PP 2016/0103

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

THIRD REPORT FOR THE SESSION 2015-16

Children and Families Social Services

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE
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CHILDREN AND FAMILIES SOCIAL SERVICES

There shall be three Policy Review Committees which shall be Standing Committees of the Court. They shall scrutinise the implemented policies, as deemed necessary by each Committee, of the Departments and Offices indicated in this paragraph together with the associated Statutory Boards and other bodies:

- *Social Affairs Committee: Department of Health; Department of Education and Children; Department of Social Care; and Department of Home Affairs.*

Each Policy Review Committee shall in addition be entitled to take evidence from witnesses, whether representing a Department, Office, Statutory Board or other organisation within its remit or not, in cases where the subject matter cuts across different areas of responsibility of different Departments, Offices, Statutory Boards or other organisations. The Policy Review Committees may also hold joint sittings for deliberative purposes or to take evidence. The Chairmen of the Policy Review Committees shall agree on the scope of a Policy Review Committee's inquiry where the subject cuts across the respective boundaries of the Policy Review Committees' remits.

Each Policy Review Committee shall have –

(a) a Chairman elected by Tynwald,

(b) two other Members.

Members of Tynwald shall not be eligible for membership of the Committee, if, for the time being, they hold any of the following offices: President of Tynwald, member of the Council of Ministers, member of the Treasury Department referred to in section 1(2)(b) of the Government Departments Act 1987.

The Policy Review Committees shall be authorised in terms of sections 3 and 4 of the Tynwald Proceedings Act 1876 as amended and of Standing Orders to take evidence and to summon the attendance of witnesses and further to require the attendance of Ministers for the purpose of assisting the Committee (or Committees, if sitting jointly).

The powers, privileges and immunities relating to the work of a committee of Tynwald are those conferred by sections 3 and 4 of the Tynwald Proceedings Act 1876, sections 1 to 4 of the Privileges of Tynwald (Publications) Act 1973 and sections 2 to 4 of the Tynwald Proceedings Act 1984.

Committee Membership

Mr D C Cretney MLC (Chairman)

Mr G G Boot MHK (Glenfaba)

The Hon S C Rodan SHK (Garff)

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To: The Hon Clare M Christian, President of Tynwald,

and the Hon Council and Keys in Tynwald assembled

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I. INTRODUCTION

1. In 2013 and 2014 we investigated the number of referrals to children and families social services. Our report on this investigation was published in March 2015 and debated in June of that year.[1] Of our five recommendations on this subject one was amended, three were carried and one was lost. The resultant resolution of Tynwald was:

> *Recommendation 1*
>
> *That the Safeguarding Children Board needs to ensure that thresholds between the different levels of need are clear and universally understood and that the referral routes to each level of support are similarly clear so as to avoid unnecessary referral into child protection.*
>
> *Recommendation 2*
>
> *That Tynwald calls on all Departments, Boards and Offices to engage constructively with the Data Protection Supervisor in developing procedures for handling personal information.*

[1] PP 2015/0049

Recommendation 3

That Tynwald would wish to see the Protecting Children Board placed on a clear statutory footing and calls upon the Department of Health and Social Care to introduce the necessary legislation into the House of Keys as soon as possible.

Recommendation 4

That Tynwald calls on the Cabinet Office to expedite its work on complaints processes whether or not that should involve implementing the Tynwald Commissioner for Administration Act 2011.

2. After we had produced this report we decided to continue looking at children and families social work. In March 2015 we were informed that Maggie Mellon, Vice Chair of the British Association of Social Workers, had been invited to the Island to address a public meeting on 29th June 2015. We took the opportunity to invite her also to have a discussion with us on the same day. In September 2015 we had a discussion with Dr David Foreman, a child psychiatrist who has worked in England and in the Isle of Man. Transcripts of these discussion are included in this report. Dr Foreman also made a written submission in advance of his oral evidence and updated it afterwards. The latest version is published as an Appendix to this report.[2]

3. In November 2015 we issued a media release stating that we wished to hear from the public first hand accounts of the working practices of children's social workers. Of interest was the impact on children and families when social workers investigate referrals, and when they process assessments and inquiries. We explained that we would not take a view on any individual case and will not liaise with the Department regarding any individual case. We could, however, listen to witnesses including public sector workers and were willing to do so in complete confidence. This was in order to ensure that we understood what was actually happening between social workers and families. This understanding would improve our ability to scrutinise the implemented policy of the Department in this area.

4. The total number of initial queries we received in response to the media release was 26. Of these, 21 led to meetings in private, 3 made written submissions only, and the remaining 2 chose not to provide anything.

[2] Appendix 3

5. Having considered what the 21 individuals or couples had said to us, we put some of the issues they had raised to representatives of the Department of Health and Social Care in a public oral evidence session on 13th April 2016. The transcript of that session is included in this report.

II. COMPARISONS WITH THE UK

6. One of the central issues in our March 2015 report was that:

> *at the outset of our investigation in 2012 the number of children in the Isle of Man in need of protection was about the same as the English average on a per capita basis, but the numbers of referrals, assessments and inquiries were proportionately higher.*[3]

7. We discussed with both Maggie Mellon and Dr David Foreman the validity and significance of this finding. Dr Foreman's written submission illustrated the difficulty of comparing like with like given the differences in which figures are collected in England and the Isle of Man.[4] He favoured using UK averages as the basis of comparison but suggested that through further research it might be possible to identify an English region or locality which would be more appropriate in terms of economic and demographic matters.[5] He was not convinced that the potential adverse effects of a social work intervention were any worse in the Isle of Man than in small communities which could be found both in urban and rural areas of the UK.[6]

8. Maggie Mellon, on the other hand, saw potential benefits in the Isle of Man's unique situation. She said:

> *It seems to me that the Isle of Man is a really human size of a population and that you have an enormous opportunity to not make the mistakes and go down the routes of… for instance, in England and in Scotland… There are lots of opportunities for building on strengths and social solidarity, rather than on treating people as individuals. We are all individuals of course, but build on the good social strengths and social systems you have got.*[7]

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[3] PP 2015/0049(1), paragraph 24
[4] Appendix 3
[5] Q 151
[6] Q 152
[7] Q 101

and later:

> *I think the Island is a beautiful size of a place… It just seems a really good size of an Island for you to be thinking about not making the same mistakes as have been made and you have got a lot of levers here in your own hands to be doing something that really works for you.*[8]

We conclude that, while the challenges of providing social services to children and families are as serious in the Isle of Man as anywhere, there is no reason in principle why the Island should not aspire to the highest standards of service delivery and social outcomes from its investment in children and families social work.

III. REFERRALS: ADVERSE EFFECTS AND CHANGES IN RATES

9. We concluded in our March 2015 report that:

> *there has been an increase in the number of instances where an agency approaches Children and Families Services in a case where an assessment is not needed. Whether these instances are defined as "contacts" or "referrals", they still have the effect of diverting social services resources from the most needy cases. The downward trend which the Department hoped for in November 2013 has not materialised.*
>
> *We conclude that over-referral is a serious issue because of its direct adverse impact on families needlessly subject to the attention of social services, its indirect impact on children in need and at risk of harm, and its cost to the taxpayer.*[9]

10. The figures below, which are based on answers given to Tynwald Questions, show that during the past eight years the average number of child protection plans has remained broadly the same.

[8] Q 140

[9] PP 2015/0049(1), paragraph 32

	Referrals	
2008		34 children subject to a child protection plan
2009		42 children subject to a child protection plan
2010		51 children subject to a child protection plan
2010/11	895	55 new child protection cases
2011/12	959	48 new child protection plans
2012/13	729	45 new child protection plans
2013/14	1385	24 new child protection plans
2014/15	795	38 new child protection plans

11. In oral evidence to us Maggie Mellon commented that:

> *the increased number of referrals isn't turning up an increased number of children at risk, and in fact the number of child homicides and serious injuries has been fairly flat over 30, 40 or 50 years. So referral and assessment is not actually identifying more children. It is not that for every 1,000 more assessments you have got a consequent rise in the number of children you are protecting, and so that is obviously not an accurate statement to say if it saves one extra child's life.*[10]

12. The Every Child Matters policy was supposed to aid the prevention and detection of child abuse but did not, in fact, lead to an overall rise in detected child abuse cases. Conversely, there was a huge rise in the number of families involved in social services investigations in the Isle of Man which, due to very poor working practices, were far from benign.

13. The situation in the UK was described in an Economic and Social Research Council (ESRC) briefing as follows:

> *There is increased pressure on agencies to refer children, but little recognition of how this affects the families. The experience of referral and assessment is*

[10] Q 110

stressful and traumatic for many families, with long-term adverse consequences.[11]

14. The *Guardian* further reported the comments of Dr Lauren Devine, author of the briefing, as follows:

> *A huge increase in the number of children being referred to social services has caused "catastrophic" trauma for tens of thousands of families without any corresponding increase in the number of child abuse cases detected' "These parents do not recover," she said. "They remain terrified of any official contact, and become unable to answer the door or telephone. They do everything in their power to protect their children from the state. They cut off social contact and leave jobs and homes to remove themselves from the stigma. Their confidence and sense of identity is damaged. "The most extreme I have come across is where parents kill or attempt to kill their children and themselves following notification of social work contact as they are so terrified they see this as the lesser of two evils.*[12]

15. Figures provided to Tynwald in October 2015 suggested that the numbers of contacts and referrals were at last beginning to come down.[13] Those figures covered the year ending 31st July 2015. Updated figures to March 2016 referred to by the DHSC in their oral evidence to us confirmed this trend. Table 1 (opposite) is based on that in our March 2015 report but updated with the figures used in the Department's April 2016 oral evidence and further data provided by the Department for the purpose of this Report.[14]

16. The Director of Children and Families Services, Miss Brayshaw, explained this change as follows:

> *What I would deduce from that is that if you only have one point of contact and people do not know where else to go to get advice and support, you would*

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[11] Child Protection and Assessment, Economic Research Council, June 2015 http://www.esrc.ac.uk/files/news-events-and-publications/evidence-briefings/child-protection-and-assessment/

[12] "Rise in referrals to social services causing trauma to families, expert says", *Guardian*, 15th April 2016 http://www.theguardian.com/society/2016/apr/15/rise-in-referrals-social-services-trauma-families-child-protection

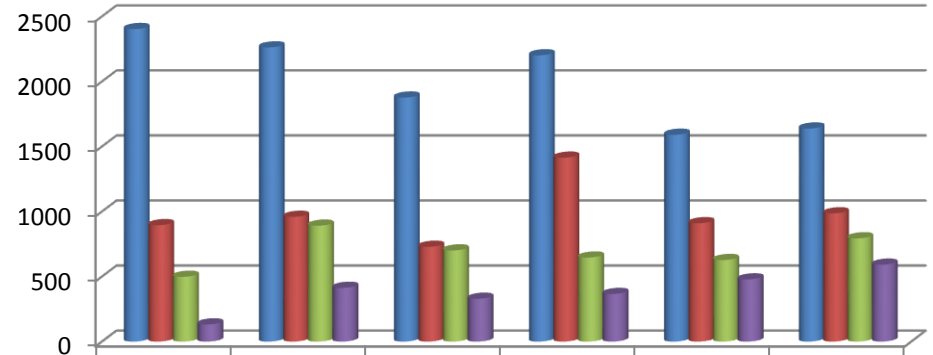
[13] Q 33 on 20th October 2015

[14] See QQ 24-26 and Appendix 4. Appendix 4 also explains the small discrepancies between the figures shown here and those used in some Tynwald answers and in our previous report.

anticipate that that would be high. I think what we have done over the past three years is get better at providing other points of contact for members of the public to see lower-level support and advice… I think it is a reflection of the fact that a number of services for children are working better together and can respond more appropriately at different points of contact for families.[15]

We conclude that since April 2014 there has been a welcome reduction in the number of initial contacts and referrals to the Children and Families Division. There remains, however, a significant risk of unnecessary referrals having an adverse effect on children and families.

Table 1



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Contacts	2403	2262	1876	2201	1590	1638
Referrals	895	959	729	1414	910	986
Initial Assessments	498	891	701	646	627	794
Core Assessments	132	413	329	366	478	591

IV. STANDARDS OF SERVICE DELIVERY

Themes arising from the experience of families

17. It is in the nature of children and families social work that much of the work is hidden from public view. In an effort to understand more clearly what actually happens between social workers and families, we invited families to talk to us in confidence. The advantage of this approach was that it enabled 21 people to come forward. The disadvantage was that, while we were able to identify broad themes to

[15] QQ 28 and 29

discuss with the Department, we were not able to identify specific cases for the Department to investigate.

18. The Department told us that it had at any one time between 400 and 480 live cases. Not all of our 21 witnesses were live cases but perhaps three quarters were. That means that in broad terms around 15 out of 500 cases, or 3 per cent of service users were so dissatisfied that they felt moved to talk to us.

19. The Department's overall response was in summary that it admitted there had been difficulties in the past but it believed that improvements were underway. Miss Brayshaw said:

> *Obviously, I would not seek to invalidate anybody's experience of the service that they have had. As you quite rightly say, the nature of the work that we do is fraught with tension. It is fraught with difficulty from the onset of doing that.*
>
> *Have we escaped the legacy? No, we have not, because I think bringing about cultural change is going to take quite a lot of time, and I would say that we have only had a stable senior management team in the past three years. Prior to that, there was an awful lot of churn within that.*
>
> *What we have to ensure we put in place is those effective systems and processes that ameliorate against that, and I think historically they have not always been in place. Something as simple as a scheme of delegation which sets out for staff who makes what decision at what point is it something very new in the Department.*
>
> *So yes, certainly looking at historical information I can see that wrong decisions have been made historically and the sorts of circumstances you are talking about have occurred. I do not believe that such similar situation could occur now, because of the checks and balances that we have in place against that.*
>
> *The work that social workers do and all of the research with service users of Social Care will show that that level of fear that the community and people involved with those services have is there by virtue of the authority that is held within that role, and they do have the authority to remove children.*[16]

20. Many of the specific concerns which were put to us were unique to an individual case. Some of the individuals had had positive experiences of social work in the past

[16] Q 46

but had come to us because this had changed. There were, however, some recurring themes, including:

- social workers being perceived as coercive and threatening
- foster carers feeling threatened rather than supported by social services
- inaccurate record-keeping
- frequent changes of social worker resulting in mistakes and delays
- social workers recruited from other jurisdictions unaware of Manx law and procedure

21. We put each of these points to the Department when they came to give oral evidence. As regards coercion, Miss Brayshaw said:

> *Currently, we are reviewing the way in which we are use agreements for children to come into care, and hopefully in the future that coercion would not be felt by parents. That does not mean to say that there may have been occasions … And I am not disputing the experience that people have had.*[17]

22. As regards foster carers, Miss Brayshaw said:

> *Over the past two years, we have had concerns with regard to the fostering service, and it would be fair to say that it has been difficult to get to the bottom of understanding some of those concerns within the service… concerns that related to safeguarding matters, both in relation to foster carers and within the service itself… But we are satisfied that those areas are now being addressed…*
>
> *Not all appropriate safeguarding checks had been undertaken in respect of some carers, and that needed to be addressed as a matter of urgency…*
>
> *The relationships that have existed – and I do have to stress that is under previous management of the fostering service – did not foster good communication and good dialogue to be had, and therefore I think that perception of fear may have been evident where it was not necessary, and vice versa. I think all of the arrangements that are currently being put in place and new processes and systems that fostering are establishing will start to address that…*

[17] Q 51

out of the existing payment scheme that was in place it was not being properly applied. Hopefully now, from 1st April when [a new payment scheme] was introduced, that will address that so that everybody is treated equally and fairly with regard to payment…[18]

23. As regards record-keeping, Miss Brayshaw said:

> *They can make a complaint with regard to the accuracy of the information. What we experience when we have been in those circumstances is that quite often it is not necessarily a question of accuracy, it is a question of perception. And so the way that we have resolved those circumstances is to make it clear to the individuals that their perception and their view of those circumstances will sit alongside the professional view and information that is currently on the file as well. Where it is a clear inaccuracy we can change that, but obviously professional judgement will not always fit with an individual's.*[19]

Positive engagement with the community

24. In his oral evidence to us Dr David Foreman, Child and Adolescent Psychiatrist, said:

> *people are frightened of Social Services, more so than almost any other group, because having your children removed is possibly the worst pain a parent can feel.*
>
> *However, there has been research on what enables social workers to engage effectively and the results, I am pleased to say, are really simple and common sense. Families are likely to engage with their social workers if three things happen: first, they are seen as competent; second, they communicate positively, not negatively; and thirdly, they come with practical or emotional help at the outset. That seems to engage families. Mrs Mellon has already given very good descriptions of the opposite to those approaches, as in 'It is entirely voluntary to talk to us but, if not, it will be held against you' – and versions like that, which clearly are not going to work. This is a key professional training issue for social workers to get that right.*
>
> *There is also – and I think you touch on it elsewhere – a very important public education component which needs to be supported, so the way that the agencies actually behave on the doorstep is adequately communicated, so people can talk about it and feel much more confident that they are going to*

[18] QQ 94, 95, 97 and 98
[19] Q 105

receive help; and that they understand the statutory duty of social workers is actually to keep children with their families unless all else fails. This is not understood in the community at large: that the social worker's job is to stop the child leaving the family if at all possible, consistent with the safety of the child. That kind of public education could be hugely helpful.[20]

25. Miss Brayshaw responded:

With regard to Dr Foreman, I would hold him as unqualified and not sufficiently informed to make comment on the referrals of the Department.

Dr Foreman specialises in the methodological, ethical and legal aspects of child protection.[21] He is in our view well qualified to make his comments, which go to the heart of this inquiry: the "catastrophic trauma" of a child protection referral and subsequent assessments and investigations.

26. Dr Foreman helpfully reminds us that the statutory duty of social workers is actually to keep children with their families unless all else fails. That being the case we should expect social workers to proceed on the basis of their ability to keep children and families together – not on their simpler ability to rip them apart.

We conclude that the Children and Families Division has a difficult job to do. Although the challenges brought to our attention by members of the public are understood by the management, there is a long way to go in rebuilding the confidence of the public in the service.

Recommendation 1

That the Department of Health and Social Care should produce a training policy to ensure that the statutory aim of keeping families together is reflected in the policy and working practices of the Department.

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[20] Q 146

[21] "David Foreman has been awarded a Visiting Professorship by the college for his contribution to both the Centre for Abuse and Trauma on its advisory board, and to the Lifespan Research Group in terms of grant applications involving adolescent experience and methodological issues around measurement. David's research lies in four main areas: methodological, ethical and legal aspects of child protection, especially Factitious Illness and Injury; the use of structured assessment tools to improve the detection and treatment of child psychiatric disorders, especially ADHD; telemedicine; and the Manx cohort of the European Longitudinal Study of Parents and Children (MELSPAC). His clinical base on the Isle of Man allows close integration of his service-related research interests and their practical application".
https://www.royalholloway.ac.uk/socialwork/staffdirectory/davidforeman.aspx

Recommendation 2

That the Department of Health and Social Care should make every effort to ensure that social workers are competent and are seen as competent; that they communicate positively, not negatively; that they come with practical or emotional help at the outset; and that they do not give the impression that any with-holding of consent will be held against a family.

Recommendation 3

That the Department of Health and Social Care should undertake public education with the aim of ensuring that the way that social services and related agencies actually behave on the doorstep is adequately communicated so that people can talk about any concerns they might have and feel confident that they are going to receive help.

Staffing

27. A number of the challenges identified by the members of the public who approached us derived from rapid turnover of staff. The Department explained that it had 81 FTE posts of which 43 need to be filled by qualified social workers.[22] Information given to Tynwald in October 2015 showed that in the year to 31st August 2015 the Department employed 24 different agency social workers.[23]

28. As regards changes of social worker, Miss Brayshaw said:

> *there is an expectation that every manager will sit down and fully brief and supervise a new social worker on that case being passed to them, and I would accept that that has been a challenge for us to achieve that.*[24]

29. As regards training in Manx law and procedure, Miss Brayshaw was asked whether it instils confidence when a social worker cites a piece of legislation that does not apply on the Isle of Man. She said:

> *No. And yes, we have had examples where that has happened in the same way that our sections of the Act are different from the UK sections. So a social worker from England will talk about section 47 as their duty to make inquiries –*

[22] QQ 2, 4
[23] Question 35, 20th October 2015
[24] Q 84

on the Island it is section 46. So whilst what you do is the same, actually to cite the wrong legislation is inappropriate, yes.[25]

30. In its oral evidence to us, the Department explained some of the difficulties with recruitment and retention of staff to the Children and Families Division, as well as the cost implications of relying on agency staff.[26]

We conclude that the Children and Families Division is over-reliant on agency staff, resulting in increased costs and reduced quality of service.

