain I used to see. I was angry but I didn't know what to do …'*

Social care recorded that it had no information regarding the school liaising with the YOT worker and senior education welfare officer (EWO) to plan for Michael to attend school full-time. The social worker also recorded that they had made several attempts to liaise with the school for an update on Michael's progress, attendance, general behaviour and emotional well-being, but this had not been forthcoming. Furthermore, the school was recorded by social care as not co-operating with the child protection process. In the meantime, Diane reported that Michael was attending school every day, which was recorded by social care to be the case. When Michael was 15, his school briefly worked with Kids Company to support Michael to attend. He went a few times but then stopped going.

- When Michael was 16, he formed a 'friendship gang.' He explained to the CSJ that they were not criminals but 'had each other's backs if anyone dissed them,' and protected each other against situations they were facing in their respective families. He added 'when Mum used to do her disappearing acts, I would tell [Donald] that I was the boss. [Donald] would chat s*** and try to fight me, but I would tell him "you're not coming for me."' Michael said his 'boys' were like his family and protected him – he made sure he had his boys. They would all 'beat [Donald] up …'

- Michael became homeless again at the age of 16 – after Diane threw him out of the home due to fights with Donald. Having submitted an application for housing, Michael was placed by Housing in a B&B, without support, where people were reported to be using crack cocaine. Requests were made by solicitors for the local authority to undertake a S.17 assessment over a period of some eight months. Only after JR proceedings were threatened, by solicitors instructed on Michael's behalf, was a S.17 assessment offered. Michael attended an initial assessment with social care but did not attend his S.17 assessment. During this period, Kids Company supported Michael through criminal proceedings. He then attended social care in person, with his key worker from Kids Company, to secure an alternative appointment for his S.17 assessment, which he did not then attend. Social care subsequently stated that they had been unable to complete the S.17 assessment because Michael had failed to contact the social worker or keep any appointments with social care. However, if Michael was not making a further request, social care suggested that he should contact his social worker to arrange an appointment. He did not do so.

- When Michael was 18 there were a number of violent altercations between him and Donald in the family home. Donald and Diane had been arguing and Michael's younger siblings had begged him to stop them. Michael told the CSJ that he stepped in and Donald hit out at him and they fought. He said that Donald had thrown knives at him and tried to strangle him. He added:

  > *'I lost it. We had the fight. I beat the s*** out of [Donald]. I was sitting strong. I cracked his eye socket with a punch and threw him down the stairs. Then I jumped on his head and my mum did too. I beat him bad that day.'*

  Michael told the CSJ that he had two more fights with Donald but was worried about repeating the cycle and didn't want his siblings to see him fighting with Donald. He decided that it had to stop.

Observations

- The initial CPC resolved that a core assessment should be undertaken, but the evidence gathered by the local authority should have led to a core assessment being undertaken without the direction of the CPC, as there was clear evidence of significant harm.

- It seems alarm bells failed to ring in relation to Diane's reluctance to confirm the true nature of her relationship with Donald, and social care failed to listen to the children's

version of it. Diane was manipulative towards her children and the agencies involved in the family's case; she masked the truth from social care with her false compliance. Michael explained to the CSJ:

> *'My mum … would give [social care] a cup of tea and a biscuit and make sure the kids weren't there. She blinded them. They were fools. Social [care] never stepped in or helped me for nothing …'*

- Why was social care so slow to conduct a core assessment, including an assessment of Donald (which appears never to have been done)? By the time of the third Review CPC, the core assessment was still not completed, and there was reference to continuing violence between the adults. Social care focussed on Francis and Diane while Donald – a new male in the home and about whom Kids Company had raised serious concerns, remained firmly in the background. This was despite Donald having been identified by social care as 'an issue.' The Chair hoped that the tension would recede once Francis moved out of the home. This was ill-informed and misguided. Social care did not get to the truth of the significant risk that Donald presented in the home, and of what the children were suffering throughout. Why did social care not act upon Kids Company's subsequent advice to reinstate a child protection investigation? Following Kids Company's referral, why did social care appear not to have investigated concerns about Diane's suspected crack cocaine use and disappearance for days, the physical fights, and Diane's alleged attempt to stab Michael? The CA 1989 was amended to include impairment suffered from seeing or hearing the ill-treatment of another.[1] However, despite evidence of on-going violence between the adults, and the adults and the children when older, no action was taken to bring the case into care proceedings to protect Michael and his younger siblings from significant harm.

- The key issue from a mental health perspective, in Michael's case, relates to the record of the decision of the initial CPC – that a referral to CAMHS would be followed up for therapeutic counselling. A report for the second Review CPC highlighted that this task was still outstanding. A social worker is later stated to have spoken to Michael and been told that Michael did not want to attend counselling. Without knowing how this was discussed, we cannot tell whether the social worker made an effort to explain why this therapeutic input may have been very beneficial for Michael, given his background.

- Michael's school appears to have failed to support him and to address his poor attendance and the underlying causes of this. This was a critical missed opportunity to support Michael with the extreme difficulties he was facing at home, and to encourage his re-engagement with education. The school's failure to co-operate with the child protection process is deeply concerning, particularly given the serious risk to which Michael was exposed and fact that he was involved in offending behaviour. How could the school legitimately claim to have fulfilled its child protection duties towards Michael in these circumstances, and why was it seemingly not held accountable for its failings? By the time that the school worked with Kids Company to support Michael to attend, it had clearly become an insurmountable challenge.

1 Children Act 1989, Section 31(9), as amended by the Adoption and Children Act 2002

- Social care continued to fail Michael when he became homeless again at 16. He was placed by Housing in wholly unsuitable accommodation for a highly vulnerable child. Social care proceeded to blame Michael for not having completed their S.17 assessment. However, it could hardly be said that social care tried very hard to engage him – and while he was in the middle of criminal proceedings. Instead, it seems that his reluctance to cooperate was a convenient means of continuing to avoid providing him with the support that he should have been entitled to. Why did social care not take responsibility for him and give him the support that he clearly needed? Kids Company believes that Michael was set up to fail by the local authority.