V. MECHANISMS FOR GOVERNANCE AND IMPROVEMENT

A statutory basis for the Safeguarding Children Board

31. We have commented repeatedly on the fact that the Safeguarding Children Board lacks statutory vires. Recommendation 29 of the Commission of Inquiry into Young People of May 2006 was that: 'The Inquiry recommends that primary legislation place the Island Child Protection Committee on a statutory basis.' As noted above, this was the subject of a recommendation of our March 2015 report which was approved by Tynwald in June 2015. Miss Brayshaw told us in April 2016:

I think the position at the moment is that that will be put into the legislative programme for the next administration, and I think, hopefully, given the right priority date that is required.[27]

32. The consequence of not implementing this is that the current Board is, in effect, no more than an informal committee. We thus have a very powerful but unaccountable body responsible for child protection policy.

Recommendation 4

That legislation to place the Safeguarding Children Board on a statutory footing should be introduced into the House of Keys before the end of the 2016/17 session.

[25] Q 73
[26] QQ 58 to 70
[27] Q 82

External inspections

33. The arrangements for external inspection are also non-statutory which means that, although Children and Families Social Services are charged with a statutory child protection duty, no statutory inspection of that duty is carried out.

34. External inspections of Children and Families Social Services are currently carried out by the Scottish Care Inspectorate. These inspections are non statutory. Worse, the terms of the inspection are set by the Department itself. This means that areas of concern to the public are left out of the inspection, for example the referrals process.

35. Child Protection procedures are supplied to the Department of Health and Social Care by Tri-x-consultancy Limited who are based in Coventry. The procedures are substantially those of English local authorities which are inspected by OFSTED. The Department uses English procedures therefore its execution of those procedures should be audited by the English authority OFSTED operating to externally set inspection criteria. This would ensure a more comprehensive inspection report which is nothing less than Tynwald and the public should expect given that the matter in hand is child protection.

Recommendation 5

That OFSTED should be enabled as a statutory body for the inspection of Children and Families Social Services.

Annual reporting

36. There is no annual report to Tynwald of the performance of Children and Families Social Services. It is a pure anomaly that Tynwald is in receipt of annual reports from bodies like the Information Commissioner and the Surveillance Commissioner. Why, given the importance of child protection, do we not also have an annual report from the Safeguarding Children Board or the Department?

37. Much of the information on which this inquiry has been based has come to light because a Member of Tynwald asked a consistent set of statistical questions about referrals and investigations over a number of years. These, coupled with other questions about policy and matters like staff turnover, have allowed us to uncover a detailed picture of a hitherto hidden operation.

38. A statutory annual report could require all this statistical information to be presented to Tynwald and would add valuable transparency. Given that the procedures and policy are similar to England the report could include data collated in the form of the annual Children in Need Census presented to the Department for Education in Whitehall together with other local information specified by Tynwald.

Recommendation 6

That the Department of Health and Social Care should be required to produce a statutory annual Children in Need census to include the same standard statistical data required by the Department for Education in Whitehall and to include any other data as specified by Tynwald.

Complaints

39. Other recurring themes in the evidence we heard from individuals was a lack of awareness of an independent complaints process, or a lack of confidence in such a process. In response Miss Brayshaw said:

> *Since October 2014 we now have access to an independent review board for complaints that cannot be resolved at any of the other levels…*
>
> *[Before that] it was always within the discretion of the Chief Officer to look at appointing an independent investigator…*
>
> *There has always been a complaints leaflet on the departmental website. Recently it was reviewed and amended because some of the information was not accurate…*
>
> *I think it would be fair to say that the processes and the systems that have been operating were not always as stringent as they could have been, and I think we have worked hard over the last few years to try and address that. So I would expect that there would be some people who still remain confused about that.*[28]

40. On 20th April 2016 Tynwald debated the following motion:

> *That Tynwald recognises that the Island's children represent its future and that their well-being is of paramount importance; views with concern serious allegations which have been made regarding the repeated conduct of the Department of Health and Social Care in the management of vulnerable*

[28] QQ 11, 15, 20 and 21

families' cases; notes that particular allegations have been made relating to the falsification of files and to oppressive treatment of individuals; and resolves that an independent inquiry be set up into these allegations, with powers exercisable under the Inquiries (Evidence) Act 2003 and that the inquiry's findings and recommendations be placed before Tynwald as a matter of urgency.

The motion was amended to refer the matter to the independent Safeguarding Chairman, Paul Burnett, for investigation.

41. The non-statutory Chairman of the Safeguarding Children Board is responsible for child protection policy. The Chairman cannot, therefore, independently investigate his own policy. Furthermore, the SCB non-statutory complaints policy only applies to complaints about a Child Protection Conference.[29] There is no complaints policy for referrals and initial assessments. Thus if a family feels threatened that if the Department has to go to court it will be a black mark against the parents' record, that family has literally no-one to complain to. This may go some way towards explaining the big response to our call for evidence.

42. In England, Local Safeguarding Children Boards are legally separated from child protection functions. This means if a case were to arise in which, for example, parents killed or attempted to kill their children and themselves following notification of social work contact, any inquiry would be conducted by a legally independent body.

43. In the Isle of Man we do not have a legally separate Local Safeguarding Children Board. Thus we have a situation where the Board responsible for child protection procedures can be tasked with investigating its own procedures in the event of a child or parent death or other serious failing. This is unacceptable and arises precisely because the "Every Child Matters" policy was allowed to be implemented even though the Children Bill was cancelled.

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[29] "11.1 Children, parents and care givers are entitled to make representations or complain in respect of one or more of the following aspects of t he functioning of Child Protection Conferences: The process of the conference; The process of the conference; The outcome, in terms of the fact of and/or the category of primary concern at the time the child became the subject of a Child Protection Plan; A decision for the child to become, or not become, the subject of a Child Protection Plan or not, or to cease the child being the subject of a Child Protection Plan."
http://www.proceduresonline.com/iom/scb/chapters/p_cp_confer.html#complaints

44. A proper, legally constituted system of child protection oversight would, ultimately, ensure that improvements can be made. Not least, a statutory complaints process would ensure acceptable working practices are developed.

45. The Tynwald Commissioner for Administration Act 2011 was passed by Tynwald but the Commissioner has yet to be appointed. The appointment of the Commissioner, coupled with creating a statutory Safeguarding Children Board as a listed authority under the Act, would enable a complaints process.

We conclude that it is in the nature of children and families social work that service users are reluctant to bring forward formal complaints for fear that this might generate delay or even reprisals.

Recommendation 7

That the Children and Families Division should encourage and welcome complaints from families and should deal with them positively so that lessons can be learned and any grievances can as far as possible be resolved.

Recommendation 8

That a Tynwald Commissioner for Administration should be appointed and that a statutory Safeguarding Children Board be a listed authority under the Tynwald Commissioner for Administration Act 2011.

VI. FUTURE DEVELOPMENTS

46. We have previously reported on concerns about policy and legislative developments in other jurisdictions such as "Every Child Matters", "Getting it Right for Every Child" and the "named person" initiative.[30]

47. In that context we asked the Chief Executive of the DHSC if the Department had any thoughts of developing policy involving early intervention and a policy based on child well-being in order to intervene, rather than child protection meeting a need, and whether it had any notions of that policy being worked up into legislation? He began his answer as follows:[31]

[30] See for example PP 2015/0049(2), Appendix 6
[31] Q 126

The very short answer would be with three letters, which is yes; obviously, it is immeasurably more complicated than that.

I think that, in terms of work with the Scottish Care Inspectorate, for example, who have recently been doing an update review, they are, we expect, going to make some recommendations about core national policies in respect of children, and those recommendations are likely to be that we have gaps in certain places, so I think they would be obliged, as a responsible service or series of agencies, to take account of those recommendations and to do something with them.

We conclude that the Department of Health and Social Care will continue to be influenced by ideas from the adjacent jurisdictions. Tynwald has an important role to play in ensuring that any future changes in policy or legislation, whether deriving from the UK or from anywhere else, are carefully weighed up and sensitively adapted for the Manx environment such that any lessons from other jurisdictions are learned and any mistakes made in those jurisdictions are not replicated.

Recommendation 9

That core national policies in respect of children should not be introduced, amended or abandoned without the express approval of Tynwald.

VII. CONSOLIDATED LIST OF CONCLUSIONS AND RECOMMENDATIONS

48. All of our conclusions and recommendations are reproduced here for ease of reference.

49. We conclude that, while the challenges of providing social services to children and families are as serious in the Isle of Man as anywhere, there is no reason in principle why the Island should not aspire to the highest standards of service delivery and social outcomes from its investment in children and families social work. (paragraph 8)

50. We conclude that since April 2014 there has been a welcome reduction in the number of initial contacts and referrals to the Children and Families Division. There remains, however, a significant risk of unnecessary referrals having an adverse effect on children and families. (paragraph 16)

51. We conclude that the Children and Families Division has a difficult job to do. Although the challenges brought to our attention by members of the public are

understood by the management, there is a long way to go in rebuilding the confidence of the public in the service. (paragraph 26)

Recommendation 1

That the Department of Health and Social Care should produce a training policy to ensure that the statutory aim of keeping families together is reflected in the policy and working practices of the Department. (paragraph 26)

Recommendation 2

That the Department of Health and Social Care should make every effort to ensure that social workers are competent and are seen as competent; that they communicate positively, not negatively; that they come with practical or emotional help at the outset; and that they do not give the impression that any with-holding of consent will be held against a family. (paragraph 26)

Recommendation 3

That the Department of Health and Social Care should undertake public education with the aim of ensuring that the way that social services and related agencies actually behave on the doorstep is adequately communicated so that people can talk about any concerns they might have and feel confident that they are going to receive help. (paragraph 26)

52. We conclude that the Children and Families Division is over-reliant on agency staff, resulting in increased costs and reduced quality of service. (paragraph 30)

Recommendation 4

That legislation to place the Safeguarding Children Board on a statutory footing should be introduced into the House of Keys before the end of the 2016/17 session. (paragraph 32)

Recommendation 5

That OFSTED should be enabled as a statutory body for the inspection of Children and Families Social Services. (paragraph 35)

Recommendation 6

That the Department of Health and Social Care should be required to produce a statutory annual Children in Need census to include the same

standard statistical data required by the Department for Education in Whitehall and to include any other data as specified by Tynwald. (paragraph 38)

53. We conclude that it is in the nature of children and families social work that service users are reluctant to bring forward formal complaints for fear that this might generate delay or even reprisals. (paragraph 45)

Recommendation 7

That the Children and Families Division should encourage and welcome complaints from families and should deal with them positively so that lessons can be learned and any grievances can as far as possible be resolved. (paragraph 45)

Recommendation 8

That a Tynwald Commissioner for Administration should be appointed and that a statutory Safeguarding Children Board be a listed authority under the Tynwald Commissioner for Administration Act 2011. (paragraph 45)

54. We conclude that the Department of Health and Social Care will continue to be influenced by ideas from the adjacent jurisdictions. Tynwald has an important role to play in ensuring that any future changes in policy or legislation, whether deriving from the UK or from anywhere else, are carefully weighed up and sensitively adapted for the Manx environment such that any lessons from other jurisdictions are learned and any mistakes made in those jurisdictions are not replicated. (paragraph 47)

Recommendation 9

That core national policies in respect of children should not be introduced, amended or abandoned without the express approval of Tynwald. (paragraph 47)

D C Cretney (Chairman)

G G Boot

S C Rodan

May 2016

ORAL EVIDENCE

29th June 2015 Evidence of Maggie Mellon, Vice Chair of the British Association of Social Workers

STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

RECORTYS OIKOIL
BING VEAYN TINVAAL

PROCEEDINGS
DAALTYN

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

OVER REFERRAL TO SOCIAL SERVICES

HANSARD

Douglas, Monday, 29th June 2015

PP2015/0106 **SAPRC-OR, No. 2**

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Members Present:

Acting Chairman: Hon. S C Rodan SHK
Mr D C Cretney MLC

Apologies:
Chairman: Mrs B J Cannell MHK

Clerk:
Mr J D C King

Contents

Social Affairs Policy Review Committee

Over referral to Social Services

The Committee sat in public at 2.30 p.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[THE SPEAKER *in the Chair*]

Procedural

The Acting Chairman (Mr Speaker): Good afternoon everyone. Can I welcome everyone to this meeting of the Social Affairs Policy Review Committee. We are taking evidence in public this afternoon and can I ask as a matter of housekeeping if people would kindly switch off their mobile phones so this does not interfere with the recording equipment.

My name is Steve Rodan. I am acting as Chair of the Committee in the absence of the Chair, Mrs Brenda Cannell MHK. My colleague on the Committee is Mr David Cretney, Member of the Legislative Council, and the Clerk to the Committee is Dr Jonathan King.

EVIDENCE OF
Ms M Mellon, Vice Chair of the British Association of Social Workers

Q89. The Acting Chairman: We are very pleased to be meeting this afternoon and to have the opportunity to take evidence from an expert witness, Ms Maggie Mellon. I would like to welcome you very much to the Committee and thank you for being prepared to give us your comments and your evidence on an area that we have been investigating, which is concerning children's social services in the Isle of Man, with particular reference to the over referral of families to the children's social services system.

For the purpose of record, could I ask, Ms Mellon, for you to give us your name, title and current position please?

Ms Mellon: Okay. It is Maggie Mellon. I am the Vice Chair of the British Association of Social Workers and I chair their Policy, Ethics and Human Rights Committee.

Q90. The Acting Chairman: Thank you very much. You are very welcome.

As a Committee we have produced a report into the question of over referral and we concluded in that report that on the basis of 2012 figures the number of children in the Isle of Man in need of protection was about the same as the English average on a *per capita* basis. In the case of the Isle of Man, 3.5 children per 1,000 in need of statutory protection as against 3.8 per 1,000 in England.

However, the number of referrals, assessments and enquiries in the Isle of Man were proportionately higher. We identified that there were more referrals and more initial assessments being carried out and of those assessments, fewer were identifying a need of short of child protection, in terms of our Children and Young Persons Act – in other words, there were

fewer children with an identified need as opposed to a child protection issue. Also there were more full-scale child abuse enquiries and, as I have just said, ultimately the number of children requiring protection following such inquiries was similar. We went on to conclude that since 2012 there had been an increase in the number of instances where an agency approaches Children and Family Services in a case where an assessment is not needed. We noted, for example, that between 2011-12 and 2013-14 there was an increase of some 90% in referrals to children's social services.

This report was debated in Tynwald two weeks ago and the Department made the point – and this is something you may wish to comment upon – that the way the UK record their numbers is somewhat different in that whereas our figures are as one, the system for identifying children with a need and in need of child protection is the same system, whereas the UK has a well-established early help system which generates children in need separately. If those figures are added in, it is therefore said that they are far closer together and the Isle of Man compares more favourably. Their early filter system for need, if added into our arguably cruder system of sweeping everyone through the same filter system, presents the Isle of Man in a somewhat more favourable light.

So, Ms Mellon, can I invite you to respond however you wish, in terms of commenting on the Isle of Man situation? It would be helpful to indicate if you share our assessment of the published figures for the Isle of Man and how they stack up as against England or the United Kingdom.

Ms Mellon: Right. Okay. I suppose I think probably the officials were right if they were saying that in England the figures of referrals are lower because they screen some out and they go down the child in need route; however, I suppose what I would invite you to ask yourselves is whether the English system is one that you think is your benchmark and that you just want to actually be at the same level as they are.

There has been recently some analysis of data trends in England, which show that in England – and I think this is the case in Scotland, but in Scotland we collect figures differently – since 1991 there has been a massive increase in the number of children referred through the child protection systems. Just as you have found in the Isle of Man, the number of children who are identified as in need of protection has gone up, but not nearly as much. So you have got a 450% increase. It went up from 160,000 referrals in 1991 and it is up to 657,800 in 2013-14. So whereas they used to register on a ratio, 25% of children referred would be identified as in need of protection in 1991… no, sorry, 24% – and now it is only 7% of the referrals. So they have got very much what you have found, that a high number of referrals does not mean a high number of children needing protection.

Q91. The Acting Chairman: Yes.

Was the report you were referring to the one called Rethinking Child Protection Strategy Learning from Friends?

Ms Mellon: That is right, yes.

The Acting Chairman: Yes, you very kindly submitted this to the Committee –

Ms Mellon: Right. You have already got it.

The Acting Chairman: Yes, thank you.

Ms Mellon: I think that report is asking questions of the English system and so that was why I was pointing you to it, to say: do you want to benchmark against that system or do you think that some of the problems you have experienced are because of replicating system?

Q92. The Acting Chairman: Yes.

Before we get into that broader area, can I just ask, in terms of the UK, how much the referral rates vary between local authorities, because the figures you have given us are very much…? Am I right in saying this is an English average or UK? Are we talking about England as opposed to –

Ms Mellon: In the data trends paper that I just read to you that is just England. (**The Acting Chairman:** Just England.) The four countries, England, Wales, Northern Ireland and Scotland all do their statistics differently. Scotland does not actually count the number of overall child protection referrals and assessments and so you cannot compare, but I think the English… it is the biggest country with the biggest population and the child protection systems are very similar and so I think you can look to that.

Q93. The Acting Chairman: Should we then regard the English average as a target or as a benchmark for the Isle of Man?

Ms Mellon: Well, I think that this analysis… and I think now people are asking questions about whether the system that we have built of child protection, whether its extension and expansion and net widening for referrals is actually a good investment of time and resources. (**The Acting Chairman:** Yes.) Also, it is not cost neutral, but it is also not neutral in its impact on families and on society if you have got quite a large number of children in your population and families being assessed and having to prove a negative that they are not harming their children, that has an impact. It is not neutral in its impact on people's families and on children's understanding of the world and adults and how families and parents relate to services.

Q94. The Acting Chairman: We have benchmarked the Isle of Man against several English local authorities – East Cheshire, their referral rate, for example, has been lower than the Isle of Man – and yet there appears to be quite a significant variation between English local authorities which reflect that average, and whenever we cite a particular local authority, a counter example is very readily given where they are not getting it particularly right. Would that be a fair comment?

Ms Mellon: Rates do differ and it is not necessarily…

In Scotland the number of children referred to children's hearings and then put on supervision orders – they become looked after – varies across different authorities quite markedly. I think in Shetland it is like one in 1,000 and in Glasgow it is 3.5 in 1,000, but actually some local authorities which have quite good or not such high deprivation, multiple deprivation counts, have high rates and some have low rates. So it is not always related to children in adversity or the amount of social deprivation there is. There is some subjective variation according to how it is implemented.

I think in Midlothian in Scotland – I know Scotland better because that is where I live and work – which is a small authority just outside Edinburgh and has a population roughly the same size as the Isle of Man I think, about 90,000, they had a blip: a big steep rise in their referrals which then subsided. It seemed to do with taking on new staff and instituting training across the authority and rates went up.

Q95. The Acting Chairman: And was this at the end of the day accounted for by new staff referring low-level cases because there was no alternative system to which they could refer or was it really to protect themselves in case a case got missed, and when in doubt refer – that approach?

Ms Mellon: Yes, when in doubt refer. I think across the whole of the countries in the UK risk aversion has become quite a major component in people's work, especially around children.

Staff will feel, because working with families, if the publicity and the coverage of any mistakes is very, very high and you stand to lose your job, your reputation and your registration as a social worker, a teacher or any of those things, or you stand to be sometimes put on the front page of *The Sun* and have your address advertised as a child killer, people are going to actually act fearfully and will think, 'Well, it is far better for me. I had better pass this on, this little worry or this little concern of this thing that might be. I will pass it on', because not to do that might be too big a risk for them.

They will also, of course, have concerns about the children, but I think that identification of the risk to your own profession, career and safety obviously becomes high when there is such an intolerance of mistakes or even a twisting of stories in the press. The latest example… not the latest, but one example of that was the Peter Connolly case in Haringey, which caused a huge rise in the number of children being referred and also being taken into care in England, and in Scotland to some extent.

Q96. The Acting Chairman: Yes.

Many of our teachers, police and social workers of course come from England and our child protection guidance is based on English models. What would you give as a reason for our rate of what turn out to be needless referrals being higher than the English average given that we appear to be applying English guidance?

Ms Mellon: Well, it could be what your officials have suggested to you in that some cases that you consider on the whole as a referral for child protection in England would have been routed away as children in need; however, it may just be the impact of introducing a new system and a new, different way of working.

Raising levels of risk and apprehension, training in the system on a small island with a small population, it is only a hypothesis, but I would imagine that that might have a bigger impact than in counties of England, people might live in one county, work in another, and people would have broader frames of reference. But if everybody… it might reinforce the impact being on an island and people saying, 'Oh, I have referred such and such' or 'I think had better refer such and such' or somebody knowing, if you talk to a colleague, and say, 'Oh, I noticed this' and they would say, 'You'd better refer it'. It might be that that is why there was an escalation so quickly, but it was a new system introduced.

There was training brought in across the board that people who came to work here did have an apprehension about risk and a certain standpoint on what should be being done and that that kind of system was introduced. Maybe the Isle of Man went from a standing start to a very accelerated process in a very short period of time; whereas in England it is actually much the same, but has happened over a longer period of time.

Q97. The Acting Chairman: Right.

So where there are early intervention strategies to deal with the low-level need contacts that are never going to progress to child protection, where that system is in place and where the staff are sufficiently trained and confident about the use of that system, we are then going to be less likely to see over referrals. Would that be correct?

Ms Mellon: Yes, I would say so, but I think there is quite a lot of evidence now that if child protection is the dominant kind of approach to children and families, and child and family welfare somewhere is marginalised and that is not how the people working in the system see their main job, I think there is quite a lot of evidence to show that that produces adverse consequences in terms of every child is seen as possibly vulnerable. Every incident is seen as possible child abuse or a child protection incident, rather than starting from a child and family welfare point of view, which does not mean that you deny that abuse ever happens or that children sometimes do need to be protected. But if you start from the assumption that you are

actually facing a massive problem and people almost have to prove that they are not a risk to their own children, then you get the system and you get the results that you have –

Q98. The Acting Chairman: So is there a feeling that every time a child comes to the attention of the authorities it is a potential child abuse case, when statistically it is not? That is not going to be the case, but it is treated as such.

Ms Mellon: Yes, the families may themselves feel that that is how they are being treated. We went from one extreme where a family – it is many years ago – could turn up at Accident & Emergency with the same child three or four times with broken bones and injuries and nothing would happen because the parents gave good explanations, and then when we discovered child abuse, which does exist – the deliberate injury of children – in fact that has not really changed much over time. That has stayed the same.

But it used to be there was very little awareness of harm and now it is almost any time a parent would appear in Accident & Emergency the first question that might be asked would be 'Give us an explanation of how this…' and so the parent immediately feels that they are under suspicion.

Q99. The Acting Chairman: What then is your view about the impact of needless referrals on families who are quite needlessly investigated and the impact on the health of the family as a family unit? Can you give us any examples from your experience?

Ms Mellon: Oh, yes, quite a lot. There is actually some very good… I could give you personal examples, but there is good research. Nigel Parton, who is a professor of child protection – and I think he is now no longer as he has retired – has produced a lot of examples from interviews with parents about the impact on them of having been put through and actually sometimes going quite far down the line of child protection investigation case conferences. But I would say that intervention and assessment, even if it ends up with nothing, even if at the end of the day there is no child protection case conference and there is no case to answer, the impact on a family is not neutral just because the child does not end up in the register. The impact has to be taken very seriously I would think.

The impact on parents' attitudes to professionals and whether they would try, whether they would – if there was an issue they were concerned about – share it if they think that they are going to be almost judged has to be quite serious. I think we have to see it in the context, as I was saying earlier, that we have lost the major focus being on child and family welfare. It is almost totally child protection and that is what a child and family social worker in a team will be doing. It is not looking for how they can assist families, although that is probably the motivation of most of the staff originally to do that, but they are then driven down a very procedural route of 'I am having to ask questions and to form assessments', and that then distorts, I think, relationships between families and professionals.

Q100. The Acting Chairman: And if it turns out to just be a need of some sort that could be fairly easily addressed, unfortunately the damage has been done. If in the future they have a similar requirement to have a need met by the authorities then they are not going to approach them again.

Ms Mellon: Yes. I have known families where exactly that has happened. For instance, one young woman who I knew whose son actually had his arm broken by the childminder's daughter, but the first assumption was… So she had taken the child to hospital – I think it was his leg actually – saying, 'This is my child and something is wrong his leg', and the doctor first of all told her she was silly. She persisted and then she found that the child was actually removed from her care as a precaution and put to a foster mother and it took her two or three months to have her

child returned to her. She then was absolutely beside herself about what she would do in future and the feeling of fear that her child would be injured again. It was established that it was actually… not the foster mother, but the child carer's daughter, and so it was actually a negligence of the child carer.

I think this is replicated across lots of parents, even if it has not been as extreme as the removal of their child, where you think what on earth would you do, even if you are the one that is presenting the child and insisting there is something wrong that you could end up… I think stories like that then go around families, they go around neighbourhoods, they go around communities, and so they have a bigger impact than just on that family.

The Acting Chairman: Yes.

Mr Cretney.

Q101. Mr Cretney: Yes, I just wondered, could I take it back a couple of steps?

I think you invited us to consider whether the English system was the best system to benchmark ourselves against and I just wondered if you would like to offer any other models or any other jurisdictions that perhaps would be held in higher esteem for us to consider.

Ms Mellon: Well, I think actually that we have come so far along this route that it is quite hard to imagine and also it is quite hard to imagine how… you cannot just pretend that we have not got to where we are. We are where we are.

Like I said, I would say I think we need to have a much stronger focus on child and family welfare and not seeing the family as a risk, not seeing children as at risk or a risk to us and proceed accordingly. It seems to me that the Isle of Man is a really human size of a population and that you have an enormous opportunity to not make the mistakes and go down the routes of… for instance, in England and in Scotland I think that social workers spent 80% of their time on bureaucracy, on computer screens, and everybody is saying, 'Well, that is crazy. What a waste of resources. That is not what they should be doing'.

I would say you would want to look at having people much more engaged in human relationships with the people that they are serving, not assessing them and not putting them under surveillance, but actually offering support and engagement and actually building on the strengths that families have, because I understand in the Isle of Man you have got a lot of native families here that are extended families. There are lots of opportunities for building on strengths and social solidarity, rather than on treating people as individuals. We are all individuals of course, but build on the good social strengths and social systems you have got.

Q102. The Acting Chairman: Thank you. Thank you, David.

Do you think the impact of a needless referral is likely to be worse in a small community – the goldfish bowl effect where everyone knows each other and knows each other's business? I think you did touch on that earlier.

Ms Mellon: I did.

Yes, definitely. In Scotland we have… well, it could cut both ways in fact. Because people know one another quite well, you might get support and understanding from people saying 'Well, they shouldn't have done that to you. I know you are good parents. We see your kids every day. You have got nothing to hide and so why have they treated you like that?' So because you are known it might mean that you are more able to get support. However, there is such a huge amount of stigma and shame around child protection, being assessed and put under suspicion that I do not know if people seek support from relatives or whether they feel it is so shameful or that they have done something wrong. I would imagine in Scotland, in small communities that everybody – the receptionist and the GP is also married to somebody who… and I would imagine that is very much the situation here. So it may inspire gossip and people

saying, 'Well, you know…' ostracism or stigma of children being… and so in any small community that is bound to be a –

Q103. The Acting Chairman: So given the severe impact of a formal referral in a small community, would it not be better if the agency of first referral – whether it be a teacher, a doctor or whoever the agency is – takes upon themselves to do more to get to the root of the problem without engaging the full might of the social service system? Is there a case for advocating that or is that really impractical?

Ms Mellon: No, it is not impractical, and I would say in a way that is the policy that Scotland is adopting. We have got a policy which followed Every Child Matters, and it is called Getting it Right for Every Child. However, if the dominant reason or the main lens that people are looking through is a child protection one, just saying to agencies, 'Do your own assessment of whether this child is at risk' is probably not the answer; it is more if there something you can do to help.

What has happened in Scotland with Getting it Right for Every Child is it is almost that every… because child protection is the main lens that people are looking through, the teachers and everybody are looking not at what they can do to help or just what is it or to have a helpful conversation with a parent, it is still under the surveillance and monitoring, rather than support, although in lots of situations that is exactly what people are offering. Health visitors and teachers are offering support… nursery workers, but the danger would be that you are not tackling the root problem which is a risk-averse system that has been built up.

So I think you would need to not just say… it is right that people should at the first point, but it is skills and values, really, of the need to engage with people, to understand their humanity, and that they are not cases to be assessed and there is not a tick box. People need to actually talk with families and find out what are the things that are strong in their situation, what might be weaknesses, who is having to cope with things on their own, what help can they be offered, what help is needed and actually work with them to provide that kind of support.

Q104. The Acting Chairman: You made reference to the Getting it Right for Every Child policy in Scotland. Is what you have just said not going to be more difficult to achieve in Scotland, given that there is now a policy of a named person, a guardian, other than the parents for every child – for example, the head teacher of the school? Because the process has now been formalised in that way, has it not, is it going to make it more difficult to have a more informal intervention at an early stage?

Ms Mellon: Absolutely. The named person does not… legally it is not implemented until August 2016, but it is already in place and it had been before the legislation in a lot of authorities. Yes, the Association, my Association expressed concerns about that at the time, mostly just on the net-widening impact it would have and whether that was the right way to spend the system's resources, to allocate a named person to every child, when actually we do ignore children who are in need and need services, support and help and the resources are not there. One of the questions that were asked was if this was the right and best use of our resources. So there is quite a controversy in Scotland about whether this should be happening, but it is the law. The law has been passed and it is going to be implemented.

In some ways although it seemed a common-sense policy initially, Getting it Right for Every Child was offer help at the lowest possible level at the earliest possible level, but if what you are looking for are signs that a child has been abused or if that is what you are identifying as the risk, it just means you have opened up and you have made child protection… you have married it with prevention and early intervention.

There is a very good article by Brid Featherstone, who is a professor of social work at the Open University, and her colleague Susan White, which says a marriage made in hell: when early intervention meets child protection. Really that points that early intervention and prevention

can be great, but not if it is purely based on a need to actually identify and assess children at risk of abuse. But when you bring them both together – and I think my concern is that that is what may be happening in Scotland – and the net has been widened…

Q105. The Acting Chairman: As the threshold has now been set so low for the state really to get involved in family life, the problems that we have talked about – the distrust of authorities and all the rest of it – are going to get very much worse.

Ms Mellon: Yes, well, that is certainly my apprehension, and some evidence of that is there is now this process where it is early or low-level concern. There is a low-level concern and a high concern and so people are referring to the named person and are being encouraged to do so for low-level concerns about a child's wellbeing which might be…

One case I know of was a mother who had counselling following the breakdown of her relationship with the child's father and the counsellor advised her that she had to send a letter of low-level concern about her child, who she had never met and who the mother had dealt with perfectly well. She was going to send it to the child's named person, who was the head teacher of the school, and this caused enormous alarm, embarrassment and shame to this woman who had assumed she was having… she hadn't made any disclosure of any concern about her daughter. It was just that the counsellor obviously thought better safe than sorry if I pass it on. There was nothing to pass on. It was just that this child may have had a need that was not being met.

Q106. The Acting Chairman: That is on the formal record for ever more.

Ms Mellon: Exactly, and that is the other concern, that what is written down and recorded is there forever and some of the things that are written down and recorded may not be true. They may just be apprehensions, but once they are written down a story tends to grow around them.

For instance, if your neighbour maliciously calls the police, say, on your child and that then gets written down as 'the police have had to be called on a number of occasions', that paints a different picture than the neighbour is intolerant and doesn't like the children playing in the garden. When things are written down they can paint a different story and people do not know what is written down about them.

Q107. The Acting Chairman: So you would not recommend the Isle of Man follows the Getting it Right for Every Child route?

Ms Mellon: I may be in trouble as well, but I said this in Scotland as well. No, I think it sounds like a common sense thing to do, but until you tackle the dominance of child protection being the only thing that we are interested in or worried about children, then it is not a common sense thing to do. You are just putting more children in the pot or more families into the pot.

The Acting Chairman: Thank you.

David.

Q108. Mr Cretney: We understand there is a false reporting offence in Ireland and we wondered if there is not an equivalent in the UK about that. What are your thoughts on such?

Ms Mellon: My first reaction to hearing that proposal was feeling that it would not be helpful. I do not think that criminalisation or criminal law is necessarily the best way to deal with social problems and concerns and it may have an impact of actually stopping people talking about very real problems.

You can imagine in situations in relationships somebody being accused of either making-up stories and then it will become a criminal case: it would have the effect of making people really afraid to talk about things that maybe needed to be talked about, about children. Because having said all I have said about not having child protection as a dominant issue, we do not want to swing the pendulum back the way it was where nobody ever considered it at all and children did actually suffer serious abuse. So you do not want to deny it and I think a law that made it a risk for somebody who raised an issue would have an unnecessarily freezing effect and would be seen… I would feel it would be illiberal and might have unjust consequences.

Q109. The Acting Chairman: Even if we narrowed it to deliberately making maliciously false accusations, rather than making a report that turned out to be false, it is the knowing and deliberate malice that would be the concern.

Ms Mellon: There are several cases that I know of where because a court has decided there is no evidence or they have decided that an allegation of child abuse is unfounded, for a mother to keep repeating that she can then lose her child. She can have the child custody taken from her – and this has happened on a number of occasions – because she genuinely believes, but the Court will say she is repeating a malicious and unfounded allegation, emotionally damaging her child and making herself unsuitable for the care of her child, and yet the mother is genuine and actually may be right.

So how you judge what is a malicious and intentional… I think it probably is already illegal to waste police time, for instance, so there is probably legislation that would allow you to tackle people who very clearly where making allegations, otherwise I think one has to assume some good faith in people expressing concerns about children and I would worry about who would decide whether it was malicious or not. The courts are not known for getting everything right.

Q110. The Acting Chairman: Thank you.

What is your view on the impact of needless referrals on professionals whose workload is thereby inflated? Does it, in your experience, result in genuine cases being missed – the needle in the haystack argument? Can you give us examples from your experience? Because we are often told here that yes, we realise there are a lot of referrals that turn out to be groundless and go no further, but if it saves at least one poor child from child abuse then it is all worth it. We would get told that in defence of having so many referrals. So there is that.

We are also interested in the impact on the professionals themselves. I think in Birmingham, for example, after that case was so swamped with low-level referrals that they were missing genuine abuse cases. Does this happen and how often?

Ms Mellon: Well, one point to make though is that the increased number of referrals isn't turning up an increased number of children at risk, and in fact the number of child homicides and serious injuries has been fairly flat over 30, 40 or 50 years. So referral and assessment is not actually identifying more children. It is not that for every 1,000 more assessments you have got a consequent rise in the number of children you are protecting, and so that is obviously not an accurate statement to say if it saves one extra child's life.

However, the other thing is it probably makes it less likely or professionals less able to identify children really at risk. One of the issues there, from my experience, is that out of every child abuse inquiry or child death inquiry some lessons will be learned. They are usually sometimes quite different ones and recommendations are made and quite often there will be tick-box indicators of risk factors. If you do have a well-trained and well-resourced workforce dealing with a reasonable number of cases, all that happens is that some of those tick-box approaches will falsely lead you down false trails and you will miss something that people afterwards say, 'How really obvious was that?'

Like the little boy, Daniel Pelka, Birmingham was experiencing anyway a high volume of referrals and in fact they had been trying to change their social services around, but it looks obvious afterwards that common humanity would have said that a child who was scavenging in dustbins for food, was very thin and had bruises, it seemed so obvious. There is a kind of needle-in-a-haystack approach, but having said that there is evidence that we quite often miss the child who is right in front of our eyes and that a lot of the children who die or are seriously injured are actually known to services. So there are other lessons to be learned than that we need to assess even more children I think.

Q111. The Acting Chairman: Since England dropped the Every Child Matters policy, which is what you have described was in place – the 'if in doubt, refer and let's not run the risk' – have things improved or are there still cases being missed with the more sophisticated approach that is supposed to be in place?

Ms Mellon: The answer is I don't know if things have improved because with social science you can never actually tell with certainty what the cause and effect is. At the moment, of course, there is huge austerity. There has been a reduction in resources and even more going to come and there are numbers of children in England apparently that we are too poor to feed. So in that situation doing assessments of child protection…

One of the biggest categories now is neglect and whether you can actually call a systematic impoverishment of thousands of children, whether you can look at that only as something that their parents are responsible for or whether… has this has all got to be seen as child protection or do we not just do the human thing and offer material support to families in those situations? So that is all happening at the same time.

So you cannot actually say that everything stayed the same. There is a kind of fast moving situation of rapidly increasing any social inequality… so what the impact of that will be – and a lessening of preventive resources that people could just access in any case. Family centres, Sure Start centres, all of those I think have closed and so it would seem that that is not likely to have a good result.

Q112. The Acting Chairman: Sorry, I was just going to ask: does the documentation in England still have the phrase 'if in doubt, refer'? Certainly, on our Protecting Children Board the written guidance actually still uses that terminology, which is the Every Child Matters terminology. Is that still the case in England do you know?

Ms Mellon: Actually I do not know whether it is in the actual official guidance or whether they have revised the guidance. I should imagine it is still very much a live feeling or an understanding that if in doubt, refer. Apart from anything else, who wants to be the one who did not refer?

Of course, it is all being referred into a system that is in overload and might not have the resources or skills to deal with it. So it is everybody passing on risk really. People quickly trying to pass risk around a system, rather than have a different approach.

Q113. The Acting Chairman: Yes.

And where it is not suspected child abuse, but in the meeting of a particular need, then it is somewhat different, isn't it? It would be more obvious what to do to get that case into the early years intervention, rather than social services.

In what you are referring to – if in doubt, refer – are you specific to child abuse or any case that might be one of neglect, indicating a need to be met, given that neglect can be a symptom of child abuse but it need not be? Is the system to which they are referring the child abuse investigation system or is it the other network of help which we are told England is better at doing than we are in the Isle of Man?

I have probably not expressed that very well. It is 'if in doubt, refer' you suspect is still the working practice, is that in every case or just child abuse cases or is it a case of whenever somebody comes to our attention refer them?

Ms Mellon: I would think it is mainly in child abuse cases. A need can be a material need and it is obvious: housing, clothes, food, a place to do their homework or needing protection from bullying or violence or whatever. I think that is where if everybody has got to be referred and assessed for a service, rather than universal services being offered generally.

You tell the difference between a neglectful parent, who is deliberately neglecting their child, and a parent who cannot provide for their child if the help is there, because then the good parent will go and get the food, resources and help if they can access it; but if they cannot, how do you tell the difference? How do you tell if everybody or if a number of people are not able?

I do not know if this exists on the Isle of Man, but the sanctions regime in England, Wales and Scotland means that people are quite often denied benefits for several months and so they have actually no resources to feed their children. Is that neglect or is it the unavailability of a service to help them? So far better to have the universal services, but with extra help for people who need extra help to use those services properly or get the benefit from them.

The Acting Chairman: Thank you.

David.

Q114. Mr Cretney: It is around where you are talking, I think, but I once had a primary school head teacher in my former constituency who said to me that he was able to identify within the first week or 10 days youngsters who came into the school and had welfare needs. I just wonder who do you think is best placed to make those identifications?

Also, then following on from that in terms of perhaps where there is a lack of parenting skills or whatever, isn't that a very important area to try and invest, rather than some of the bureaucracy and things you spoke about previously?