- As a result of the serious violent altercations that took place between Michael and Donald, when Michael was 18, the threshold for care proceedings was crossed regarding his younger siblings, as a result of their continuing exposure to violence within the home. However, not even a S.17 assessment was undertaken concerning the younger children. Had social care supported Michael under S.20, they could have learned more about the reality in the family home, and taken appropriate steps to protect the younger siblings. The incident also demonstrates just how bad the situation got for Michael.

- Michael did not have a childhood. Kids Company tried for years to shed a critical light on the reality of the home environment – to secure social care's intervention to ensure the safety of the children. However, despite the gravity of its concerns, Michael and his younger siblings remained in Diane's care – exposed to continuing chaos, danger, neglect, emotional abuse and trauma.

appendix 5: David's summary (23-years-old)

'There was no fun in my childhood. To be honest, there was no childhood … I literally feel like I was born an adult, just … smaller.'

Background

David is understood to have been placed with a foster carer for a year when he was six years old. The CEO of Kids Company (CEO) first raised the alarm with social care over David's neglect when he was six years old. The CEO had concerns over his mother, Patricia's, substance misuse, the unsuitability of his home environment, and his lack of care.

Key features of the case

- The CEO informed social care about Patricia's drug misuse when David was *'about 10 or 11.'* David informed the CSJ that from when he was about six until he was 12, someone from social care *'visited sometimes,' but that 'nothing really happened.'* He told us that he wanted to say something to his social worker about Patricia's substance misuse but he didn't – *'I think it was because I was scared to. They kind of gave up and disappeared.'*

- After Sarah, one of David's neighbours, first met David, at the age of 12, she called social care to raise her concerns that he seemed to be very neglected, was with Sarah and her husband, Bill, almost daily, and always ate at their home. She recalls *'social [care] were really awful. They asked if David had bruises. When I said no but that he had signs of neglect, I was told that if he had no bruises, there was no reason for social [care] to go around.'* Several months later, David came to Sarah in a lot of pain; she took him to the dentist and arranged treatment for him – his front teeth were rotting.

- David told us that he does not remember social care as much from the age of 13 – *'They visited once every couple of months, if that.'* Neither David, the CEO, nor Sarah – who David visited almost daily, are aware of any action having been taken by social care. Sarah and Bill

were so concerned about David that they made another referral to social care. Patricia was informed of this and banned David from seeing them for five months.

- After Sarah and Bill *'bumped into'* David, he began to visit them almost daily again. David told Sarah about a man he had been spending time with. It took for Sarah to alert Patricia that David was being groomed by a paedophile (while travelling on buses instead of attending school). Soon after this, at 14, David was placed on the CPR under the category of neglect. The CEO informed the CSJ that social care would not give her any information, and that she was never invited to a CPC. David informed us that he does not know how long he was on the CPR for – *'… it was the same thing as before and after, as in nothing was happening … about anything.'* Sarah informed the CSJ that social care arranged for a worker from a VSO to take David out once a week to do an activity. In the meantime, David told us that the situation remained the same with Patricia's substance misuse – *'It was terrible. I had arguments every single day with my mum … verbal fighting.'*

- The CEO subsequently attended a meeting with a Team Manager at social care to raise the alarm again. She was told that social care had no evidence that Patricia was a drug user. Sarah and Bill attended a meeting with social care, during which they reiterated their concerns. They were promised a family and friends meeting with Patricia and everyone involved with David. When this did not transpire, Sarah wrote to social care, offering to attend a meeting with the aforementioned present to give social care *'the full story'* of what David was experiencing. However, this was not taken up. Sarah wrote to social care again, informing them that she had called them five times in the two and a half years she and Bill had been caring for David, and had asked for someone to call her to arrange a visit. However, she had never received a return call; she had always had to re-phone. Sarah again expressed serious concerns over David's welfare. She informed social care that she believed David was being severely neglected and emotionally abused; he had also not been to school for seven months. Sarah presumed that when social care had told her and Bill that Patricia 'needed a rest and to go away for a while,' they meant that she should go into rehab. Sarah referred to social care having asked a couple of David's relatives if they would care for him during this time; they declined and, as a result, Patricia had not gone to rehab. Sarah asked whether this was because social care did not want to pay a foster carer to look after David during this period. Sarah informed social care that they had been involved in David's case for eight years, and that they seemed totally complacent regarding his case.

- At 15, David informed his social worker, in front of Sarah, of Patricia's verbal and emotional abuse towards him, that Patricia was using Class A drugs, that dealers frequently visited their home, and that he wanted to go away and stay with family. Each time David spoke to his social worker after this on the telephone, they asked David if he was sure he did not want to go home. David recalls:

> *'[The social worker] was very dismissive … it was like [they were] trying to persuade me in a manipulative way … like it was little. If something is big for the young person, it should be big for the social worker; it should be bigger for the social worker. But in that case, it was the smallest of things … Nothing changed.'*

The social worker visited again, at Sarah's request, as nothing seemed to be happening. The social worker told David that social care would need to have agreement from Patricia that David could go to stay with family, and would decide if David should remain with Patricia or not. David arranged a ticket himself and left London. He lived with Patricia again on his return when, he informed the CSJ, that he showed his social worker Patricia's crack pipe. David told us that he could not see anything changing at home – with Patricia's substance misuse, and that it was more outside of the home.

- At 16, David was allocated a new social worker, who took him to Connexions, where he established a relationship with one of its workers – *'he cared.'* With respect to his new social worker, David recalls that they *'cared and possibly tried to help but there was not much change at home – it was more outside of the home that changed.'* David does not believe that efforts were made to try to help Patricia with her difficulties – *'If there are two batteries in a remote control and one of them doesn't work, the whole thing doesn't work … both batteries need to be charged.'*

- At 17, David witnessed a violent incident between two drug dealers at Patricia's home. Six months later, Patricia reportedly set fire to the home, rendering it uninhabitable and David homeless.[1] Social care proposed to place David in a hostel. However, given his extreme vulnerability and fact that he was deeply traumatised, Kids Company did not feel that this was suitable, and arranged temporary accommodation for him. He was then privately fostered by Sarah and Bill shortly before he turned 18.