Ms Mellon: Definitely, I would say so.

One of the best experiences of family support I can offer is in a multi-deprived area of Scotland, where the charity that I was working for had a family centre. Instead of having a lot of hoops for professionals to have to go through in order to refer a child and a family for help, the family centre had an open-door policy and anybody could introduce a family to that centre, which is quite different to referring. So in the case of your primary head teacher, having a family centre available where he could say, 'Oh, I can introduce you' or a health visitor might have done that before. A neighbour could do it or someone else – a relative, a neighbour or another mother or father who had help from the centre – whilst talking to a friend or neighbour recognise the same isolation, post-natal depression, money worries, domestic violence, all the issues that can affect families. But they have got an open door there that they can walk through or that somebody can walk through with them and that is like an open-door service.

Actually I did some of the research and evaluation of that and it has been replicated in other areas that they did actually work with the most vulnerable families and at-risk children in the area, but without anybody having to say, 'Well, you only come through this door if your children are at risk and you have been assessed as a failing parent', and so the parents actually had quite a different attitude towards everybody who worked there and to themselves. They were able to do art work and creative work. They helped one another. If there was a child protection case conference then the parents would be in charge of it, in the sense that they would welcome the professionals into the room. They would be offering people tea and coffee and they would have an advocate there and they would be prepared for the meeting. So that totally turns the relationships around and makes people feel a lot better about themselves and it does build a capacity a lot quicker.

Q115. The Acting Chairman: Was this a pilot system that you are describing or is this a general policy?

Ms Mellon: It wasn't. It was just a brilliant head of the family centre. She was a former teacher and that was how she developed the service.

Q116. The Acting Chairman: Who funded the operation of this?

Ms Mellon: At the time it was funded by the social work department. I think the service no longer operates like that. They went onto a rationed model, where people had to be referred and go through hoops. It is still valued, but it is not the same. It is not a centre in that same open-door way.

Q117. The Acting Chairman: And that potentially deflected a lot of the case load from formal social service investigation that would have otherwise turned out to be meaningless.

Ms Mellon: Well, yes, because at the moment I would say something like 90% of child and family social workers' time is spent on child protection, but if you have got services like that you would need far fewer because the social workers in the local area office had the comfort of knowing that these are families who are being seen regularly and it was in a very friendly way. So if somebody didn't show up, somebody would just pop up and see that they were okay, and that offer of help I am sure would be accepted by many families.

There was a case in Edinburgh where a little boy ended up being alone with his mother who had died and he was alone with her for 10 or 12 days and he was only three. She had not shown up at the nursery and the child had just been taken off the child protection register. So one minute he was on it, but she had a drug problem and she was desperate to come off the register and to have the fact that she had got off drugs or she was on a methadone programme and that he was not at risk. So because of the stigma of being the register, he was deregistered. Then it was as if there never had been any risk and you could not help feeling if somebody had just said to her, 'Look, you are on your own in a tower block and so if you don't show up in the morning can somebody just pop round and see if you are okay, because otherwise who would know?' And I think any woman living on her own with a child would feel that was a wonderful comfort to know, that somebody would come. But if the only way people come to your door is because of child protection and because you might lose your child, then that is not the way to work with people I think. You can see the difference between the two things, like a friendly, 'We will pop round and see if you are okay…'

Q118. The Acting Chairman: The Scottish Government is not looking at the potential of this as a model, are they?

Ms Mellon: Well, I think different local authorities may have that, but I think of the resources that are going to be available it seems decisions that are being made by councils are because these kinds of services are seen as a luxury – that is prevention – and they have got to meet, which is true, their statutory duties. The problem is then that if you do not have those preventive services, more children come into care and you are then spending your money on expensive resources and not having the money for prevention. That seems to be the decisions that are being made.

Q119. The Acting Chairman: You could head off what are statutory cases if you –

Ms Mellon: Yes, and you could stop children coming into care.

Q120. The Acting Chairman: I think we would be interested in hearing a bit from you as well about the practical impact of social workers who arrive for the first time at the door of a family where perhaps there has been a referral – it might have been by a neighbour, it may and may not have been backed up and could be circumstantial backing-up by a school or somebody – and the way the social workers engage with the family. Do they or do they not make families aware of their rights that, for example, they are under no obligation to share information and they must positively consent to share information or indeed to be allowed across the threshold? Is it the case that some social workers are invoking section 47, I think it is… section 46 here – of child abuse inquiry legislation, and 'Unless you let us talk to you, we are going to…' you know?

Ms Mellon: Yes.

Well, I could not generalise. I think there are some really brilliant social workers that would be able to go and do that kind of contact. Whether they should be doing it or… without alarming or twisting arms.

But I think in Brid Featherstone's latest book, *Re-imagining Child Protection*, they call it 'muscular authoritarianism', that is the term, which is that probably because of the high level of risk that this is almost seen as being just that that is the correct practice: 'We have got a concern about your child and if you do not cooperate with us, you will be seen as an uncooperative parent, non-compliant', and that will be in itself proof that there is something for us to worry about.

I have to say there is also now a category of disguised compliance, which in some ways parents cannot win, and that is the more helpful they are can be seen a warning sign as well that they are secretly not compliant. (**The Acting Chairman:** Yes.) That was because, again, people take lessons from things like the Peter Connolly case because the mother in that case was compliant. She would come along to interviews. She would take the child to the doctor. She would agree to go to the hospital, but meanwhile, of course, she was concealing the fact that she had two men in the house who were seriously abusing the child. So that and other cases meant they called it 'disguised compliance'. Obviously she was disguised. Most parents in that situation would just be doing what they were asked to do, but that in itself can be questioned.

Q121. The Acting Chairman: It is a question of the practice.

You are aware of the Haringey judgment, a little while ago, where there were false and malicious allegations made about a family as a result of passing on information, following which Haringey was taken to court. You would have thought that would put social workers on their toes to ensure that they were complying by the letter of the law in terms of getting consent for information. If it was a case such that consent was not required, suspected child abuse, then there needs to be, does there not, a warrant from the court to oblige the family to share information? We know from asking questions here that there has never been a court order produced. We are not saying there ought to have been, but it is just a fact it is not done. Is that the same in Scotland or England –

Ms Mellon: Probably pretty much.

The Acting Chairman: – of bluffing their way into the home?

Ms Mellon: For social workers it is often said that they are damned if they do and damned if they don't. So basically, if they were to not share information or not ask for information, then you can imagine the headlines, 'They read the family their rights and the family refused to let them in and they went away'. So there is that scenario that people are holding in their head.

The other scenario is that they do not see any abuse or they do not see anything and they do nothing.

Q122. The Acting Chairman: Have you come across such cases?

Ms Mellon: I think it is very little used. Child protection orders can be sought, but in general just in doing an assessment I think there is an assumption that a family will and should co-operate and open their door.

I know that recently there has been advice to families to film, because now everybody has got phones and it is just much easier to film interviews with social workers. I think some social workers were expressing fears of how that would make them feel awkward and watch what they said. It was in response to that, that that is how families feel when they are meeting social workers and in fact it might be a good safeguard for –

Q123.The Acting Chairman: Do you think it is a good idea?

Ms Mellon: Well, I don't see what would be wrong with it and actually it could be good learning material afterwards to look at it, collect it in, and say, 'Oh, that sounded a bit…' but also you have got the absolute clear record of what was said and what was asked. So in some ways, given the kind of level… because child protection has become the major reason for actually interfacing and meeting families, because of that, perhaps that would be a reassurance for families that –

Q124.The Acting Chairman: Yes, because getting it wrong procedurally can have devastating consequences.

You referred earlier to a foster carer being in the process and child adoption similarly is the end of the spectrum in this process; therefore it is so important to get it right at the start of the process. Have you got cases that you can bring to mind where sadly things have gone to court and adoption proceedings needlessly?

Ms Mellon: There have been some publicised cases where that has been the case, where parents have been accused of causing injuries to their child, which have subsequently been proved to be the child having an illness, a syndrome or a disability, but once an adoption order is made, of course, it is irrevocable – the link – and they cannot have the child back. The question posed there is: do we really do everything in the best interests of the child? Because if we have got this law that it is absolutely irrevocable, that the link with the birth family is absolutely severed and cannot be remade, then is that a best-interest-of-the-child decision? What is that for?

But there certainly have been cases where it has been wrong and now that we have got this kind of timeframe… and in England I think the government is pushing that to be even faster and talking about targets and social workers having to complete adoptions within 26 weeks, which is a very short time. Again, I would say that when child protection meets adoption that is also a very dangerous liaison if you are thinking that the solution to family problems is to transplant children into different families. It is putting two different things together.

The Acting Chairman: Thank you.

Jonathan.

Q125. The Clerk: Thank you very much.

I have been listening with great interest to this. I wanted to come back to your central proposition that child protection has become the dominant lens through which social workers do their work. I think maybe that is perhaps putting it too crudely, but it is something that is in everybody's mind, both in professions and in the community.

We have talked about different policies, different structures and different guidance, and the sense that I get listening to the conversation is that whatever we do, we don't really get away

from that dominant lens. We might try to shift the balance one way or the other and maybe talk about agencies in the first instance or change the words around, but we are still back at child protection and it is attitudes that you were talking about, I think, and it goes back to risk aversion, which you mentioned. How do you change those attitudes? It should be easy in the Isle of Man: it is a small group of people and you are talking to an influential committee. What are the messages that would make the difference here? Are there any good news stories that could get people thinking in a different way, because we always hear the bad news stories and the risk aversion comes from the bad news stories? How do you actually change those attitudes?

Ms Mellon: Well, I suppose some of it might be around the messages actually, that you tell yourselves and you tell your workforce about where you live and that this is a small and friendly island where people know one another well. There are people who are incomers from elsewhere, but generally it is a very safe place and there are no high levels of crime. You want children and families to be nurtured and supported and believe that families are the best way to bring up children. Those are the kind of main line… and that sounds very commonsensical and kind of 'Well, that is just the way it is…'

But actually, what people are hearing now is that the family is quite a dangerous place and children are quite at risk there. Many children, if they are abused, are abused within their own families. There are also children, if they are allowed out too much and too long, who are at risk from stranger danger. So that is a whole other narrative that is being told about the world that people live in. And so actually some truths and reality about the world that we live in, but without painting over the nasty bits of it, that is one way of doing it.

Then I think an ethos of service amongst the staff that we are here to serve the community. As a social worker, BASW, the British Association, promulgates our code of ethics, which sets out the ethical values of what we are doing. My feeling is that we have moved away from ethics and gone into some sort of technical prowess of tick boxes, assessments, tools, bureaucracy, and moved away from actually this understanding of human rights and the individual worth of every person, parent and child and everybody in the situation. So I think those kinds of messages and that kind of training.

Q126. The Clerk: Would you say that the Human Rights Act… you mentioned human rights (***Ms Mellon:*** I did.) and just picking up on that, that is another area where it has become a bit of a tick-box mentality hasn't it? I am guessing that you might have been using the term 'human rights' with a small 'h' and a small 'r' more in the sense of an attitude of mind: treating human beings with worth.

Ms Mellon: Yes, as worth, and actually the Human Rights Acts and the UN Convention on the Rights of the Child, people quite often think that they are the cause of a lot of problems because they have set children against parents or whatever. Both of them actually stress the importance of family life and the right to… well, the Human Rights Act – the right to private and family life.

The UN Convention stresses the right for their parents to be supported to bring them up, that is a UN Convention right. There is one right, which is the right of children to form and express an opinion, which I completely support, but sometimes that is the only right that people will talk about because it does not cost a lot to offer it. But the UN Convention talks about children's right to education, to health, to identity, to citizenship and to have parents supported to bring them up. So actually those are rights that I think everybody could sign up to and could underpin a good strategy, because you are saying to your staff and everybody, 'This is our duty: to give expression to these rights in a way that suits our Island environment and our culture here'.

Q127. The Acting Chairman: Thank you.

You have some 35 years' experience, I see, in professional social work, you chaired the Scottish Child Law Centre and you are currently Vice Chair of British Association of Social

Workers. I just wonder, in view of the changes you have seen over the years, if you are in a position currently to influence the profession, in terms of its procedure and the thing you talked about just now? In fact, do you see there will be quite a need for that within the profession to change the attitudes of social workers or are social workers unfairly getting the blame and having the buck passed to constantly sort out all of society's ills when it ought to be parents or teachers in classrooms doing their job better?

Ms Mellon: First of all, not all social work is done by strategy social workers in offices. The social work that I do now, my practice is mainly doing expert reports or independent reports for courts working with families who are actually trying to make a case or defend themselves, or get their children returned to them or not have adoption orders made. There are other social workers working in a whole range of ways.

My Association has just produced a new strategy and a vision for the next five years and it very much celebrates social work as in the round. I think we would say that what social work has been forced to be… in statutory social work the line that has been driven down, target driven, bureaucratic, not focused on the ethics of what we are doing, and so much as implementing policy, following procedures, all of those things I think need reviewing. We are certainly hopeful to give voice to the real social workers… the original, hopefully, vocation that people join the profession for, which is to help people in adversity, help them get the best from their lives and help them get social justice. I think those kind of ideals need to be re-presented and possibly we need to give a message to government that social workers are not here just to follow some tick-box policies and that we can offer a lot more than that.

Q128. The Acting Chairman: Is it going to be an uphill battle, given the bureaucratic world we live in generally and the huge caseload that is hitting the profession constantly?

Q129. Mr Cretney: It is something here all the time, for example, about nurses. Their profession has gone more to a tick box mentality, which is very sad as well isn't it?

Ms Mellon: It is, I know, but I think obviously, austerity… I know that the Isle of Man has got a slightly different economic model of income, but generally across countries that are facing the kind of measures that are happening in England, it does make the mind focus on what needs to be done and what needs to be done differently. If what you are doing is an investment in a wrong way and is not getting you the outcomes you need or even if you could just say, 'Well, actually, the rate of return on this investment is very low', there is an opportunity to review what you do. I think that the pendulum has only swung so far, it seems to me, in one direction, and it could carry on in that direction, but certainly in a small area like the Isle of Man you have got an opportunity to really do something quite different.

Q130. The Acting Chairman: And being a small area and having our own legislative ability, is there any particular advice you feel, based on your experience, that you could give us, in terms of how we frame our child protection legislation… how we frame our legislation addressing the needs, short of child protection? What mistakes should we avoid? If you were coming in here, given what has gone on in England and Scotland, what would you advise us to do?

Ms Mellon: Probably not to have child protection legislation, but to have family welfare legislation or even just to start with policy that very clearly gives us the steer that family welfare, in its broader sense, is what you are about and it is strengthening families.

Family conferencing, for instance, is something that was adopted. It was adopted in New Zealand and people then say, 'Oh, well, it is quite exotic and it was working with Maori families', but it has been used in a number of places, including Norway, and evaluated. It is one of the most evaluated and most successful social work interventions or interactions with families that

is completely based and built around strengthening families. You bring the whole family together, not just like that… the co-ordinator will go and talk to everybody and identify what the problem is around a child. There sometimes genuine problems – a child not going to school or a child who has got all sorts of problems – but you identify the problem, you talk to everybody, you bring the family together, and out of the family resources, coupled with your own authority's resources, the family develops a plan for looking after their children. Well, that is a model that I am very enthusiastic about and in my last job with a charity in Scotland, we introduced that model in Scotland and we are working to promote it.

Q131. The Acting Chairman: Is it a bit like the nurture units in schools? I don't know if you have them in Scotland, but we have certainly had them here at one time, where children needing extra care, it was very much a case of involving the family, whether it was teaching them social skills or whatever and the family would be brought in.

Ms Mellon: Well, it is a model more that recognises that the family is actually one of our best strongest social institutions. Families exist in every society and they are based usually on reciprocity, duty, love and affection, and they have been found to be the best way to bring up children, even though I think some of us feel that we have departed from that wisdom and think that the state might be better at bringing up children or that families are maybe not a very good idea or whatever. But families exist and there is no point in… so it is a model that actually builds on family strengths and it does not deny that in families there can be problems, friction and all sorts of things.

It was described to me as a model by Mike Dillon, who was the former Chief Social Work Officer in New Zealand, who helped introduce it, that if you put a parent and a child on a table and you tell them to reach down and pull the table up themselves, to lift the table up underneath them, they cannot do it, and that is what we try to do when we concentrate on just one bit of a family that has got a problem. We isolate it as 'that single mother with a child' or 'that father with a drink problem' or whatever… that sounds a bit stereotypical – but if you actually invite the whole family and the whole system to come along, they can lift a table quite easily. So it is that sort of idea that by joining in all the strengths you can actually create a completely different situation.

Plus for families that are not used to making decisions and making plans, most families will normally do that. You just get together or you get on the phone and you say, 'Mum has gone into hospital and so you will you do this and you will do that'. But some families have been quite damaged by circumstances so they need help to begin to develop those responses and family conferencing is a way of actually reinforcing those kinds of 'We can do it. We can come up with solutions. We can come up with a plan and we will be supported to implement it'.

Q132. The Acting Chairman: But the agency that brings about that support for that family would have to be a different body than the children and family social services, possibly, under the old model, would it?

Ms Mellon: Well, in New Zealand that is children and family social services and I think you would not add it on to… I think that you would make that the dominant way of working.

When I talk about it with social workers, people say, 'Oh, yes, but that is just good social work', and you say, 'Yes, so why don't you do it? How is it that that child was taken into foster care and it was two weeks while his aunt was phoning to try and find out what was happening?' These are things that happen: we do not even go beyond the immediate family and if a child comes into care we do not search out the whole family and go and talk to everybody.

Q133. The Acting Chairman: Where does this work more successfully? You mentioned New Zealand… and Norway did you say?

Ms Mellon: They have introduced it in Norway as a programme. I do not know how it has been evaluated out there, but New Zealand has now actually gone further down the child protection route that I have been critical of and that you have experienced. So for some reason they have changed policy a little bit and so I do not know quite what the situation is there.

But in Norway they introduced it as a national programme. They have got a federal structure and so central Government will evaluate programmes and then say, 'These are one of our four core programmes for children and families, and hand it over to the regional authorities to implement.

Q134. The Acting Chairman: In the case of New Zealand, is this part of the integration of their social care and healthcare systems?

Ms Mellon: No, it predates that. It came from Maori families originally because they were being so torn apart and they could not understand this way of working, which was to focus on one bit of a family and children were being removed. They actually got together to say, 'Look…'

I do not think that situation necessarily is replicated on the Isle of Man, but what they did was to say, 'This is our family. It is bigger than just those two people you have been looking at. This is our family. Come and talk to us'. So out of that it was developed, but it is not just located there. It is not so much the programme in itself, it is what it says and what values it expresses about how we should treasure, support and strengthen families, rather than take them apart to monitor them.

The Acting Chairman: Thank you.

Yes, Jonathan.

Q135. The Clerk: Just a thought about national and local government.

In the UK, the subject we have been talking about is a local government subject and in the Isle of Man it is handled statutorily for the whole Island – in other words, it is through central Government here. With the Isle of Man, although it is all central Government, there are quite a lot of barriers between different Departments because each central Government Department in the Isle of Man is its own legal entity and so you can give information to social services and there is a certain amount of confidence, I think.

One of the reasons we have separate legal entities is that social service is not the same person as, for example, the Police or the Health Service or the schools. But there is a debate in the Isle of Man about whether all those different departmental structures should be brought together into a single legal entity and I just wondered if you had any thoughts about that.

In the UK, for example, is it completely established that social services should always be done at local authority level or is there a debate about joining together across local authorities, co-operation with other services and that sort of thing? Does it make any difference, in your view, how these organisations are structured?

Ms Mellon: I think there is quite a lot of evidence that local democracy is important and that in Scotland we have actually got less local democracy than England. We have actually bigger authorities and we have got increasing centralisation, like one Police Force – a central Police Force. I think joining things together is what one big authority would take away from local accountability and people being aware of who was making decisions about what and what information was being held.

On the Isle of Man the population is under 90,000, I think –

The Acting Chairman: It is 85,000 to 86,000.

Ms Mellon: Eighty five – and so you cannot have very many people in any of these departments and so whichever way, whether they are legally separate or whatever, actually having people able to work together to get the best results should not be that much of a problem.