- David's social worker recalls trying to get David on to a pathway plan, and that he arranged some appointments with housing but that David *'didn't turn up.'* David's file was closed to social care when he was 18. Sarah recalls that David did not engage with his social worker but that *'he was in a terrible state. He was totally outside of society, had no life and no friends …'* The CEO recalls that David was chronically traumatised, unable to participate in normal procedures, and was no way near being able to survive in a hostel; he was very frightened.

> *'From the time I met him as a six year old, standing in the snow with just his underwear, I tried to get social services, the police, both the primary and secondary school settings, as well as the [PRU], to see his needs were more than the system was acknowledging. I was worried about him and used to take him out once a week for half a day so that he could have some kind of interaction beyond being at home with his drug addicted Mum. But I felt everywhere I went there was a brick wall. Years later I found out that social [care] had labelled me as 'oppositional' for raising the alarm, and that's probably why the schools wouldn't respond. It was as if I was being described as part of the problem. This is the way voluntary sector workers are sometimes disempowered. We don't get to see what's in the files of the children, or what is being said about the concerns we raise. I couldn't understand why he was being visited occasionally by social workers, yet he was being failed so profoundly.'*
>
> **Camila Batmanghelidjh, CEO of Kids Company, in evidence to the CSJ**

1 This was disclosed by David

Observations

- A fundamental difficulty in this case appears to be the lack of any proper investigation into Patricia's parenting and her substance misuse. We understand that social care would visit when David was between the ages of about six and 12, and so there must have been concerns of some description. However, this did not appear to have led to any support being put in place. Alarm bells should have been raised about Patricia's ability to care for David when he was taken to the dentist by Sarah because his front teeth were rotting. After David was placed on the CPR, this did not seem to result in any effective practical action being taken. Social care did not involve the CEO in child protection meetings. There is no indication that social care listened to David. In failing to investigate Patricia's parenting capacity and substance misuse, a critical opportunity was missed to address a fundamental problem within the family home. Social care's interventions appear to have focussed more on practical issues in and outside of the home.

- Why, when the CEO had informed social care that Patricia was misusing drugs, did it not seek to establish the evidence for itself and promptly? David informed the CSJ that he had shown social care Patricia's crack pipe on two occasions – the second of which was when he was 15. Why did social care not support David robustly then, or when he told his social worker about Patricia's substance misuse and fact that dealers frequently came to the home? Social care should not have relied on Patricia's consent to accommodate David, given the facts known to them. The facts generated a duty to provide him with accommodation under S.20 as David was refusing to go home. Furthermore, nobody was able to exercise parental responsibility for David, and care proceedings were required. However, instead, there were ongoing breaches of various duties to safeguard David.

- There are several instances where it appears that the local authority relied on other people close to David to support him rather than take actions to support David. For example, that provided by Sarah and Bill as neighbours and then taking David into their home. When Patricia was apparently due to go into rehab it is understood that the local authority was intent on trying to find someone to take David because it did not want to fund a foster care placement. As a result, it is understood that the rehab placement for Patricia did not take place. The local authority also delayed in providing a ticket for David (when he was 15) so that he could stay with family. As a result, he arranged his own transport.

- It is also clear that the local authority developed an oppositional approach with Sarah, Bill and Kids Company, rather than exploring concerns that were being raised. It is concerning that when the CEO and Sarah and Bill intervened to raise concerns on behalf of David, their involvement met with defensive and negative responses from Patricia. However, the local authority did not appear to make any credible attempt to investigate concerns about Patricia, and seemed to try and play her criticisms of the CEO and Sarah and Bill off against the concerns they had raised, instead of investigating them. This approach effectively enabled the local authority to take itself out of the equation, and give the impression that the issues centred on a clash between Patricia and Kids Company/ Sarah and Bill.

- Sarah, Bill and the CEO persistently sought to help social care and to meet and share information. However, social care was invariably unreceptive to their contact, input or concerns. This is despite the fact that the CEO and Sarah had developed an informed understanding of David's day-to-day struggle to survive. David told us:

  'I should have been taken away from my mum at the age of seven at the most and never seen her again. I wish that had happened.'

- However, he remained in her care. He felt like he was the one being punished. His voice, wishes and feelings do not appear to have been taken into account.

- Social care left David, an extremely vulnerable child, exposed to severe neglect, abuse and risk for years, and out of education for significant periods of time – with profound consequences. This is despite alarm bells having been raised continuously by the CEO and Sarah. Sarah, Bill and the CEO provided regular care and support for David during certain periods – including in response to various crises. They were driven to do so by a deep rooted and prolonged concern for David's wellbeing. David explained to us:

  'Camila and [Sarah] joined forces and did a lot more than a whole company … could. It's amazing how a complete stranger can do so much more for you than a company that's meant to help. I say company because I think of social [care] as an organisation that deserves to get shut down and rebuilt.'

- David is said to have been profoundly traumatised by his experiences. He is recognised as having developed OCD, high levels of anxiety and delayed emotional development. There were times when David's lifestyle was said to be chaotic and was badly effected by his physical and emotional neglect. This raises issues as to whether David should have received mental health input. It is noteworthy that a Kids Company psychologist wanted David to access therapy when he was 17. However, David was not prepared to engage at this stage. Therapeutic input might have been better received if it had been proposed when David was considerably younger. However, without a proper assessment, which was child centred and listened to David's views, there was unlikely to have been any impetus to take such steps.

appendix 6: The Voluntary Sector: A Poor Position For Exercising Influence

Our research has revealed the severe challenges that some VSOs are facing at the interface with social care, in engaging with them to secure optimal outcomes for vulnerable children (and young people).[1] In reality, there appears to be very little that a VSO can do to redress this. We highlight some key areas below, to illustrate the voluntary sector's weak position in this respect.

What duties do local authorities have to consult VSOs when undertaking assessments?

None. In order for local authorities to be under a 'duty' to consult VSOs, legislation would need to state that the local authority 'shall' consult. This is not present in the primary legislation nor in the statutory guidance.