Q136. The Acting Chairman: It is interesting because government as a single legal entity is being actively considered here at the moment and a lot of the evidence for doing that comes from the Scottish government… that has been the system, I think, the last five or six years – and Sir John Elvidge, who was the –

Ms Mellon*:* Senior Civil Servant, yes –

The Acting Chairman: Secretary there, now retired, has been doing a report for the Isle of Man Government to the same end. I suppose we wondered whether in practice you felt, from a social care point of view, it had made much difference.

Ms Mellon: I think most of us in Scotland would say that the government still works in silos despite many years of saying they are not going to do that anymore. Many years of government urging local authorities and other services to work together and they have got community planning structures and all sorts of other things, but the government itself… and I think they acknowledge it too. So I do not know whether John Elvidge would acknowledge that that was the case, but certainly that is what is seen to be a major issue with central government, not joining things up. So they will have the Department of Justice working away, and within that Criminal Justice and Civil Justice separate and then Health on the other hand, and not able to actually see the connections between somebody doing something in one area then massively impacts on demand in another area or making policy in a silo and not actually getting the best results. How you do that, I don't know. I mean that has not been my –

Q137. The Clerk: Sorry, can I just follow very briefly on local democracy. What is the difference between what the social worker should be doing in Midlothian as compared with Glasgow or Shetland? Why is local democracy important in this particular field of endeavour?

Ms Mellon: Well, standards might be universal, and certainly we would say the code of ethics that we work to is across any jurisdiction or any country – that is the rights, ethics and values – but a rural place is going to have… well, just for some of the reasons we have identified, that in a small rural area people know everybody and everybody knows everybody. The policeman might be married to the health visitor and so there are those kinds of connections and it would be important that people develop and feel that they can shape the kind of services that they want. There might a standard of entitlement, but *how* it is delivered could be completely different. It might come with the post office van or the service of looking after elderly people who are isolated in rural areas, you might actually develop a partnership with the post or the bakery, or the school bus might be able to bring in people to town that –

Q138. The Clerk: Does that really happen, because as you have said yourself, a lot of what people do in social work is driven by statute and the statute is probably Scotland-wide or UK-wide?

Ms Mellon: I think there is statute, but there is also some amazing creative work that goes on and there actually are social workers doing really different creative things and working with the resources and the areas that they have and not just the social workers, but it can be…

Also you could build on those different… it is not… If you live in a tower block in Glasgow it is quite a different way of delivering a service to people than it would be in Kyle of Lochalsh or Orkney.

The Acting Chairman: Thank you.
David, any concluding questions?

Q139. Mr Cretney: Just to say how interesting it has been discussing this with you. I think what I am picking up is – if we didn't know already really – it used to be that these kinds of issues always went on but they were somewhat hidden. They became very high profile, as inevitably they would because they are so horrible when they do have the extremes, and as a result social workers very often become risk averse. There is this thing between welfare and child protection and they need to be more for welfare and family intervention and working with families. I think it is more about policy, really, than anything else. It is trying to encourage those who work – in the Isle of Man in our case – to try and adopt those, if they are not already, to work more towards those kinds of ethics and things you have talked about, rather than some of the tick box stuff.

Ms Mellon: Absolutely, yes. I think you have summed it up very well.

Mr Cretney: Yes. Good! Well, I have –

Ms Mellon: I have talked for a long time in here!

The Acting Chairman: You've done my job. Thank you!

Mr Cretney: Yes!

Ms Mellon: Yes, if that is the message that you got, I am happy with that.

Mr Cretney: Yes.

Q140. The Acting Chairman: We would like to thank you very much and just give you the opportunity if there any concluding comments or advice you would like to give us or anything at all?

Ms Mellon: No, not really. As I said, I think the Island is a beautiful size of a place. I have seen some of the Island this morning as I was given a wee tour, which I am very grateful for. It just seems a really good size of an Island for you to be thinking about not making the same mistakes as have been made and you have got a lot of levers here in your own hands to be doing something that really works for you.

The Acting Chairman: Thank you.
Well, thank you very much.

Ms Mellon: It has been a pleasure. Thank you.

The Acting Chairman: It has been a very interesting discussion and as a Committee we are very grateful to you and we wish you well with the rest of your visit to the Island.
Thank you very much indeed.

Ms Mellon: Thank you very much.

The Acting Chairman: This session is now closed. Thank you.

The Committee adjourned at 4.06 p.m.

10th September 2015 Evidence of Dr D Foreman, MB ChB MSc FRCPsych FRCPCH

STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

RECORTYS OIKOIL
BING VEAYN TINVAAL

PROCEEDINGS
DAALTYN

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

OVER REFERRAL TO SOCIAL SERVICES

HANSARD

Douglas, Thursday, 10th September 2015

PP2015/0130 **SAPRC-OR, No. 3**

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Members Present:

Acting Chairman: Hon. S C Rodan SHK
Mr D C Cretney MLC

Apologies:
Chairman: Mrs B J Cannell MHK

Clerk:
Mr J D C King

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Social Affairs Policy Review Committee

Over referral to Social Services

The Committee sat in public at 11.00 a.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[THE SPEAKER in the Chair]

Procedural

The Acting Chairman (Mr Speaker): Good morning everyone, welcome to this public meeting of the Social Affairs Policy Review Committee which is a Standing Committee of Tynwald.

I am Steve Rodan, Acting Chair of the Committee in the absence of Mrs Brenda Cannell. My colleague on the Committee is Mr David Cretney MLC, and our Clerk is Jonathan King.

Please ensure mobile phones are switched off to reduce interference with *Hansard*.

The Social Affairs Policy Review Committee is one of three Standing Committees of Tynwald established in October 2011 with a wide scrutiny remit, and we cover the Departments of Education and Children, Home Affairs and Health and Social Care. One line of inquiry before the Committee is to do with concerns over the level of referrals to Children's Social Services. In March of this year we published a report which includes some conclusions and recommendations on the subject. This report was debated at the June sitting of Tynwald. At the end of June we had a further discussion on the topic with Maggie Mellon, and today we welcome another expert witness.

EVIDENCE OF
Dr D Foreman, MB ChB MSc FRCPsych FRCPCH

The Acting Chairman: Good afternoon, Dr Foreman, you are very welcome.

Dr Foreman: Good afternoon, thank you.

Q141. The Acting Chairman: Before we get underway, for the record could you state your name and summarise your qualifications and experience in the subject matter we are talking about today.

Dr Foreman: Yes, the Committee is in receipt of my curriculum vitae, so it does have a full account. Very briefly I am a doctor, I have worked as a child psychiatrist on the Island and have qualified as a child psychiatrist. I hold fellowships of the Royal College of Psychiatrists and the Royal College of Paediatrics and Child Health. I am, or have been, an academic in a variety of universities, both as senior lecturer and for visiting professorships.

I am currently a member of the Child and Adolescent Faculty Executive of the Royal College of Psychiatrists, and also a member of the Perinatal Faculty Executive responsible for liaison between those two faculties. I have published extensively and among my publications include

topics related to child protection. I have published in *relation* to social services but I must stress I am not a trained or qualified social worker.

Q142. The Acting Chairman: Thank you very much indeed and, as I say, you are very welcome.

Could I begin by putting the following scenario… and by the way we do thank you for your written evidence. We sent you a number of questions in advance and we have got your very detailed written response which will be incorporated into the body of our reports and our deliberations. But we thought we could expand on some of those issues which you have put to us.

We concluded in our report that the number of children in the Isle of Man in need of protection was about the same as the English average on a per capita basis, and that this figure has been fairly consistent over a number of years. But the number of referrals, assessments and enquiries in the Isle of Man were proportionately higher than in England.

Dr Foreman: Yes.

The Acting Chairman: We went on to conclude from examination of the figures, that since 2012 there had been an increase in the number of instances where an agency approaches Children and Family Services in a case where an assessment is not needed.

I would ask three things: do you share our assessment of the published figures for the Isle of Man; how much do referral rates vary between different local authority areas in the UK and should we be regarding the UK average rate as a target for the Isle of Man; and the fact that many of our teachers, police and social workers come from England, and with our child protection guidance being based on English models, what reasons do you think there could be for our rate of what turned out to be needless referrals to Social Services being higher than the English average?

So it is quite a wide-ranging –

Dr Foreman: Yes and a very crisp summary of the questions that I was asked in writing.

Do you mind if I refer to my written evidence?

The Acting Chairman: Please do.

Dr Foreman: Thank you very much.

The first two points: I think it is reasonable to take the overall English rates of child registrations on the child protection register as an appropriate benchmark. The reason for that is not only the overall potential similarities between the Isle of Man and England, but also that is the area where standardisation is most intense. The children in England and on the Isle of Man have been seen by social workers with the same training, have gone through the same processes and have been registered according to the same criteria. So if you are getting as a result of that process, the same rate, it seems very likely that you are getting the same results using the same methods – so it is likely to be a very similar population.

So that would be my first point: yes, that is reasonable.

The second point, which was that there had been an increase: I think there are some problems looking between agencies and trends, as I discuss in my written report; but overall if you look at *absolute* figures there is no significant difference – it just goes up and down a lot. However, that picture differs if you look at the ratio between different areas – and I will just talk you through that…. calling up the screen. If you look at the ratio of contacts – this is the Isle of Man concept, and if you recall in my written report I did stress that this was rather different and effectively operated as a separate filter stage. So if you talk about contacts to referrals in 2010

only 37% of contacts went on to a referral, while in 2013 63% went on from a contact to a referral.

If you look then, moving on from the referrals to a preliminary assessment, the picture is much more mixed: 55% went on in 2010, and that jumped as high as 96% by 2012, which I think is when concerns first started to be raised, looking back. Following the raising of concerns, that then dropped back again to 46% – so, following the raising of concerns in 2012 you had a drop and a much stronger filter.

However, if you then look at the move from the initial assessment to the core assessment – and remember it is the core assessments that then lead on to the section 46s, that led to the result, so that is another crucial result – that has showed a steady upward trend from 26% in 2010 to 56% in 2013. So what appears to be happening is that the filters are becoming progressively less effective – and that is consistent with the hypothesis I put forward in my written report, that over time more and more cases are going through each stage of the referral prior to the very highly standardised and determined section 46 and 47 assessment that determines registration.

Q143. The Acting Chairman: Are you saying that, because in the Isle of Man the filtering system that we have does not discriminate adequately between children in need of a service and children in need of child protection; everybody being referred – or the subject of a contact – is going through the same filtering process? Whereas in England I think you have made the point about the English guidance being, and I quote: 'to decide whether the child is a child in need and/or is suffering, or likely to suffer, significant harm'?

In the Isle of Man the guidance is about decisions whether or not the child is a child in need *and* at risk of significant harm, that we are using the same filter system for children in need but not in need of *protection*, as children who *are* in need of protection.

Dr Foreman: That is a very interesting point because 'and/or' implies a looser filter system, while 'and' implies a tighter. So despite having more filter stages and a tighter filter system you are still getting more through until the end result.

To understand that I think you have to look at the issue of need, which I deal with under my answer to question 1, paragraph b). The key thing to notice is that though the overall rate of referrals is three and a half times higher, 'need' is only identified at 34% of English rates – very, very much lower.

I would not recommend in terms of changing the process described in figure 1, because all too often you only find out about child protection when you look into a case of need in more detail. Obviously people do not normally wave, 'I am abusing my child' from the hilltops, so it is important that they be combined at the outset.

But as I stated and I believe in my report, and the trends show… *that* then puts *huge* pressure on local services who are also trained in the English model if the criteria for welfare is set very much higher than in England… because they are not necessarily equipped or resourced to deal with that level of need – if they have been English-trained and are resourced to broadly English levels – if they are not able to refer through at the same rate. And then comes the question of what do they do.

This is where I think Mrs Mellon's report – which I was very helpfully given access to – was very helpful, because she pointed out that the boundaries of child abuse, particularly with the extension of the concept of safeguarding, are now very broad.

So that gives an opportunity for other agencies desperate to meet severe needs of children – which as you saw Mrs Mellon was prepared to say could extend as far as economic difficulty in some circumstances – to attempt to use the abuse system to try and meet those children's needs. And that, I believe, explains the pattern of figures that you have here.

Q144. The Acting Chairman: Can I ask you, then: on the basis that over referral is a serious issue – because of its direct adverse impact on families who turn out *needlessly* to be brought to the attention of Social Services, and because of the indirect impact on children in need and at risk of harm, and the overall cost – what is your view about the impact of needless referrals on families who are investigated, in terms of the health of the families concerned?

I wonder if you have any illustrations from your own experience, about the adverse effects on families of child protection procedures being brought to bear as a filter, when there is no child protection issue at all, and it is a question of a statutory need of a different sort?

Dr Foreman: Yes… I am so sorry, I am dropping things.

I will start with a personal experience to illustrate this and then a generalised. The personal experience was many years ago: a woman who was subjected to a very significant child protection investigation, with the potential of losing her child. I was called in on that occasion as an independent witness and what I found was that the woman had a mental health problem that had not been identified as part of the process, and that was severely adversely affecting her ability to care for her child adequately.

I was able to recommend and ensure that appropriate treatment for the mental health problem occurred, her mental health improved and she was able to continue to care for her child. That would be a personal example of the harm that a misreferral into the care system, or the abuse system, can bring.

More generally, of course, if you feel that – as is often the case – referrals to the local mental health services for children or adults… you are not sure which to go for, both have long waiting lists and you are not convinced they will engage, and Social Services are effectively saying 'We are only offering statutory services'… and you are extremely worried about this family and you can see real problems… you are going to seek not necessarily the *best* help, but what help you *can,* as a referrer. So it may not be the case that you even *want* to refer the family through the abuse system, that maybe the *only* way that, following negotiations with various agencies, you feel you can get *somebody* to pay attention to this family in some way.

Q145. The Acting Chairman: I see.

Is it the case that needless referral is worse, would you say, in a small community where there is a goldfish bowl, as they call it, and everybody knows everyone else's business?

Is the adverse effect about being needlessly caught up in the referral system as a result of a referral which turns out to be groundless?

What are some examples of adverse effects on families when this happens – based on your experience as a child psychiatrist?

Dr Foreman: First of all, I would be very wary of using the term 'needless referral' – this follows on from what I was previously saying about need and welfare. There may well be a *need* for referral but the only path left open is down the child protection pathway, because there are statutory duties and requirements to be called. But that does not mean that the family does not need help in some way or another. If you look at the figures, in only a minority of cases – though there were *some* cases – no need was found. So the bulk of these have *needs* but are not going down the route to which they are taken.

That having been said, there is always the risk – I think Mrs Mellon called it the 'child protection lens'; I would probably call it 'mission drift'. The referrer is intending to try and get help somehow but when it gets fed into the system, to use a quote: 'If all you have is a hammer, then everything starts to look like a nail.' The worst example I can give in my experience as a child psychiatrist actually does not involve individuals, but groups.

You may have noticed from my CV I was previously involved in a social services scandal in Staffordshire helping to expose it – the 'Pindown' scandal. In the year or so prior to it breaking I attempted to offer a basic training course in mental health and social work to the local social

services department. It was declined on grounds that this was all a part of child protection and they already had a child protection training programme in place; and that was a year before the 'Pindown' scandal broke, and not all of these people were just bad and difficult people. That gives you an idea of how serious, and how seriously blinkering, the child protection lens can be.

I have the other classic example I have actually published on, which was the famous case… not Mellor, I have blanked out the name of the case… but this involved both Roy Meadow and David Southall; and they were focusing so hard on the possibility of avoiding harm by preventing abuse they could not look at – as you were already raising – the probability of producing harm by suspecting it falsely. So that is certainly there. And on that occasion it led to the eventual death of the mother who was falsely accused, by alcoholism and suicide. So it can be potentially *very* serious.

However, it should not therefore be assumed that those needless referrals lack need, they may have very considerable needs that are not being met, but the abuse system is not going to meet them either.

Q146. The Acting Chairman: If, though, the system is geared up to focus on a potential result of child protection, is there not a real danger from the outset that parents will regard the initial involvement of social workers with suspicion – that the family is under suspicion for child abuse – and therefore the family will be very distrustful, will not engage with social workers and will be fearful? And in a small community if this becomes the norm, are you not then going to simply have families putting up the shutters at the first suggestion of social workers being involved with a family, when it might very well only be a case of meeting a fairly low-level need?

Dr Foreman: This is a fear that social workers face worldwide because part of the statutory duty of social workers worldwide is to protect children, if necessary, by removing them from their families. And this can never be entirely removed, for whatever reason they turn up. Woody Allen actually put it beautifully when he talked about 'a monster with the body of a crab and the head of a social worker'. So people are frightened of Social Services, more so than almost any other group, because having your children removed is possibly the worst pain a parent can feel.

However, there has been research on what enables social workers to engage effectively and the results, I am pleased to say, are really simple and common sense. Families are likely to engage with their social workers if three things happen: first, they are seen as competent; second, they communicate positively, not negatively; and thirdly, they come with practical or emotional help at the outset. That seems to engage families. Mrs Mellon has already given very good descriptions of the opposite to those approaches, as in 'It is entirely voluntary to talk to us but, if not, it will be held against you' – and versions like that, which clearly are not going to work. This is a key professional training issue for social workers to get that right.

There is also – and I think you touch on it elsewhere – a very important public education component which needs to be supported, so the way that the agencies actually behave on the doorstep is adequately communicated, so people can talk about it and feel much more confident that they *are* going to receive help; and that they understand the statutory duty of social workers is actually to *keep* children with their families unless all else fails. This is not understood in the community at large: that the social worker's job is to *stop* the child leaving the family if at all possible, consistent with the safety of the child. That kind of public education could be *hugely* helpful.

Q147. The Acting Chairman: We have a long way to go then, would you say, in conveying the message to the public that the social work system is not something to be feared, on the basis that it is an indication of potential child abuse and child protection – but is there as a facilitating mechanism?

Dr Foreman: I would hesitate to comment on how social workers behave on the doorstep generally on the Isle of Man – I do not have that information. It is, however, a matter of training that social workers should not respond in the way that Mrs Mellon described; and as I have implied here, I believe that those sorts of responses are a training issue and they can be corrected by appropriate training.

Additionally, the Island already has – I think it was about four or five years ago – introduced 'Triple P' in collaboration, I think, between the Department of Social Care as it then was and the Isle of Man Children's Centre. There was a randomised controlled trial in 2009 showing that type of very positive early engagement operated on an islandwide basis was very helpful in reducing child protection issues. So when you say 'a long way away', I am not sure how far it is away if adequate will, management, resources etc. were put in – that would be something for your own social services team to answer. But it is certainly possible.

Q148. The Acting Chairman: Before I invite my colleague to put a question… just rounding off this issue of adverse consequences on families.

The 'Every Child Matters' strategy in England has now been moved on from… and Prof. Eileen Munro's report has superseded all that. But a few years back the 'Every Child Matters' strategy was very much the policy and it was being, in effect, copied in the Isle of Man.

I understand just from looking back at the records that it was flagged up to the UK Chief Medical Officer after the 'Every Child Matters' strategy was being implemented… there were a number of concerns by professionals about these adverse effects on families, such as: distrust of health visitors, fear of accessing medical care, concealment of postnatal mental illness, increased use of alternative practitioners, concealment of domestic violence and more choosing home schooling. Issues like this meant that families and individuals would become distrustful of health visitors, agencies or anybody official, for fear of being caught up in the whole panoply of investigating Social Services who might have a suspicion that the slightest problem with that family was an indication of a child protection issue. This was all flagged up at the time.

Are such concerns, in your experience, real or imagined?

Dr Foreman: I think… and the reason I am pausing is that the short answer would be 'yes and no'; but can I enlarge on the 'no' first and then move to the 'yes'?

If you look at the overall rates of child protection registrations before and after 'Every Child Matters', there has not been a dramatic shift. So the overall pickup rates stayed round about the same – that is just my recollection. If you look at the number of serious enquiries where things have gone wrong one way or another, the numbers are very low, so they go up and down, but also not a lot has changed – I think Eileen Munro brought that out very well. What is interesting is that if you look at 'Every Child Matters' there is a lot that is similar about it with Mrs Mellon's discussion in terms of 'Getting it right for every child' – and they were drawn from a similar basis.