Prior to the *2013 WTSC*

The *2000 Assessment Framework* set out the expectations of initial assessments and core assessments.[2] Local authorities were expected to consult/liaise with universal services and, as a matter of good practice, to do the same with any other agency with current or historic knowledge and understanding of the children and family. VSOs were recognised as being 'key providers of a number of different types of services for children and families.'[3] However, the *2000 Assessment Framework* contained no more than a good practice expectation for local authorities to consult VSOs, and there was no legal requirement for them to do so.[4]

1 As discussed in Chapter Three and Chapter Four
2 Department of Health, Department for Education and Employment, Home Office, *Framework for the Assessment of Children in Need and their Families*, London: The Stationery Office, 2000
3 Ibid, p66
4 Ibid, p63

The *2013 WTSC*

The guidance states: 'Local authorities, with their partners, should develop and publish local protocols for assessment.' These should be agreed with the relevant LSCB. 'The local authority is publicly accountable for this protocol and all organisations and agencies have a responsibility to understand their local protocol.'[5]

We have been advised by a barrister that *'if the position was bad before for [VSOs], it is now even worse.'* For a VSO to comply with the responsibility to understand the local protocol, and to know how a case will be managed, following the acceptance of a referral by social care, then it will need to have a copy of the local protocol. A search on the internet by the CSJ has revealed that an extremely small number of local protocols appear to be available on local authority websites across England. Social workers are required to 'lead on an assessment and complete it in line with the locally agreed protocol according to the child's needs …'[6] Where the document is not publicly available, as it should be, what is the local agreed protocol in the relevant local authorities, and how does a VSO (or any one else for that matter) obtain a copy of it – assuming that it in fact exists?[7]

The local protocol is required to 'clarify how *agencies and professionals* [CSJ's emphasis] undertaking assessments and providing services can make contributions.'[8] Some VSOs could provide a valuable contribution but, without a definition of 'agencies' or 'professionals,' it is not clear whether this is intended to also apply to VSOs. As our evidence highlights, various attitudinal barriers exist within some social care teams towards VSOs, and a lack of professional respect towards the voluntary sector – as a valid, key stakeholder in a vulnerable child's (or young person's) life.

The position under the *2013 WTSC* is now much less specific regarding the consultation of VSOs by social care when undertaking assessments. For example:

- 'The principles and parameters of a good assessment' – at paragraph 34: does not state who the information should be gathered from.[9]

- 'Focussing on the needs and views of the child' – at paragraph 40: 'Every assessment should draw together relevant information gathered from the child and their family and from relevant professionals [CSJ emphasis] including teachers, early years workers, health professionals, the police and adult social care.'[10] Express reference to VSOs, as was included in the *2010 WTSC*, no longer features. The guidance does not appear to contain a definition of 'relevant professionals.' This could include VSOs but raises the same point as above.

5 This is discussed further in Chapter Four; HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p24 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

6 Ibid, p30

7 This point is discussed further in Chapter Four

8 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p24 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

9 Ibid, p19

10 Ibid, p21

- 'Assessment of a child under the [CA] 1989' – 'All involved professionals [CSJ emphasis] should be involved in the assessment and provide further information about the child and family … '[11] The guidance does not appear to contain a definition of 'involved professionals.' Again, this could include VSOs but raises the same point as above.

Failure by social care to include all relevant agencies in its information gathering may be criticised by the court, or within CPCs, or as part of looked-after children reviews, and may result in recommendations to undertake a more comprehensive assessment. However, it may go un-noticed unless it is raised by another member of the CPC or looked-after child review. If a VSO is being excluded by social care, then it seems that a VSO's lack of contribution to an assessment may well go un-noticed. A VSO could address the failure of social care to consult with it by making a direct complaint to the local authority (although, as revealed by our evidence, this is not always effective), or through the LSCB.

Who is required to be part of the core group meeting? How can VSOs secure their place on a core group?

Prior to the *2013 WTSC*

The position relating to core groups was set out in the *2010 WTSC*.[12] The core group was appointed at the initial CPC. It was the responsibility of the chair to ensure that relevant professionals were identified as part of the core group. Which professionals were included would vary on a case-by-case basis and there were no minimum requirements. There was no express reference made to the inclusion of VSOs.

The *2013 WTSC*

The guidance states that the purpose of initial CPCs includes 'identifying membership of the core group of professionals [CSJ emphasis] and family members who will develop and implement the child protection plan.'[13] Again, without a definition of 'professional,' and in the absence of express reference to the inclusion of VSOs (as given in other places in the *2013 WTSC*), it is not clear whether this is intended to also apply to VSOs.

The position remains unchanged under the *2013 WTSC* – i.e. for a VSO to secure a place on a core group, they would need to attend the initial CPC, and request to be part of the core group. However, we are aware of some VSOs not being invited to initial (or indeed subsequent) CPCs.

11 Ibid, p31

12 The position regarding core group membership was set out under paragraphs 5.102 and 5.105; Department for Children, Schools and Families, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, Nottingham: Department for Children, Schools and Families, issued March 2010, pp168–169

13 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p40 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

Alternatively, following the initial CPC, the core group has the power/ability to co-opt any other professionals with knowledge of the child, or who are working with the child, onto the core group. We believe considerable benefit could be gained by effective VSOs being part of a core group, and that greater information sharing and enhanced contact with social workers could help to foster stronger working relationships between them.

Where a VSO has concerns over not being invited to join a core group, it would need to challenge local practice by making a complaint directly to the local authority or through the LSCB.

Who is required to attend CPCs? How can VSOs secure their place on a CPC?

Prior to the *2013 WTSC*

Prior to the *2013 WTSC*, the position was the same regarding CPCs as it was for core groups. Local authority duties were contained in the *2010 WTSC* and LSCB policies. All those with professional expertise, knowledge/ongoing involvement with children and families were expected to be invited to a CPC. The *2010 WTSC* stated that:

> *'There should be sufficient information and expertise available – through personal representation and written reports – to enable the [CPC] to make an informed decision about what action is necessary to safeguard and promote the welfare of the child, and to make realistic and workable proposals for taking that action forward … Those who have a relevant contribution to make may include: … NSPCC or other involved voluntary organisations …* '[14]

Any agency could request that a CPC should be held. The decision as to whether to hold a CPC or not, and over who to invite or exclude, rested with the chair.