If you look at the original wording around 'Every Child Matters' and 'Getting it right for every child' it is not primarily about catching abusers – in fact the working-together documents produced at the time make it very clear it is *not* the job of professionals to decide who has been abused, that is the job for the courts. Their information, and their approach, is to support and help and act for the benefit of the child, and assessing protection issues is only one of those things.

Where I move now towards the 'yes' – and also therefore more away from the figures, to my own research – is when I say that if you look within that, however, and you think about things like press coverage, what is very clear is that catching abusers was enormously prioritised at an organisational and operational level. I believe – and that is why I make the recommendation at the end of my own written report – that simply organising policy is not necessarily going to lead to a change in the kind of attitudes and behaviour we are going to manage.

People are very averse to losses and if people feel that they could potentially be faced with a loss to their own professional career by missing something, they will always go the extra step and do the extra investigation – because, even if they get it wrong, at least they can say they have done it and no one is going to say that they have not. And until another loss is imposed, as it was on the Island in 2012, suddenly too many were going through and suddenly the rates dropped down. That is my interpretation and it is entirely speculative at this point. But it is about giving people confidence about what set of risks they are willing to take because, as I say, you cannot do this risk-free; and it is also about ensuring that people who have need *elsewhere* do get those needs met elsewhere in some way.

The Acting Chairman: Yes, thank you very much.

David?

Mr Cretney: No, you have addressed the points that I had, thank you.

Q149. The Acting Chairman: Widening the caseload and enabling, as you have just said, social workers to protect themselves by 'When in doubt, refer', will have the effect of potentially swamping the system – that is what we have just been talking about – to the extent that genuine cases get missed, and they drop through the net.

Dr Foreman: I totally agree.

It can also occur with information within a case: if you can think about just how much information social workers collect, the files are that thick – and frequently they are *that* thick. Trying to find the key evidence would be like trying to find a diamond in a heap of cut glass – incredibly hard to do. That is why I disagree with Mrs Mellon when she is talking about a tick-box culture. I agree with the outcome, but I do not believe it is arising from tick-box assessment measures.

I believe it is arising from the kinds of process that I described in my original report, with people being averse to being caught out – so collecting information and not being able to organise it, but they can at least say, 'I collected it'. And also the problem of what to do with these cases – and a disagreement between the agencies over how to manage this. This is also unpleasant to families: we are talking a lot about what it feels like to be falsely accused, which I have indicated can be managed by appropriate training.

Also imagine what it feels like to be passed between agencies, with everyone forever saying, 'Yes, there is a problem but it is not ours'; and you are left still saying, 'I need help.' That is as stressful and, on a small Island, as potentially damaging to families' reputations… they become a family who cannot be helped, who cannot cope, and who go round the agencies. And of course reputations within agencies are important as well, because agencies have power.

Q150. The Acting Chairman: Yes.

Is the answer, then, to ensure that the agency of first instance deals, if possible, with a potential referral to Social Services – and that Social Services are only used when necessary?

Do we need to be better at heading off what, chances are, will be low-level concerns and needs way short of child protection, that these are dealt with without the whole apparatus of Social Services getting involved?

Dr Foreman: As I said in my written report with rates of assessments for need, or children being identified, as only 34% of the English rates – I think that is the figure, around a third of the English rates – that means that we are actually asking our agencies to manage rather more serious cases of need than they would be expected to manage in the UK, where they might get a higher level of social services engagement. That is the first thing to say.

That raises issues about – if we are to agree with that process – what sort of training needs to be put in, because obviously on a smaller scale you cannot have the same level of specialisation; it is simply not doable. So, what level of training is needed to be in those primary agencies?

The other issue is that fortunately the 'If in doubt, refer' thing is now no longer there in the latest versions of child protection – I notice that question in your query to Mrs Mellon and I checked, and it is no longer there. What they are then saying is that the local Children Safeguarding Board should be setting appropriate thresholds in conjunction with the other agencies. I entirely support that approach because – and I have to say for this, I can demonstrate it more clearly using my UK data on another topic – I believe that how this is happening is because of the sharp elevation of threshold of need, leading to the demand pouring into the other sector.

So with a negotiation of what constitutes an appropriate threshold level combined with an appropriate threshold of what constitutes need, calculations using UK figures of what the referrals should be and checking whether it is matching or not, would be how I would be approaching bringing the problem back under control – because I agree it is not under good control at the moment.

Q151. The Acting Chairman: Would you be looking, then, at English regions with the same demographics of need and social deprivation as the Isle of Man?

It is perhaps not surprising that the Isle of Man has less social deprivation than many parts of the adjacent isle, and the identified needs are therefore less. But given the big variation among English local authorities, should we be looking at a particular benchmark rather than an average, or should we be looking at Scotland who count the figures a bit differently again?

How should we measure ourselves?

Dr Foreman: That is extremely tricky, and I think I state that if you want to be the absolute best, you would need to do an extra piece of research to find out. However, you could also quite legitimately say, 'We need to do something while the people with great brains sit there and spend a couple of years doing this.'

My inclination would be to use the UK national average, simply because you have already got one statistic that works – and that is the child protection registration rate. That one, despite all the variations… we know that, for example, the Isle of Man is anything between the third and the sixth wealthiest country in the world per capita, versus England being about the 20th; and we know that level of wealth is a good predictor of levels of harm.

So if, despite that level of difference, we are getting similar rates on the English average, I would start with the English average… after all, it can always be changed later, particularly – if you *want* to commission the research – when the people who do the research come back and give you the answer; you can change it. But at the moment there are some national figures you can make use of and extrapolate across now. As I commented, I did a review myself on the public mental health which contains potentially quite a bit of the data that could be used to assist in that.

The Acting Chairman: Okay, thank you.

Jonathan, do you have any points?

Q152. The Clerk: Thanks, Mr Speaker.

Dr Foreman, you have mentioned the small community a couple of times, and just to come back to this you spoke about the agencies getting to know a family, and the family having a reputation among agencies as difficult to help. But I do not think you answered the more general question about in a small community where everyone knows everybody else's business, do you think that makes the potential adverse effects of a social work intervention worse than, say, in a big anonymous city?

Dr Foreman: I am going to say no, and I will explain why I am going to say no.

When we talk about England or Scotland we refer to global populations. I was born and brought up in London and worked for a while in Stoke-on-Trent, as well as in London boroughs, and I trained in Bristol. What I learnt was that very large places like London are lots of small places squeezed tightly together, usually with the space snipped out in between. If you ask directions in London you can have the curious phenomenon that if you ask for a street in one direction everyone passing you will know it precisely – if you ask for a street just as far away in the opposite direction no one will know it, because there is an invisible boundary around where people actually live.

In Stoke-on-Trent – slightly bigger than the Isle of Man, maybe 120,000 compared to 80,000, with five towns – what mattered was which town you lived in. Some people never left the town of their birth. On the Isle of Man I think it is highly unlikely that people who live in Peel will know a great deal about everybody in Douglas, but they will probably know a lot more about people in Peel than other Douglas people will know about people in Douglas. And I think that question in a sense does not apply at the *Island* level but at the village and town level; and that means it affects the UK as much as it affects here. It is very important, but it is actually more local than the Isle of Man.

The issues where that lies round in particular, and as a matter of concern, are in relation to schools – because schools are universal, they are community. They do not have similar rules about confidentiality as other agencies – yet they get plugged in and *have* to be plugged into the process. So in my experience of working as a child psychiatrist here, the school was the major route by which information leaked. Some of that leaking was unavoidable. If it was children abusing other children – which is actually one of the commonest forms of child abuse – of course the perpetrators and the victims would both be known in the school system. Secretaries would also be friends of local people in their communities as well.

I do not have an easy solution to this, but for me that really stresses the importance of including confidentiality as part of Level 1 child protection information, as well as information sharing – because it is the Level 1 training to which all the people in the schools will go. Also once again social work training, so that when they are on the doorstep this becomes part of their positive communications: 'How are we going to manage this so you do not face complaints at work losing your job? What are we going to do about that?'

After all, no one has problems about a policeman knocking on the door – it can be for any sort of reason. The public perception of social work needs to be changed and that can be managed.

Q153. The Acting Chairman: Yes.

Information sharing and data protection, then: are they bigger issues in a small community… however you wish to *define* a small community?

Does that become more important where people know each other's business?

Dr Foreman: Oh yes. However, it is not specific to the Isle of Man, but the smaller the community the easier it is for leakage, because individual… *[inaudible]* will be relating to each other in more than one role. You live among your patients or your clients; in London, typically, people may deliberately choose to live away from their clients or patients. On the Isle of Man that is much less possible. I was in Douglas last night being greeted by two of my old patients, grown up! You cannot separate roles.

The Acting Chairman: Yes, thank you.

Any final questions – Mr Cretney? Jonathan?

Q154. The Clerk: May I just ask – because maybe everybody else knew – but Dr Foreman used the expression 'Triple P' earlier. What is that?

Dr Foreman: Triple P stands for Positive Parenting Programme – one of the most robust… just to refer again to Mrs Mellon. The evidence around family group conferences is strong regarding *practitioner* enthusiasm, but less strong regarding client enthusiasm, and *least* strong regarding efficacy – it does not seem to be, on the two randomised trials that have been done, more effective than using other methods.

What does seem to work in reducing child protection rates is effective support to parenting. There are a large number of these, but one that was brought to the Island was called the Positive Parenting Programme – 'Triple P' for short. It is unusual in that it has a public health component that can be delivered at a community level.

The community level involvement was tested in a randomised controlled trial in the United States in 2009 and got good results – and that is something that was already here on the Island, but I do not know whether it is still in use.

Q155. The Acting Chairman: When you said 'child protection programmes', does that not imply that the whole purpose of such an exercise is –?

Dr Foreman: Positive Parenting Programme is not a child protection programme.

The Acting Chairman: Right, that is an important distinction.

Dr Foreman: It is essentially a parent education programme and it is a practical education. As we all know sitting there and listening is probably the least effective way of learning how to do something; the most effective way of learning to do something is to see other people do it, copy other people doing it, and do it with other people and get lots of positive feedback – and that is how all of these programmes work.

Q156. The Acting Chairman: I think when Mrs Mellon gave evidence she referred to a project in Scotland which was community-based and was run by parents and families themselves, where it was like a drop-in service and children and family issues were dealt with, where the parents invited the social workers in to discuss the issues – so they very much had control of the process and were not like subjects in a bureaucratic process of which they might be highly suspicious or distrustful.

Dr Foreman: All of these parenting programmes stress the principle of empowering parents being at their centre and the professionals – as is truly the case – being at their service.

Q157. The Acting Chairman: So that is the sort of approach which in your professional experience works best?

Dr Foreman: I have seen from the research background that there are various levels. I have seen it and been trained in it, working in groups of parents as a facilitator. I have also published parent support group research and I am absolutely committed to the idea of families being able to influence the services that they receive.

Q158. The Acting Chairman: Yes, thank you.

Dr Foreman, I would like to thank you very much indeed for coming to meet with us this morning, it has been much appreciated; your input has been of value to the Committee both this morning and your written evidence. We will be considering what you have to say in greater depth.

Thank you very much for your time.

Dr Foreman: Thank you.

I would like to slightly update my written evidence to include the trend data and its interpretations. Do you have any objection to me forwarding you the slightly updated version?

The Acting Chairman: No objection at all, we would welcome it. Thank you very much indeed.

Dr Foreman: Thank you very much.

The Acting Chairman: Thank you, ladies and gentlemen. This oral evidence session is now closed and the Committee will now sit in private. Thank you for your attendance.

The Committee sat in private at 12.02 p.m.

13th April 2016 Evidence of Dr Malcolm Couch, Chief Executive, Ms Deborah Brayshaw, Director of Children and Families Service, and Ms Lisa Hall, Head of Contracts and Business Operations, Department of Health and Social Care

STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

RECORTYS OIKOIL
BING VEAYN TINVAAL

PROCEEDINGS
DAALTYN

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

CHILDREN AND FAMILIES SOCIAL WORK

HANSARD

Douglas, Wednesday, 13th April 2016

PP2016/0064 **SAPRC-CFSW, No. 1**

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Members Present:

Chairman: Mr D C Cretney MLC
Hon. S C Rodan SHK
Mr G G Boot MHK

Clerk:
Mr J D C King

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Standing Committee of Tynwald on Social Affairs Policy Review

Children and Families Social Work

The Committee sat in public at 2 p.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[MR CRETNEY *in the Chair*]

Procedural

The Chairman (Mr Cretney): Welcome to this public meeting of the Social Affairs Policy Review Committee, which is a Standing Committee of Tynwald.

My name is David Cretney MLC, Chairman of the Committee. The other members are the Hon. Steve Rodan, Speaker of the House of Keys, and Mr Geoffrey Boot MHK.

If you could please ensure that any mobile phones are on silent so that we do not have any interruptions. For the purposes of *Hansard*, I will be ensuring that we do not have two people speaking at once. I think with mobile phones it is probably better if they are off altogether, if that is convenient.

The Social Affairs Policy Review Committee is one of three Standing Committees of Tynwald Court established in October 2011 with a wide scrutiny remit. We have three Departments to cover: Education and Children, Home Affairs, and Health and Social Care.

The Committee is concerned about the level of referrals to Children's Social Services. In March 2015 we published a report which included some conclusions and recommendations on this subject. The report was debated by Tynwald at the June 2015 sitting. At the end of June 2015 we had a further discussion on this topic with Maggie Mellon, and in September we heard from Dr David Foreman.

In November 2015 we issued a public call for evidence. We explained that we would not take a view on any individual case and would not liaise with the Department regarding any individual case. We have, however, listened to a number of witnesses, including public sector workers, in complete confidence. This has been in order to ensure that we understand what actually happens between social workers and families. This understanding has been intended to improve our ability to scrutinise the implemented policy of the Department in this area. We are very grateful to those who come forward.

EVIDENCE OF
Dr Malcolm Couch, Chief Executive,
Ms Deborah Brayshaw, Director of Children and Families Service, and
Ms Lisa Hall, Head of Contracts and Business Operations,
Department of Health and Social Care

Q1. The Chairman: Today we have the opportunity to ask three questions ... sorry, to ask questions of three representatives – if only it *was* three questions – of the Department.

I would like to begin by asking each of you to state your name and job title, please, for the record.

***Dr Couch*:** Malcolm Couch, Chief Executive of the Department of Health and Social Care.

***Ms Brayshaw*:** Debbie Brayshaw, Director of Children and Families Service.

***Ms Hall*:** Lisa Hall, Head of Contracts and Business Operations.

Q2. The Chairman: Thank you very much.

Given that we have a number of questions, we will get straight into them. Without wishing to interfere in any way in terms of your response, if it is a straightforward response that would be appreciated. Okay, thank you.

I would like to begin by asking some questions about the scale of your operation. How many people work for the Children and Families Division, and what is your budget?

***Ms Hall*:** We have 81 FTE posts and our budget last year was £19,605,000. I think this year it has reduced down to £16 million.

Q3. The Chairman: Thank you.

How many children or families are you dealing with at any one time? I obviously realise it varies.

***Ms Brayshaw*:** Yes, it is an average, and it averages something between 400 and 480 at any given point in time.

Q4. The Chairman: Okay, thank you.

How many of the staff are qualified social workers? And could you please explain any other categories of employee that you might have.

***Ms Hall*:** We have got 43 positions that require the qualifications of social worker to hold that position, we have some administrative positions, and then we have a number of workers who are support workers in our resource centres for children with disabilities, and within our social work statutory service we have some unqualified workers as well.

The Chairman: Okay, thank you.

Mr Boot: Can I just ask –?

The Chairman: I was just going to say my colleagues may at any time come in.

Q5. Mr Boot: How many support workers are there?

***Ms Hall*:** That work directly with our social work service we have got eight support workers, who are called family support workers.

Q6. Mr Boot: They are not qualified in any way?

***Ms Hall*:** They are not qualified as social workers, no.

Q7. The Chairman: Could you outline what use you make of private sector and third sector partners in the delivery of your services?

***Ms Hall*:** We have contracts for the delivery of the fostering service, adoption services, children's homes and aftercare services to care leavers; and we have got a contract for early help and support services to families, a supervised contact centre … I think that is it.

Q8. The Chairman: Thank you.

Do you have any figures or targets for gender balance amongst the people delivering the services?

***Ms Brayshaw*:** We do not have targets for gender balance in delivery, no. Social care, by its nature, is predominantly female, but we do have a mix of male and female staff.

Q9. The Chairman: Okay, thank you.

Could you describe the management structure of the Children and Families Division?

***Ms Brayshaw*:** Yes. In the service itself every team that we have got … We have got three care management teams and each have a team manager.

We have an initial response team, the Duty Team, which has a team manager and two supervising social workers – the nature of the work is very fast moving in Duty; and a Family Support Team with a team manager.

We then have two heads of service: a head of service for statutory social work, and we now have a head of service for our early help and other services, which include children with disability.

The resources centres have, at head of service level, a service development manager, who is responsible for performance management and divisional plans and business plans of the Department; a senior independent reviewing officer, who manages a small number of chairs, who chairs the looked-after children reviews, which I think you have made reference to.

And then there is Lisa as the Business and Contracts Manager, and myself as the Director.

The Chairman: Thank you very much.

Q10. Mr Boot: Within the teams that you have, do the people revolve around the different teams; or are they set in the team, and that is it?

***Ms Brayshaw*:** People sit within a team, so they have a manager they are accountable to. Their workload is not geographical – they can take any piece of work that sits anywhere across the Island. In the absence of their own team manager they would revert to another manager. Automatically, the managers would work collectively to cover for each other if one was absent.

Q11. The Chairman: Who deals with complaints, and what are your complaints procedures?

***Ms Brayshaw*:** Complaints can come into the Department at any level. They can come in via the social workers themselves through a manager, sometimes emails to myself, and sometimes complaints come directly in to the Minister or the Chief Executive. They are always logged in a central log that is held departmentally in the directorate of the Minister.

The concept behind the complaints is to try and achieve resolution at the lowest level. Stage 1 would be between the worker directly and/or the team manager to try and resolve that. If that was unresolvable and the complainant was still dissatisfied, level 2 would be where a second team manager would be appointed to look at that. Level 3 would either be myself or a discussion about whether it should be looked at independently outside of the organisation.

Since October 2014 we now have access to an independent review board for complaints that cannot be resolved at any of the other levels.

Q12. The Chairman: Is that a similar arrangement, or is it the same review board that deals with Health Service complaints?

***Ms Brayshaw*:** It is not the same review board; it is a separate arrangement with slightly different terms of reference, but the concept is similar.

Q13. Mr Boot: And where do the individuals come from that sit on that board?

***Ms Brayshaw*:** They are independently appointed. We do not manage that board.

Q14. Mr Boot: You have no involvement?

***Ms Brayshaw*:** No.

Q15. The Speaker: This board has been in place only since October 2014, so before that there was no process of independent assessment of complaints as a final stage?

***Ms Brayshaw*:** Well, there was, because it was always within the discretion of the Chief Officer to look at appointing an independent investigator if they felt that would be –

Q16. The Speaker: An officer from another Department, you mean?

***Ms Brayshaw*:** Not always. We have had investigating officers appointed completely externally as well.

Q17. The Speaker: Are you aware of how many cases this independent appeals tribunal has dealt with?

***Ms Brayshaw*:** In Children's Services, none. There has been a conversation, I think, over two cases recently where there has been a suggestion that it may be helpful, but we have used other mechanisms to try and resolve it prior to that.

Q18. The Speaker: And in your view is that because the complaints have been dealt with satisfactorily at stages 1 and 2 and not had to go to the independent board? Or is it because this board is fairly recent that it has not actually processed to date – ?

***Ms Brayshaw*:** I think, really, it is attempting to try and resolve wherever we possibly can. So on the two where there was a suggestion of would it be helpful to go to the board, what in fact we have done is a senior manager from another division has come in to have a look at it before that to see if it can be resolved.

Q19. The Speaker: How do you make people aware of the complaints process – your customers and members of the public?

***Ms Brayshaw*:** There is a leaflet for members of the public. It is available on the Government website and it is available through distribution by workers. So if anybody says they wish to make a complaint, then a worker or a manager would issue them with a leaflet.