The *2013 WTSC*

The guidance states that 'Following [S.]47 enquiries, an initial [CPC] brings together family members (and the child where appropriate), with the *supporters, advocates and professionals* most involved [CSJ emphasis] with the child and family, to make decisions about the child's future safety, health and development.'[15] Supporters, advocates and professionals could include VSOs. However, it is not clear whether the wording is intended to apply to them. Express reference to VSOs as having a relevant contribution to make, no longer features in the statutory guidance.

14 Department for Children, Schools and Families, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, Nottingham: Department for Children, Schools and Families, issued March 2010, pp162–163

15 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p40 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]

The position remains unchanged under the *2013 WTSC* – i.e. a VSO that has not been invited to a CPC would need to contact the chair to request permission to attend. There is no mechanism by which a VSO can seek to compel the chair to permit its attendance. Where a VSO has concerns in the absence of permission being granted, it would need to challenge local practice by making a complaint directly to the local authority, or through the LSCB.

What is the potential for a VSO to contribute its input through a LSCB?

As required by the CA 2004, every local authority has a LSCB – a multi-agency board with 'a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.'[16]

The objectives of LSCBs are:

- *'to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and*
- *to ensure the effectiveness of what is done by each such person or body for those purposes.'*[17]

Prior to the *2013 WTSC*

The key parts of the *2010 WTSC* for the voluntary sector were:

- *'Safeguarding and promoting the welfare of children is the responsibility of the local authority, working in partnership with other public organisations, the voluntary sector, children and young people, parents and carers, and the wider community.'*[18]
- *'The voluntary sector is active in working to safeguard the children and young people with whom they work, and plays a key role in providing information and resources to the wider public about the needs of children.'*[19]
- *'There should be clear and published local guidance for the voluntary sector on access pathways to services and how thresholds are applied when making a referral to social care.'*[20]
- *'Membership of the LSCB is made up of senior managers from different services and agencies in a local area, including the independent and voluntary sector …* '[21]

16 Children Act 2004, Section 13; cited in ibid, p58
17 Children Act 2004, Section 14; cited in ibid. The functions of LSCBs are set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006
18 Department for Children, Schools and Families, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, Nottingham: Department for Children, Schools and Families, issued March 2010, p9
19 Ibid, p12
20 Ibid, p85
21 Ibid, p13

- *'The function of an LSCB also includes advising the local authority and Board partners on ways to improve. The LSCB might do this by making recommendations (such as the need for further resources), by helping organisations to develop new procedures, by spreading best practice, by bringing together expertise in different bodies, or by supporting capacity building and training. Where there are concerns about the work of partners and these cannot be addressed locally, the LSCB should raise these concerns with others, as explained further in paragraph 3.109.'*[22]

- *'The local authority should also secure the involvement of the NSPCC and other relevant national and local organisations. The knowledge and experience of the NSPCC and other large voluntary sector providers is an important national resource on which LSCBs should draw. At a minimum local organisations should include faith groups, children's centres, GPs, independent healthcare organisations, and voluntary and community sector organisations including bodies providing specialist care to children with severe disabilities and complex health needs …'*[23]

The *2013 WTSC*

The guidance states:

- *'Voluntary organisations … play an important role in delivering services to children. They should have the arrangements described in paragraph [four] of this chapter in place in the same way as organisations in the public sector, and need to work effectively with the LSCB.'*[24, 25]

- *'The LSCB should either include on its Board, or be able to draw on appropriate expertise and advice from, frontline professionals from all the relevant sectors. This includes … .the voluntary and community sector.'*[26] Reference is therefore made to the potential for VSOs to be included in the membership of LSCBs. The expectation on local authorities to secure the involvement of VSOs no longer features.

What action can a VSO take to compel a local authority to consult with it, or to secure an invitation to join a core group or to attend CPCs, concerning a child it is supporting?

A VSO can make a direct complaint to the local authority, or representations to the LSCB, if it has any concerns about the practice of a local authority regarding safeguarding children. All agencies are bound by the safeguarding policies for the LSCB area, including those on assessments, core groups and CPCs.

22 Ibid, p94
23 Ibid, p105
24 HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, March 2013, p57 [accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf (08.04.14)]
25 The arrangements referred to (under paragraph four of the specified chapter) relate to the duties contained within Section 11 of the Children Act 2004, and should 'reflect the importance of safeguarding and promoting the welfare of children, including … arrangements which set out clearly the processes for sharing information, with other professionals and with the … [LSCB];' ibid, pp47–48
26 Ibid, p62

- Where issues exist over a failure by social care to consult a VSO when undertaking an assessment, or over core group membership and/or attendance at CPCs, a VSO can seek to address these through the LSCB, if they have not been resolved by representations to the social care team or CPC chair, or following a direct complaint to the local authority. In addition, a barrister has advised us that, in their view, anyone can make a representation to a local authority's monitoring officer.[27] However, the difficulty here is that in order for this potential remedy to be available, the local authority would need to be in breach of a rule or law or a code of practice. There is no explicit rule of law or code of practice for VSOs to rely upon.

- Issues for looked after children should be raised with the independent reviewing officer (IRO), who now have greater duties.[28] IROs have the power to request that placements are frozen, they can create a dispute process to challenge senior managers about decision making, and have the power to refer to Cafcass/courts if plans are not being followed. There is an expectation that any agency should refer to an IRO if a care plan is not appropriate/not in place, or recommendations are not being carried out for a child.

- Ultimately a VSO could support children in pursuing applications against the local authority for breaching/failing in their statutory duties. However, as stated by Darren Howe in the legal foreword, this merely 'sets the VSO and the child against the local authority in costly court proceedings, when all that is required is for the local authority to work cooperatively with, and give adequate weight to the role of the voluntary sector that, after all, has the most contact with and holds the most detailed information concerning the child.'