Q20. The Speaker: How recent has that information been made available on the website?

***Ms Brayshaw*:** There has always been a complaints leaflet on the departmental website. Recently it was reviewed and amended because some of the information was not accurate.

The Speaker: Right, okay.

Q21. Mr Boot: I was going to say that one of the things that has come up when we have been taking evidence is that people have not been made aware of the complaints process or an appeal process, that they were aware of, and they felt that there was no independent review of what was happening to them when they did make a complaint.

***Ms Brayshaw*:** I can appreciate that. I think it would be fair to say that the processes and the systems that have been operating were not always as stringent as they could have been, and I think we have worked hard over the last few years to try and address that. So I would expect that there would be some people who still remain confused about that.

The added difficulty that we have, with the staff turnover that we have, is ensuring that all staff members remain up to date in knowing how to give that information to people as well.

Q22. The Speaker: Is part of the procedure when a social worker is dealing with a family …? I know we are going to go into more detail about these things, but the information leaflet about complaints, along with other literature such as the sharing of information, would that routinely be given to the family?

***Dr Couch*:** No.

***Ms Brayshaw*:** No, it would not, but there is an expectation that it is spoken of. We can audit that through our electronic systems, and that is what we are starting to do now – to set that expectation as a standard of staff. We can audit it through it being recorded that that information has routinely been given.

Q23. The Chairman: We will move next to numbers of referrals. This Committee published a report in March 2015 which looked at the problem of over-referral. Is this still a problem?

***Ms Brayshaw*:** My view, as the Director, would be that it is not. That view has been discussed and shared with the Safeguarding Board, and the Safeguarding Board are of the same view. They look at the information on a quarterly basis, and there is analysis of the information that is coming forward as well.

Q24. Mr Boot: How many referrals a year – or for the last 12 months – have you actually had?

***Ms Brayshaw*:** In the last period, 2015-16, going on the financial year, we had a recorded number of 986 referrals.

Q25. Mr Boot: And the year before?

***Ms Brayshaw*:** The year before that was 907, and the year before that was 1,414.

***Dr Couch*:** If I may, Chair, obviously the phrase 'over-referral' is a subjective view. From the perspective of the service, we deal with the referrals that we receive

***Ms Brayshaw*:** Yes, we do not have a choice to turn away a referral. We determine if it meets the threshold to move forward, but anybody is free at any time to contact us with a concern and we cannot turn that concern away. So I think, yes, it is a bit of a misnomer to talk of 'over-referrals'.

Q26. The Speaker: The figures that you are giving, are those initial contacts that distil down to assessments, or is that the initial number of contacts with the Department?

***Ms Brayshaw*:** No, that is the number of confirmed referrals that we actively process. The number of contacts is higher.

Q27. The Speaker: Much higher?

***Ms Brayshaw*:** Yes.

Q28. The Speaker: Could you give us a figure for that?

***Ms Brayshaw*:** Yes. The number of contacts in 2015-16 was 1,638. In 2014-15 it was 1,590. And in 2013-14 it was 2,201.

What I would deduce from that is that if you only have one point of contact and people do not know where else to go to get advice and support, you would anticipate that that would be high. I think what we have done over the past three years is get better at providing other points of contact for members of the public to seek lower-level support and advice.

Q29. The Speaker: So that accounts for the drop from 2,200 to 1,600 over the three years of initial contacts?

***Ms Brayshaw*:** I think it is a reflection of the fact that a number of services for children are working better together and can respond more appropriately at different points of contact for families, yes.

Q30. The Chairman: In my opening remarks I referred to Maggie Mellon and Dr David Foreman. I was wondering if you have had the opportunity to review the evidence, which is online, which we received from them; and do you have any comments about what they said?

***Ms Brayshaw*:** Yes. I think Maggie Mellon's views were informed but they were informed by UK practice – we do benchmark against UK practice; we do not always follow the trends and themes, if you look at what has happened in the Island compared to the UK, but I think she is suitably qualified and in a position to be informed on that. My concern about that would be that she had no prior consultation with the service or the Department itself, so she was making theoretical comment as opposed to informed comment of the situation of the Department.

With regard to Dr Foreman, I would hold him as unqualified and not sufficiently informed to make comment on the referrals of the Department.

Q31. The Chairman: Okay. in relation to Maggie Mellon, have you since met with her as a Department?

***Ms Brayshaw*:** No, we have not.

Q32. The Speaker: One of the themes that she was bringing to our attention, of course, is that the system that has developed – certainly in the UK, and we can talk about the extent to which it happens here – is that dealing with children through the lens of child protection produces, to quote her words:

> adverse consequences in terms of every child is seen as possibly vulnerable. Every incident is seen as possible child abuse or a child protection incident,

And:

> if you have got quite a large number of children in your population and families being assessed and having to prove a negative that they are not harming their children, that has an impact.

That has been the situation here, has it not – that the system for assessing children, from a child protection and a child need and a welfare point of view, is the same filter system?

***Ms Brayshaw*:** No.

Q33. The Speaker: That is not?

***Ms Brayshaw*:** No, it is not. I would explain it … I understand what Maggie was attempting to say. What I would say the experience on the Island has been, having had 30 years' experience in the UK too, would be that the situation on the Island is that the only point of contact was Social Care, whether or not a family required support and advice, *or* if there was a referral of a child protection concern. That meant that thresholds operated within one service, but in fact not every referral was being treated as a child protection referral, because we were distinguishing between a child in need requiring support and a child requiring protection.

What was different, and what we are now attempting to do on the Island – and the Scottish Inspectorate identified – is there was a lack of strategic arrangements for early-help support, where families could seek support outside of a statutory service. And that is what we now seeking to address.

Q34. The Speaker: Is that not what we are actually saying: that the system *had* been that the only point of contact was with Social Services and you had to filter out appropriately the cases that were a welfare issue in order to process, through the various assessments and stages, the child protection issues; so you were actually dealing with a lot of children whose cases ought not to have been referred to you in the first place?

***Ms Brayshaw*:** We were providing support to some of those families, but I would still suggest caution on suggesting it was through the lens of child protection, because the front door would clearly distinguish between what was a child protection referral requiring an investigation or an inquiry as opposed to a referral that required support under 'child in need'. So, although we dealt with both, actually the two lenses were still operating.

Q35. The Speaker: Yes, and it is the case that a high number of referrals does not mean a high number of children needing protection?

***Ms Brayshaw*:** No, that is correct.

Q36. The Speaker: Right. And the number of children on the child protection register, can you just tell us in round terms the individuals and number of families and how consistent this has been in recent years?

***Ms Brayshaw*:** Yes. The number of children that are the subject of a plan … I have not got the breakdown of that into families, although we do provide that. And this is a snapshot, because it can change on a daily basis, but the number of children subject of a child protection plan at the end of this year is 89, the number at the end of 2014-15 was 50, and the number at the end of 2013-14 is 46. So it has increased significantly over that three-year period.

Q37. The Speaker: It has increased?

***Ms Brayshaw*:** Increased, yes.

Q38. The Speaker: Significantly?

***Ms Brayshaw*:** Well, 89 compared to 50 the year before.

Q39. The Speaker: What do you see as the main risks to children in the Isle of Man?

***Ms Brayshaw*:** If we look at the reasons that children are being subject of a child protection plan, some of the key areas that feature very strongly for most children where neglect and abuse is an issue relate to domestic abuse, and alcohol misuse/substance misuse are two key factors. That is followed closely by physical abuse and then sexual abuse, which is actually steadily increasing, which you would expect with the changed media profile around sexual abuse that has been happening over the past two years.

Q40. The Speaker: Yes, so that is the safeguarding category. What about the child in need statutory category?

***Ms Brayshaw*:** That can be very varied in terms of the reasons for child in need support, so it was very difficult to categorise it. Usually it is where there is very low resilience in families, and that can either be related to a development issue for a child, such as a disability that a child has; a vulnerability in a parent, whether that be a mental health problem, alcohol misuse, or learning difficulty for the parent themselves; or it can be related to the environment in which they are living, where they are socially isolated, do not have a lot of support, poverty, homelessness. So there is a variety of reasons that would warrant support.

Q41. The Speaker: And as benchmarked with English local authorities or the north west, which is what I think you do, how do the children in need requirements in the Isle of Man compare with England?

***Ms Brayshaw*:** In terms of services available?

The Speaker: In terms of, yes, need for a statutory service.

***Ms Brayshaw*:** It is probably very similar in terms of the breakdown in proportion of children that are requiring that support. What has happened in the open cases in Children and Families Services over the three-year period, if you look back three years, two thirds of our work would have been children in need, which would have been disproportionate benchmarked against the UK. That has now shifted to about just over a third – probably about 37%-38% of the work is now child in need – and the rest of that relates to looked-after children and children who are subject of child protection processes.

I think what that is reflecting is the ability to provide that support outside of the statutory service. So the number of families still receiving that support on the whole has remained the same, but they are now being managed within the early help strategy arrangements that we have put in place.

Q42. The Speaker: The difference in the figures in recent years shows you are getting better at identifying those cases that need further assessment and investigation and those that can be dealt with by other agencies at an earlier stage.

We noticed in the Children and Families Division Annual Report for 2014-14, which is quite a new document that you are producing, that you refer to the single assessment framework

replacing the current system of initial and core assessments, and this coming in from 2015, late last year. Can you tell us how effective that has been?

***Ms Brayshaw*:** There has been a delay to implementing that because we have had to change all the electronic systems that support it, so that actually is not going to be introduced until 1st May this year.

Q43. The Speaker: So it has not started?

***Ms Brayshaw*:** It has not yet come in, but we are currently benchmarking to set a benchmark so that in 12 months' time we can measure the impact of what it has had.

Q44. The Speaker: And would you expect that new system, which I think has now become standard in England, to reduce significantly further the active caseload that your social workers are having to deal with in the Department by screening out the low-level needs that can be dealt with through other agencies?

***Ms Brayshaw*:** I think it will change the complexion of the caseload. I think what can be seen is that the overall number of open cases to the Department has tended to be round about a similar figure. I think it changes the complexion, because what always happens in circumstances, and is the experience of early help in the UK, is that as you establish early help mechanisms in the community you also, in the short term, identify unmet need with regard to child protection and inquiry requirements as well. So the complexion of cases will change as opposed to the numbers.

Q45. The Speaker: One of the key performance indicators that you have concurred needs significant improvement, of course, is the percentage of children taking part in child in need reviews. It is a very low figure of 9%, as against a 75% target. Is making that sort of improvement one way, would you think, of handling more effectively child in need cases – the ones that are being processed in the Department? Or is that just one of a number of areas that you would like to see improved?

***Ms Brayshaw*:** It is a number of areas, but it is about how you do that, and so the very formal processes that are used within the Department work against the involvement of children in that particular process. The new arrangements that are in place with the new early help arrangements … nothing moves until you have had a meeting with the family, including the child and young person in that as well, so they are involved from the onset. So it is actually changing the expectation of what is required.

The Speaker: Okay, thank you.

The Chairman: Mr Boot.

Q46. Mr Boot: This is more about what happens on the ground. Having taken evidence from a number of people – who were frightened in some cases, damaged in other cases, upset about the way Social Services had dealt with cases, particularly when it comes down to safeguarding – I got the feeling that sometimes Social Services overreact, they do not tell people what they are doing, children are removed, and people are then frightened to seek support because they feel that Social Services are going to intervene in an aggressive way rather than offer support.

We interviewed a lot of people over a period who have been affected by Social Services for quite a period of time. Do you think that that legacy is still following you, in terms of if you get a referral, or someone refers, there seems to be evidence from our side you react … remove

children without proper explanation or exploring the situation, or letting people know what the evidence is that you are acting on?

***Ms Brayshaw*:** Obviously, I would not seek to invalidate anybody's experience of the service that they have had. As you quite rightly say, the nature of the work that we do is fraught with tension. It is fraught with difficulty from the onset of doing that.

Have we escaped the legacy? No, we have not, because I think bringing about cultural change is going to take quite a lot of time, and I would say that we have only had a stable senior management team in the past three years. Prior to that, there was an awful lot of churn within that.

What we have to ensure we put in place is those effective systems and processes that ameliorate against that, and I think historically they have not always been in place. Something as simple as a scheme of delegation which sets out for staff who makes what decision at what point is it something very new in the Department.

So yes, certainly looking at historical information I can see that wrong decisions have been made historically and the sorts of circumstances you are talking about have occurred. I do not believe that such similar situation could occur now, because of the checks and balances that we have in place against that.

The work that social workers do and all of the research with service users of Social Care will show that that level of fear that the community and people involved with those services have is there by virtue of the authority that is held within that role, and they do have the authority to remove children.

Q47. Mr Boot: We have evidence of that, obviously. (***Ms Brayshaw*:** Yes.) I think one of the key features was an overreaction on occasions without explanation. Also, you talk about the churn, and hopefully that is being addressed. But lack of continuity – one social worker, then another coming to the case with no real briefing or proper case notes – that is being addressed, or has been addressed?

***Ms Brayshaw*:** Yes. There has been a lack of continuity. Lisa would have finer figures than I have got to hand, but just under 50% of our qualified workers are agency workers. What we have put in place … We have a difficulty in that we cannot do the work required of us if somebody is not in the role to do it, but what we have done is extend the arrangement around the contracting for agency workers so they stay with us for longer. They have to commit to a minimum of six months. Some stay far longer than that. In fact, we have got agency workers who take on permanent posts and an agency worker … some of whom have been with us one, two, three years at most at the moment. So we are trying to manage the continuity whilst recognising we have a big issue over the recruitment and retention of permanent posts as well.

I would qualify the 'overreaction'. I think there is a fear amongst people that when we begin an inquiry we have made a decision, and we have not. We pursue an inquiry in order to determine what action we must take.

Q48. Mr Boot: If a child has already been removed?

***Ms Brayshaw*:** I am not aware of any circumstances in my time as Director where a child has been removed unnecessarily, and those decisions are only made by myself or my immediate deputy, and that has been the position for the past 18 months for those decisions to be made. So I would take responsibility for that.

Obviously, if a parent is not in agreement with the child being removed, the only recourse that we have is to either involve the Police to use police protection – and it would have to be very serious for the Police to exercise their powers of police protection in an emergency – or we must go to court, and it would be the court's decision whether a threshold was made to remove

the child. But we cannot remove the child without either a court order or police protection powers in an emergency situation.

Q49. Mr Boot: You *can*?

***Ms Brayshaw*:** *Cannot*, no. So, whilst we have the authority to take a child into care, it either has to be with the agreement of the parent, under police protection or with a decision made by the court. We cannot act unilaterally to remove a child.

Q50. Mr Boot: Well, we have evidence that this seems to have happened.

***Ms Brayshaw*:** But we have not.

Q51. Mr Boot: Well, maybe there is slight blurring of the edges, but one of the things that did come out when we were talking to people about children being removed was that they felt coerced into co-operating with any requirement of a particular social worker – in other words, maybe taking the child into care – because they felt that there would be repercussions, if they did not do that, in terms of the Police or whatever. Some of the evidence we have had was fairly harrowing in that respect.

***Ms Brayshaw*:** Currently, we are reviewing the way in which we are use agreements for children to come into care, and hopefully in the future that coercion would not be felt by parents.

That does not mean to say that there may have been occasions … And I am not disputing the experience that people have had. If people can seek agreement with us for that to happen, in those circumstances where agreement was not sought then we have to be confident that it would be appropriate to go to court or include the Police in the arrangements that we are making.

So, in some respects we are talking about people who feel in a Catch-22 situation, but they should not feel coerced; they should still be properly advised of their rights in those circumstances, yes.

Q52. The Speaker: So where the approach by a social worker is, 'Well, I'm going to ask you to co-operate; but if you don't, you do realise we have the power to take your children away from you' … If that sort of approach is used, what does that show – a deficiency in training of the social worker concerned that they should actually use threats of that sort?

***Ms Brayshaw*:** The expectation of a social worker is that if they feel there are grounds for a child to be removed they should have a discussion with their manager, and that decision is made by me or, as I said, my senior manager, who deputises on my behalf. That would be an in-principle decision in respect of whether the threshold for removal is met.

The expectation on the social worker is to advise the parent, 'This is what we think we need to do and the options available to you are either to co-operate or' – and I think it is appropriate to advise a parent that they may face court action as a possibility – 'it may be serious enough that we have to have conversations with the Police.'

They should be set down as options for the family so that they are fully aware of the consequences of whatever option they take. They may be perceived as threatening – and I cannot say that some workers may not have acted in a threatening way, but it is not an expectation and if I received a complaint that a social worker had been threatening then that would be fully investigated.

Q53. The Speaker: Is there not a difficulty, though, that if the evidence that led to the social worker's visit – bruising, for example, on a child – turned out to be entirely groundless following discussion with the parent, it is quite wrong for it to be set out from the word go that 'you realise we have the power to take children away if you don't co-operate' – if it turns out to be an unsubstantiated case? Is it any wonder that families become very nervous when social workers appear, and refuse to engage or co-operate further because they know of the threat that the child can be taken away?

***Dr Couch*:** But this is the enormous challenge, Mr Rodan. Obviously, our obligation is the safeguarding of the children first and foremost. Some form of reference to service has come in, and as Ms Brayshaw is saying, that has to be assessed. There may then be a view that that child needs to be protected urgently. We are then obliged to try to explain to the family what is going on.

It almost comes back to your question to us earlier about whether we should give information at the beginning of our complaints. We have to try to explain to people the situation. As Debbie was saying to Mr Boot, inevitably from the outset this is a very emotionally charged situation. I do not think any of our officers would be wanting to coerce or intimidate; however, we do need to give certain information, which is that there is an issue relating to a child or children, an initial assessment has been made, we need to safeguard, this is the array of scenarios.

Q54. The Speaker: Yes. I do not think that we would dispute that that is the correct approach, but evidence we have had is that that is not necessarily the approach that has always been taken.

***Ms Brayshaw*:** Well, as we said, I can only set out the process and the expectation of what should happen. Then I would anticipate or expect that a parent could complain about the way that they had been treated.

In the circumstances that you have heard, I would not know whether they have or have not complained. All I can reassure at this point is if they made a complaint of that nature it would be fully investigated.

The Speaker: That is fine, and if it happens – and clearly it should not happen – there is an issue there for the training of that individual social worker.

Q55. Mr Boot: Can I just take a step back to what you said originally when I asked the question about a child being removed, because we have had several cases … I know you cannot talk about individual cases here, and I do not want to either, but where social workers have gone in because of a complaint and the child has been removed, you were saying that there is a process involved and that unless there is a court order or something the child should not have been removed without their consent.

***Ms Brayshaw*:** The only way that a child could have been removed on the first visit of a social worker would have been under police powers, so if the social worker had attended with a police officer there would have been a decision made in a meeting between the two agencies that the information was of such severity that we may need to take urgent action, and the only circumstances in which they can be removed on that very first visit is under police powers.

Q56. Mr Boot: Well, I think in the past that has been very blurred, and whether it is because they were frightened of further action from Social Services by not agreeing … but certainly there have been cases that we have heard … and we cannot verify the truth or untruthfulness of the

evidence that we have received, but nevertheless that has happened in the past, according to the evidence that we have received.

***Ms Brayshaw*:** And my responsibility as Director is to ensure that the most effective processes and systems are in place from this point forward to ensure that that does not happen, and I think we have been working really hard over the past three years to set in place and fill those procedural and systems gaps where due process needs to be followed.

***Dr Couch*:** If I may, Committee, again this is a challenge for us. Not in any way being disrespectful to the Committee or to your witnesses, but we cannot easily respond to hearsay, which is effectively what we have, and it is almost a case that you might put hypothetical positions to us based on information that you have and we can respond to those hypothetical situations. But as you say, the great difficulty is, not being able to open up the confidentiality, it is hard for us to respond other than generically, which I think is what Ms Brayshaw is doing.

Mr Boot: Well, I am trying to be generic with my comments and questions.