- A barrister informed us that they suspect the reason JR is so frequently used is that the use of the complaints procedure to change a decision is often not fruitful. It is vital that effective VSOs are able to participate meaningfully in the decision making process, so as to influence the end decision. This may be likely to lead to less frequent applications for JR on behalf of vulnerable children.

27 Under Local Government and Housing Act 1989, Section 5

28 Under the Care Planning, Placement and Case Review Regulations 2010, and the statutory guidance (IRO handbook) – available at: http://nairo.org.uk/wp-content/uploads/2011/03/IRO-handbook-Statutory-guidance-IROs-and-LAs-March-20101.pdf

appendix 7:
Better Outcomes, New Delivery (BOND)

We are aware that some local authorities and the NHS are tackling the challenge of investing in early intervention, as opposed to reactionary or crisis services, and seeking to utilise voluntary as well as community sector services more effectively through their commissioning arrangements – for example, through BOND, a Department for Education funded programme, which ran from November 2011 to January 2014.

> *'YoungMinds led a consortium of [nine] partners to deliver capacity building and commissioning support that increased the quality and availability of voluntary and community sector provided early intervention emotional well-being and mental health services for children and young people.'*[1]

BOND supported voluntary and community sector organisations (VCSOs), schools, local authority and NHS commissioners and CAMHS to work together in five pilot areas, on an improvement programme – a whole systems approach to improve outcomes for children and young people in their respective areas. [2, 3]

BOND saw a total increase in spend on VCSO services across the pilot areas to the value of approximately £2.4 to £4 million.[4] Qualitative feedback showed that the pilot support

1 The partners included: 'Cernis, CAMHS EBPU, FPM, Lisa Williams, Mental Health Foundation, Place2Be, Youth Access and Dawn Rees (until [September] 2012);' BOND, *BOND Evaluation Report, November 2011-January 2014*, p5 – available from www.youngminds.org.uk/BOND

2 YoungMinds, About BOND [accessed via: http://www.youngminds.org.uk/training_services/bond_voluntary_sector/about_bond (01.04.14)]

3 The five pilot areas included: 'Tees Valley, Liverpool, Knowsley & Sefton, Cambridgeshire, Staffordshire and South West London … BOND supported over 30 health and education commissioners; over 50 head teachers representing 88 schools; [and] 95 VCSOs providing a range of early intervention mental health and emotional wellbeing support;' BOND, *BOND Evaluation Report, November 2011-January 2014*, p5 – available from www.youngminds.org.uk/BOND

4 The scale is stated to be due to 'one or more of the contracts offering a range in value.' The target increase in spend set by the Department for Education is also stated as having been exceeded; BOND, *BOND Evaluation Report, November 2011-January 2014*, pp5–6 – available from www.youngminds.org.uk/BOND

programmes *'created increased social capital, evidenced by the co-design of new delivery models, identification and sharing of local best practice, and increased specialist knowledge.'*[5, 6]

Concerted efforts are being made to continue to help build the capacity of VSCOs and support their sustainability, and to make commissioning easier for commissioners. A collection of resources, information and best practice guidance for VSCOs, commissioners and schools has been produced.[7] For example:

- A range of tools have been published to support VCSOs in contract bidding, including:
  - a cost-benefit analysis tool;
  - collaborative VCS structures – including consortia, partnerships, legal mutual structures (i.e. co-operatives, collectives and associations), social franchises and prime contractor and supplier/s;
  - a guide to winning bids for small organisations; and
  - a workforce planning tool.

- A number of commissioning support resources have been produced, including:
  - a catalogue and glossary of mental health terms;
  - learning exchanges; and
  - Academic Resilience, beating the odds for better results – an on-line resource and toolkit for schools to use to identify what needs exist within their pupil population, and to adopt a whole school approach to building resilience and improving mental well-being, thereby promoting good mental health.[8]

- A number of resources have also been developed for the benefit of VCSOs, commissioners and others. For example:

  Youth Wellbeing Directory:
  - a free on-line resource 'for all those who share the aim of improving' the emotional well-being and/or mental health of children and young people – including statutory and non-statutory service providers, commissioners, those up to the age of 25, and others seeking help; and
  - enables users to locate and compare services.

  ACE-Value Quality Standards (ACE-V):
  - VSCOs are required to complete 11 categories in four domains – accountability, compliance, empowerment and value; and
  - enable service providers to 'demonstrate their effective, safe and quality practice,' [and] commissioners and those seeking help to compare different providers against ACE-V Quality Standards.'[9]

5 Ibid, p6

6 The BOND evaluation report stated that the programmes of commissioning support identified the following 'key challenges facing local areas and what needs to be addressed in any consultancy offer in the future: dissatisfaction with large provider contracts, engagement with schools, clarity of shared understanding of the issues facing different parts of the local system, unrealistic expectations, lack of money, isolation, lack of trust, the need for an impetus to come together;' ibid, p7

7 These are available from YoungMinds' website: http://www.youngminds.org.uk/training_services/bond_voluntary_sector/resources

8 Academic Resilience is available for schools to download (free of charge) from YoungMinds' website, and which YoungMinds hopes to support schools to implement – from: http://www.youngminds.org.uk

9 YoungMinds, *What is the Youth Wellbeing Directory and ACE-V Quality Standards?* [accessed via: http://www.youngminds.org.uk/training_services/bond_voluntary_sector/ace-v (05.04.14)]

appendix 8: Schools

> *'…what really worries me is that we're only in 100 schools. And it relies on those head teachers in those schools to put what is perceived as their education money towards supporting the social care of families. They have got to be visionary head teachers to see that and want to be able to do that. Loads and loads of children across the country are not engaging in school because of home circumstances, and there's a serious issue of the inability of statutory services to intervene before children and families end up in crisis.'*
>
> **CEO, School-Home Support, in evidence to the CSJ**

In numerous cases across our evidence, we have discovered serious missed opportunities by schools to safeguard and promote the welfare of vulnerable children, and to work in partnership and collaboration with VSOs – as well as statutory agencies – to help meet their social care and/or mental health needs.[1] This has included cases where concerns existed over the children being at risk of or suffering street gang violence. A VSO informed us that:

> *'School child protection leads are often overstretched and some schools seem very reluctant to get involved with child protection, with some notable exceptions.'*

Resources appear to be stretched across the board.

> *'I'm very concerned about the recent reductions in educational psychology provision, as well as the fragmentation of such services resulting from the increasing autonomous functioning of schools, exemplified by the free school and academy developments. The more detailed specialist areas of educational psychology, like cognitive assessments are a rarity now. More generally, the importance of education cannot be overemphasised, particularly for high risk children with complex needs. Those who are struggling or not managing or not being managed in education frequently end up with very little, unless they end up in a really highly specialist setting … '*
>
> **Senior CAMHS clinician, in evidence to the CSJ**

1 As discussed in Chapter One, and further evidenced by, for example, Michael's, David's and Daniel's cases

We have found a repeated failure on the part of schools, across our evidence, to provide vulnerable children with the requisite support. Educational exclusion has featured heavily across the evidence to our Review. A number of in the Kids Company cases we reviewed appear to have been illegal. We exposed the unscrupulous and illegal practices adopted by some schools in England in our in-depth inquiry *No Excuses: A review of educational exclusion*.[2, 3] *No Excuses* also highlighted the huge challenges faced by schools and PRUs, in understanding and addressing the issue of street gang activity where it affects their pupils and educational community. Some schools are demonstrating best practice in this regard, as we profiled. However, it is clear that this remains an issue of the utmost concern in others. In *Rules of Engagement*, the CSJ has since identified that whilst schools have a central role to play in youth crime prevention, given their unique position in the community, 'it is clear that many schools are not fulfilling this potential role.' It also revealed that 'Given the correlation between exclusion and subsequent offending, many of those giving evidence to [the CSJ's] review have questioned why greater efforts are not being made to prevent exclusion.'[4]

> In Adam's case, Kids Company highlighted the requirement to develop new structures in order to meet the needs of those in psychological distress originating from trauma. In response, the CAMHS Consultant Psychiatrist, expressed the view that an integrated systems approach would certainly be helpful at an earlier stage, if resources could be found for this. They felt that the key hub would probably be education, with an increased focus on working with families, and moving away from a culture of excluding children from school.[5]

More recently, in *Girls and Gangs,* the CSJ highlighted the plight of girls and young women who are associated with street gangs, including their sexual exploitation. Further issues of concern arise over this cohort's social care and mental health needs, and the crucial involvement of schools in helping to identify them and secure the necessary support.[6] However, tragically, the report exposed that some schools are failing to confront this issue.[7]

In *No Excuses*, we contested that schools (and PRUs) should not be left alone to address the often complex, multiple problems faced by vulnerable children and young people – which

2 Our report found that many pupils are being profoundly misunderstood within some mainstream schools. The underlying causes of their behaviour, and their needs, are not being addressed properly. We revealed that some schools are failing to comply with their legal obligations in respect of official exclusions, are carrying out unofficial (i.e. illegal) exclusions, or are otherwise failing to provide an acceptable level of pastoral care and education. In doing so, they are also failing to comply with their child protection and safeguarding obligations in many cases. Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, September 2011, pp125–164

3 A number of other reports have also since been published including: Office of the Children's Commissioner for England, '*They never give up on you,*' *Office of the Children's Commissioner School Exclusions Inquiry*, March 2012; Office of the Children's Commissioner for England, '*They Go The Extra Mile,' Reducing inequality in school exclusions*, March 2013; Office of the Children's Commissioner for England, '*Always Someone Else's Problem,' Office of the Children's Commissioner's Report on illegal exclusions*, April 2013 [all of which accessed via: http://www.childrenscommissioner.gov.uk/content/publications?search=exclusions (23.04.14)]; and Contact A Family, *Falling through the net: Illegal exclusions, the experiences of families with disabled children in England and Wales (2013)*, February 2013 [accessed via: http://www.cafamily.org.uk/media/639982/falling_through_the_net_-_illegal_exclusions_report_2013_web.pdf (23.04.14)]

4 Centre for Social Justice, *Rules of engagement: Changing the heart of youth justice*, London: Centre for Social Justice, January 2012, p41

5 A snapshot of Adam's case can be found in Chapter Two, and an analysis of the mental health issues in his case in Chapter Four

6 The CSJ will set out a detailed plan covering the aspects raised in its report, as part of an in-depth gang study beginning later this year. However, in Chapter Two, it suggests five initial areas where action would make a real difference. One of these includes ensuring that gang-affected schools are open to support; Centre for Social Justice, *Girls and Gangs*, London: Centre for Social Justice, March 2014

7 Recommendations have also been made to help schools tackle the impact of street gang activity and influence in *No Excuses* and *Dying to Belong:* Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, September 2011, and Centre for Social Justice, *Dying to Belong: An in-depth review of street gangs in Britain*, London: Centre for Social Justice, 2009

this Review has demonstrated can continue to be the case as a result of gatekeeping, higher thresholds and diminishing resources in some areas of the country. This is in circumstances where they are also under pressure to meet various targets, and where there continues to be an emphasis on academic performance.

> *'And wouldn't it be ideal if from that identification of emerging mental disorder in the vast majority of the key vulnerable age group, who are school age, if there was a really strong link in with primary care from the schools and statutory services like ourselves to pick up those who have the more severe problems emerging, to really nip those in the bud if possible, at the time they first appear. And additionally provide more universal resilience building interventions to all in the school years. I think there's a really strong potential in bringing education and mental health services into working much more collaboratively…Again the shocking thing is, the policy statements have been there for years, and the understanding for decades in some cases, saying this is exactly what we should be doing…the Children's Plan, Every Child Matters. They're all saying the same things – that education and mental health should be working side by side, and we're still not doing it yet.'*[8]
>
> **Public Health Manager, BSMHFT, in evidence to the CSJ**[9]

Education has a vital role to play in educating all children about mental health. Teachers should be 'skilled up,' the importance of resilience understood as a positive language, and the language of mental health literacy raised (which could help with the potential identification of mental health problems, and early intervention).[10] We recommend that schools:

- Encourage teachers to teach a module in PHSE on mental health – to introduce a series of evidence-based educational modules to school, with a focus on resilience building and developing good mental health. These could also show that mental health issues can underlay, for example, teenage pregnancy, substance misuse or bullying. We suggest that the way to introduce mental health modules into PHSE would be to train teachers to provide these modules, so that they also learn about mental health and its relevance and importance to themselves, as well as to their pupils, in the process. These could sit as individual one-off modules, or comprise a full course on resilience/mental health;

8 We heard about The Health and Education Links Service (HELS) – an innovative organisation that is trying to get more health professionals into schools (primary and secondary), as well as special schools and PRUs. The aim of its work is to break down the barriers for children and young people – '*this is my friendly local GP, I know him and I'll talk to him about what I'm worried about.*' It also helps teachers teach subjects they may find difficult including, for example, mental health. Despite the time pressures, amongst others, that GPs are under, a GP was confident in HELS' potential to link GPs and schools. They said '*there are enough GPs and practice nurses who would be interested. If you had the time and resources and worked hard enough at it, you would get a GP or a practice nurse from a local surgery linked with every school.*' Further information is available at: http://healthykids.org.uk

9 It should be noted that the views expressed by the Public Health Manager, BSMHFT throughout this report are their individual views, and may not represent those of BSMHFT

10 One of the three fundamental changes proposed by the *2008 CAMHS Review* was that 'The whole of the children's workforce needs to be appropriately trained and, along with the wider community, well informed,' with respect to mental health and psychological well-being. The *Review* recognised that part of the solution to the continuing barriers to effective collaboration was ' … schools and other universal services doing more themselves to promote and support mental health, by improving the skills of their staff;' *CAMHS Review – Children and young people in mind: the final report of the National CAMHS Review*, Department for Children, Schools and Families and Department of Health, November 2008, p10, p12 and p46 [accessed via http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399 (25.04.14)]

- Offer 'work discussion' – where a group of teachers can meet with someone who is more skilled, to reflect on some of the things that they are seeing. This involves the potential for one person to see a lot of teachers, and is regarded as an economical approach.[11, 12]

- A support response – in *No Excuses* we referred to the provision of therapeutic support for teaching and support staff in some schools and PRUs, as well as for pupils and, in some cases, their families.[13] *Completing the Revolution* has since proposed an integrated school-based mental health service – which 'would be family focussed and designed to meet the emotional needs of pupils, parents and teachers, and spot dawning mental health needs.' It has recommended 'making more universal and targeted mental health services available in schools as a key component of a public mental health approach.'[14, 15]

11 We would argue that ideally both of these recommendations ought to be in place, to provide a forum for learning, and self-reflection

12 Again, this has been identified as another example of where PIE could be extremely beneficial – i.e. with a senior mental health professional holding surgeries with teaching groups/governors/parents etc. It has also been suggested that mental health first aid could also be helpful here

13 We also recommended that teachers should be given supportive training in self-reflection and responding to their own experiences in schools; Centre for Social Justice, *No Excuses: A review of educational exclusion*, London: Centre for Social Justice, September 2011, p107 and p124

14 The report recognised that 'Providing such community-based, easily accessible services can, in some cases, prevent escalation to the higher levels of need that will require the expertise of CAMHS professionals in specialist clinics; *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, October 2011, pp123–124

15 We are aware that the BIG lottery funded Headstart programme is set to test this approach, focussed on 10- to 14-year-olds, and the transition between schools, over at least the next five years

appendix 9: Glossary

Abbreviations

ADCS	Association of Directors of Children's Services
ADHD	attention deficit and hyperactivity disorder
AEP	alternative education provision
AMHS	Adult Mental Health Services
APMS	Adult Psychiatric Morbidity Survey
APPG	All Party Parliamentary Group
ASD	autistic spectrum disorder
AYSE	Assessed and Supported Year in Employment
BASW	British Association of Social Workers
BOND	Better Outcomes, New Delivery
BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust
CA 1989	Children Act 1989
CA 2004	Children Act 2004
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services

CBT	cognitive behavioural therapy
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPC	Child Protection Conference
CPD	continuing professional development
CPR	Child Protection Register
CSE	child sexual exploitation
CSDPA 1970	Chronically Sick and Disabled Persons Act 1970
CSJ	Centre for Social Justice
CSW	College of Social Work
CYP IAPT	Children and Young People's Improving Access to Psychological Therapies
DNA	did not attend
DSM	Diagnostic and Statistical Manual of Mental Disorders
EHA	early help assessment
EHC	Education, Health and Care
FCAMHS	Forensic Children and Adolescent Mental Health Services
GP	General Practitioner
GPC	General Practitioners Committee
HCPC	Health and Care Professions Council
HEI	higher education institution
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Children's System

JHWS	joint health and wellbeing strategy
JR	judicial review
JSNA	joint strategic needs assessment
LAC	looked after children
LASSA 1970	Local Authority Social Services Act 1970
LAA	Legal Aid Agency
LD	learning disability
LGO	Local Government Ombudsman
LSCB	Local Safeguarding Children Board
LSE	London School of Economics and Political Science
NHS Act 2006	National Health Service Act 2006
NHS CB	National Health Service Commissioning Board
NICE	National Institute for Health and Clinical Excellence
OCD	obsessive compulsive disorder
ONS	Office for National Statistics
PLO	Public Law Outline
PRU	Pupil Referral Unit
PTSD	post-traumatic stress disorder
RCGP	Royal College of General Practitioners
S.7	Local Authorities Social Services Act 1970
S.17	Section 17 of the Children Act 1989
S.20	Section 20 of the Children Act 1989
S.47	Section 47 of the Children Act 1989

SEN	special educational needs
SHS	School-Home Support
SLCN	speech, language and communication needs
TAC	Team Around the Child
TFP	Troubled Families Programme
UCL	University College London
UNCRC	United Nations Convention on the Rights of the Child
VSO	voluntary sector organisation
2010 WTSC	Working Together to Safeguard Children 2010
2013 WTSC	Working Together to Safeguard Children 2013
YJS	Youth Justice System
YOT	Youth Offending Team

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