The Chairman: One of the *generic* questions *(Laughter)* that I have asked is –

***Ms Brayshaw*:** If it is helpful, in terms of the number of looked-after children, that has reduced significantly, and that started to change three years ago. We changed one particular procedure. We introduced a procedure that enabled us to manage that. I think prior to that there were more children in care than needed to be in care, and I think however those decisions were made there may have been situations that were precipitous, resulting in that. I cannot talk historically on how far back, as the Chief Executive has said, with knowledge of those cases, but there is a clear process to be followed now.

Q57. The Chairman: What I was going to say was that one of the generic questions I have asked when people have come to us and spoken to us is, 'Has your experience improved latterly; is this a historic thing?' because I have heard this being said before and there have been instances where people have indicated that this is a more current … they have more current concerns, that it is not just a historic thing. So our interviewees would suggest that there is still room for improvement, I think.

***Ms Brayshaw*:** And I think, with all due respect, with the nature of the work that we do, none of our customers are voluntary customers. We are giving very difficult challenges to families. Our first priority is the child, and sometimes the needs of the child do not connect with the needs of the parents. We will always leave some customers dissatisfied by the action that we have taken – that may not mean it is the wrong action – in order to protect the child.

Q58. The Chairman: Yes, I accept that.

Could I ask, in terms of agency … You referred to agency workers. Do you use more than one agency? Are there several agencies which supply workers for the Island?

***Ms Brayshaw*:** We do, but Lisa …

***Ms Hall*:** We have three agencies which are currently supplying, but we have more that we could call on.

The Chairman: Okay.

Q59. Mr Boot: When you employ staff through an agency, what is the mark-up over a normal salary that you would pay a directly employed social worker?

***Ms Hall*:** For my financial calculations I have a rule of thumb that it will cost you twice as much.

Q60. Mr Boot: Twice as much?

***Ms Hall*:** Per annum

Q61. Mr Boot: When we are looking at recruitment, we have heard there are no career pathways for aspiring social workers who want to get qualified, because I gather degree level is a social worker qualification nowadays.

***Ms Hall*:** It is.

Q62. Mr Boot: So I am just asking a question: if it is double to bring in agency staff who do not have knowledge of Manx law and procedures, would it not be beholden upon the Department to bring in some sort of scheme that would help sponsor or help –?

***Ms Hall*:** We have such. We are sponsoring two students on the degree course with Robert Gordon University as we speak, and they are in a long line of students whom we have sponsored through to qualifying.

Q63. Mr Boot: So at the moment you have got your qualified social worker here, and then below that you have got your unqualified staff?

***Ms Hall*:** And two of our unqualified staff are on the programme to qualify.

Q64. Mr Boot: So there is already something in place to do that?

***Ms Hall*:** Yes.

***Ms Brayshaw*:** And there has been for a number of years.

Q65. Mr Boot: But it does not seem to have had much of an impact.

***Ms Brayshaw*:** Well, it is a bigger picture than just recruitment, to be perfectly fair.

I think, just to qualify Lisa's point that it will cost the Department twice as much for an agency worker, that does not mean the agency worker gets twice as much in their pocket. Much of that is obviously the –

Q66. Mr Boot: No, I was not inferring that. I was just trying to find out what the actual cost to the Department was of an agency worker.

***Ms Brayshaw*:** Yes. Mapping our needs for qualified workers in the future, we are fishing in a small pool on the Island. Social work in other areas on the Island can be far more attractive at certain points of people's lives and careers than working in Children and Families Services.

To make the point that Lisa was saying, in the past … I do not know how long it was, Lisa, but certainly when we started looking at this, six workers in the past few years who have been seconded to become qualified have become qualified but actually been employed elsewhere in

other services across Government, and although we have met the cost of them being funded and qualified we have not benefited when they have come back to the Department.

We are also recruiting in an area where, obviously, vacancies are significant across the UK in all jurisdictions as well.

***Dr Couch*:** This is a challenge facing the whole Department, as I am sure the Committee is aware. So if we look on all professionals that the Department might seek to employ, filling vacancies is an enormous challenge: social workers, nurses, midwives, doctors, allied health professionals.

Q67. Mr Boot: Are we constrained by the UK rates of pay?

***Dr Couch*:** No, not at all. We are close to or higher than.

Q68. Mr Boot: I am just floating this. If it is costing twice, what we are paying to employ agency staff, and 50% or more of our staff are agency staff, would it not be beholden upon the Department to perhaps look at the salary level and make it more attractive?

***Dr Couch*:** I think the challenge there is that Tynwald gives us an annual vote to spend and a very large proportion of that is salaries, so if we adjust salary scales the services we deliver cost a lot more.

***Ms Brayshaw*:** Yes, and actually, with all the research that has been done, certainly for children's social work salary is not the motivator, so we have to look at the other benefits in the package for them as well.

***Dr Couch*:** Agency physicians, for example, can cost three times an establishment salary. Very short-term locums for extremely specialised work are so expensive that you would not believe it.

Q69. The Speaker: So how does the number of locum social workers, temporary social workers, compare now with what it has been in recent years?

***Ms Brayshaw*:** It has been in flux.

***Ms Hall*:** At the moment, it has been similar levels for the last two or three years because as fast as we fill our vacancies people leave for one reason or another. We have had, in the last three years –

Q70. The Speaker: Is there difficulty about retaining staff in the Isle of Man?

***Ms Hall*:** There is. Some people come here thinking this is going to be a new beginning, a new life. It is not for everybody, despite the fact that obviously we think it is the best place in the world to live. People have family circumstances which take them back to where they are from, which they had not anticipated when they came. We have had a number of workers retire. And then, as mentioned, we have had a number of workers move to a different area of social work within the Department because that has fitted better with their personal circumstances, work-life balance, whatever you want to call it, at that particular moment.

Q71. The Speaker: Is your system of training or induction of external social workers up to scratch in terms of differences between English and Manx law and procedures? Are you satisfied that you are meeting the challenge with this turnover that you are having to cope with?

***Ms Hall*:** I think we could improve, and we have recently prepared a new induction programme which we are rolling out at the moment for all new workers, whether they are agency workers starting or new employees that begin with us, which does include that legal difference and being explicit about what those differences might be, so that they are under no misapprehension that they can just pick up their English legislation and apply it locally.

Q72. The Speaker: What are the key differences, would you say, between Manx and English practice in terms of the guidance that is to be followed and the law that is to be applied?

***Ms Brayshaw*:** From the best practice perspective there is very little between ourselves and the English law. It is subtleties in terms of the differences in that. Obviously, the legislation is based on the UK 1989 Act; it is very similar. What we have not got is subsequent amendments that have been made, such as the 2004 Act in the UK. So it is reminding people that some of those additional requirements are best practice here, as opposed to legislatively required.

There is a bigger challenge with social workers who come from Scotland, for example, because their legal process around children is very different in Scotland, so there is far more for them to learn in terms of particularly the court process if there are court proceedings.

But all of our procedures are available to everybody on their desktops and, as Lisa said, we are improving the induction process for the number of workers we have got.

Q73. The Speaker: Therefore, when a social worker cites a piece of legislation that does not apply on the Isle of Man at all to a parent – it is something, obviously, to be avoided – it does not instil confidence between the two parties, does it?

***Ms Brayshaw*:** No. And yes, we have had examples where that has happened in the same way that our sections of the Act are different from the UK sections. So a social worker from England will talk about section 47 as their duty to make inquiries – on the Island it is section 46. So whilst what you do is the same, actually to cite the wrong legislation is inappropriate, yes.

Q74. The Chairman: Okay, we were making good progress but there is a passion for the subject amongst my colleagues, so we will try and make some more progress and talk about safeguarding procedures. We need to talk about the interagency guidance which applies not just to social workers but to everyone working with children. Who is responsible for producing and maintaining this guidance?

***Ms Brayshaw*:** It is the Safeguarding Children Board.

Q75. The Chairman: Who is on the Safeguarding Children Board and how are they appointed?

***Ms Brayshaw*:** There is an independent chair who is externally appointed – that is Mr Paul Burnett at the moment – and the board is made up of each of the chief officers from each of the Departments that are represented. I attend as a safeguarding adviser to the board and there is a safeguarding board co-ordinator who attends also.

Q76. The Chairman: Thank you.

In our March 2015 report we referred to them as the Protecting Children Board. Have they changed their name back to Safeguarding Children Board; and, if so, why?

***Ms Brayshaw*:** They have, and that was in order that they could embrace the concept of safeguarding in its broadest sense.

Q77. The Speaker: Is 'safeguarding' a statutory term in Manx law?

***Ms Brayshaw*:** No, it is not.

Q78. The Speaker: But child protection is?

***Ms Brayshaw*:** Child protection is, but I think, with all due respect, since the commission of inquiry in 2006 there has been an outstanding recommendation to put the safeguarding on to a statutory footing, and that remains outstanding. And I think, from your own report, you supported the requirement for that to happen. So, from a best practice point of view, it is to encompass the work of safeguarding.

Q79. The Chairman: I think you have answered this, but is the interagency guidance based on UK models?

***Ms Brayshaw*:** It is, but again it is amended to reflect Manx law.

Q80. The Chairman: And what, if anything, is the role of the company known as tri.x in producing this guidance?

***Ms Brayshaw*:** Triex is the company that we commission, which actually manages the web-based procedures, so they take responsibility for putting the procedures on there in the first instance, undertaking any changes that we request, and I think it is at twice-yearly intervals they update those procedures with any amendments that are needed.

That said, it is the responsibility of the board to ensure that the right information is given to that company to update the amendments. They are not responsible for anything that is on there. They maintain it and put on what is requested of them.

Q81. The Speaker: So it is not just simply an English local authority model that is …? *[Inaudible]*

***Ms Brayshaw*:** No.

Q82. The Chairman: When is the Safeguarding Children Board going to be placed on a statutory footing?

***Ms Brayshaw*:** I think the position at the moment is that that will be put into the legislative programme for the next administration, and I think, hopefully, given the right priority date that is required. That is beyond my influence, unfortunately.

Q83. The Speaker: Yes, it has been on the go for some time, and as Departments have moved around the responsibility seems to have moved.

Would you agree, though, that it is important that it is on a statutory footing because the end process of this whole thing could be a child being put up for adoption at the far end of the process, and there has got to be a system that is robust and that can withstand legal challenge?

***Ms Brayshaw*:** Yes is the first answer. I think, in terms of decision making for individual children who are in care, the status of the Safeguarding Board is not going to impact on that. The status of the Safeguarding Board impacts on the ability, for example, to review situations where there are concerns about actions that may have been taken by different Departments or different services. But for arrangements around a child who, for example, may end up being adopted, those arrangements fit squarely with our service.

Q84. The Chairman: Just back to social workers for a moment. When a case is passed from one social worker to another – as we have indicated, we have had people saying they have had numerous social workers – how is the information passed on? We have heard cases where the new social worker did not appear to have been briefed by the previous social worker, leading to errors.

***Ms Brayshaw*:** Yes, there is an expectation that every manager will sit down and fully brief and supervise a new social worker on that case being passed to them, and I would accept that that has been a challenge for us to achieve that.

Q85. The Chairman: Do you have any problems with discipline and morale? Again, we have heard from people who have said social workers admitted to being unhappy with what they were being told to do by their managers.

***Ms Brayshaw*:** It is something that we monitor at regular intervals. I am just trying to recall … There was recently the full staff survey, I think, that happened across Government. I think Social Care was a little bit of an outlier where their confidence in their managers was higher than any other areas, and certainly that has been also reflected in a staff survey that was undertaken for the recent Scottish Inspectorate, so I would hope that is something that has changed.

Q86. The Chairman: What is the rate of sickness absence within your organisation?

***Ms Brayshaw*:** Off the top of my head I could not tell you that.

Q87. The Chairman: Do you think it is any worse than might normally be seen in such organisations, or you do not?

***Ms Brayshaw*:** I think it is probably towards the high end. When we do have members of staff off sick for prolonged periods of time, if it is not for a serious medical condition then it is usually stress related.

Q88. The Chairman: I think we can understand that.

We will go on to looked-after children reviews and child protection … *[Inaudible]* Could you please tell us what a looked-after children review is and in what circumstances it would be undertaken.

***Ms Brayshaw*:** Yes. For every child that comes into care we should have a care plan for them, which is decision making around what the arrangements for that child in the future are going to be. So the option for a child may be to return home, it may be that they need to stay in foster care, or it may be that a permanence plan through adoption … or now we have the option of special guardianship as well available to us.

The role of the looked-after child review is it is an independent review that checks that everything in relation to that care plan is happening for that child. The chair of the review is an independent reviewing officer. They work within the Department but they are independent of any operational decisions in relation to that child, and their role really is as a quality assurer of the processes being undertaken.

Q89. The Chairman: How do you go about ensuring that any meetings are held at a time when it is practical for parents or carers to attend?

***Ms Brayshaw*:** I think the principle here for children that are looked after is that it is the child's meeting and we try, wherever possible, to make the meeting as convenient to ensure

that the child or young person can attend. Obviously, we are constrained by the working day, but we do hold many reviews towards the end of the day, after school time.

Q90. The Speaker: So there should not be any excuse, really, for an LAC, when parents have indicated they are going to come, to start without them?

***Ms Brayshaw*:** No, that should not happen if the parents are attending.

Q91. Mr Boot: It appears to have happened in the past.

***Ms Brayshaw*:** All right, then yes, and any complaint I received of that currently would be addressed because that would not be acceptable.

Q92. The Chairman: What is a child protection conference, who chairs it and how are they paid?

***Ms Brayshaw*:** A child protection conference is a similar process. Well, no, it isn't – I tell a lie, actually. A child protection conference is, after a child protection inquiry, a meeting that is convened. It is a multi-agency meeting where a decision is made whether there is sufficient evidence to warrant placing a child on a child protection plan, and that means they need a multi-agency plan to keep them safe at home. Most children subject to a child protection plan remain at home.

So, in principle, it is an independent person who chairs it. In our service it is the IRO, so those who chair looked-after children's reviews also chair child protection conferences. Again, the key principle is that they are independent of any operational decisions that may have been made, and the same principle would apply. There is an expectation that the chair of the meeting will meet with the parents prior to the meeting starting and establish their understanding of it.

Q93. The Chairman: Okay, thank you.

We now move on to fostering and adoption, which is, I think it is fair to say, one of the areas where we were contacted perhaps by as many as any other of the areas that we have discussed.

How would you describe the relationship between the Department and foster carers? Are you helping them, or are they helping you?

***Ms Brayshaw*:** Foster carers provide a service to us, in that they provide, obviously, homes for children who are requiring substitute care out of their families.

Q94. Mr Boot: I think, from some of the evidence we took, that there is this barrier between you and the foster carers on occasions – that they feel that Social Services are working against them, or they are frightened of Social Services. That came through on several occasions. I do not know whether it is still in existence, but certainly we took a lot of evidence on that basis and they felt that Social Services was this … They were frightened of Social Services. I really found that quite amazing.

***Ms Brayshaw*:** I think the landscape has changed. The first thing to say is we commission fostering through a care provider, and so the commission provider is responsible, obviously, for recruiting, training and maintaining the approval of foster carers.

What has certainly happened in the last three years is we have had the Regulation of Care Act, which now establishes clear standards in relation to fostering that must be complied with. It is a requirement in the legislation to comply with those standards. What has happened as a result of that in the relationship between the Department and the contracted provider is we have had to work really hard to challenge and improve the standard of care that is being

provided so that it meets those standards set down. That is a relatively new requirement. The fostering service is now a registered service with registration and inspections. They have not yet been inspected against those standards.

I think most recently, certainly over the past two years, we have had concerns with regard to the fostering service, and it would be fair to say that it has been difficult to get to the bottom of understanding some of those concerns within the service. What has been helpful most recently, in the past 12 months, is there has been a change of management within the fostering service itself – a change of CEO and a change of managers. We have used all the powers available to us under our contract arrangements with them to bring about change to the difficulties that were there, and I think with the new management that is in place and the additional support that they have got they have had a really strong improvement plan, and that is starting to bring about change now.

Q95. Mr Boot: Can you give an example of the concerns that you have had?

***Ms Brayshaw*:** Well, concerns that related to safeguarding matters, both in relation to foster carers and within the service itself. I think it would be fair to say that there was a period of time where we felt information was not being shared with the Department, and therefore there was probably a barrier between ourselves and understanding what the experience of the carers within that service was as well. But we are satisfied that those areas are now being addressed.

Key things for us were the numbers of carers there. We have a number of children for whom long-term placements were not being actively sought and therefore they were not in the right placement that they should be in. Not all appropriate safeguarding checks had been undertaken in respect of some carers, and that needed to be addressed as a matter of urgency. And there were those occasions where concerns about the care given … We were not satisfied with how they had been challenged and investigated within the service either.

Q96. The Chairman: How many foster carers are there, and do you think the Island needs more?

***Ms Brayshaw*:** Yes is the short answer. I may stand corrected on this, but the numbers that we did for the end of year … We had 58 placements available. That represented 64% of placements available for all children that are looked after. The rest are in children's homes or in kinship arrangements through special guardianship or residence or other arrangements.

Q97. Mr Boot: From what we have taken in evidence there seems to be a lack of morale among foster parents, and if I can go back to this … They think that Social Services are working against them rather than with them. People have said outright, who are foster carers at the moment, they would not in any way come into it again if they knew what they knew now and they would not recommend anyone to do it in the future. That is a bad position to be in, I think.

***Ms Brayshaw*:** It is, and I think the relationships that have existed – and I do have to stress that is under previous management of the fostering service – did not foster good communication and good dialogue to be had, and therefore I think that perception of fear may have been evident where it was not necessary, and vice versa. I think all of the arrangements that are currently being put in place and new processes and systems that fostering are establishing will start to address that. Again, that change will take time to embed, but there is far greater communication, there is more connection in the availability for members of the Department to go to meetings with carers and vice versa to be involved in things. So I think that culture is slowly changing, but again I would not invalidate the experiences those carers have had.

Q98. The Chairman: You indicated earlier that social workers are not primarily motivated by the financial reward. Are foster carers paid for their services, and how much? And do you think that they fall into the same category that you have just described for social workers?

***Ms Brayshaw*:** Yes is the short answer to that, but we have recently undertaken a whole review of the fostering payments arrangements and the working group that addressed that, half of that group was made up of foster carers themselves so that their experience informed, and the final position that we reached was after consultation fully with foster carers as to the options available to them … which they indicated which their preference was.

That came about primarily from a complaint from a foster carer in relation to payments, and what became clear was that out of the existing payment scheme that was in place it was not being properly applied and there were a number of outliers to that. So there were carers within that process who probably were not getting paid the right amount that they were entitled to, and there were a number of carers who were being paid exceedingly high amounts of money that fell completely outside of that policy as well.

Hopefully now, from 1st April when it was introduced, that will address that so that everybody is treated equally and fairly with regard to payment.

Q99. Mr Boot: Is there a standard payment per child?

***Ms Brayshaw*:** Yes.

***Ms Hall*:** It is in age bands, so the child's allowance is based on the age of the child and then there is a standard payment for the carers, which is called the skills payment, on top of that. The new scheme has considerably increased both of those elements, so although the motivation, no, is not money – and that was clear from the discussions that we had with those carers when we met to look at the payment scheme – clearly money is necessary, and therefore it is hopefully a scheme that now they feel is appropriate.

Q100. Mr Boot: Can you give us the median level per child?

***Ms Hall*:** You mean for the allowance?

Mr Boot: Yes, please.

***Ms Hall*:** Median, we are talking £200 per week per child. That is for the child's allowance. That is without the money that goes to the carer's skill.

***Ms Brayshaw*:** So the carers, in addition to an allowance in relation to the age of the child, will get a skills fee that recognises their own level of training and experience and success in what they do.

Q101. Mr Boot: And in what range would that fall?

***Ms Hall*:** That is one flat fee of £150 per child per week.

Q102. The Chairman: Are foster carers told what to expect? Is there a handbook for them when they start off?

***Ms Brayshaw*:** There is a process of induction for foster carers, and that starts from the time that they make their enquiry to the service, and they also attend preparation groups. So there is an enormous amount of information. They have an allocated supervising social worker who also

goes through that induction process with them. So I would suggest that they do have access to relevant information and are appropriately supported into the role that they have.

Q103. The Chairman: Are records kept up to date? Do you get a lot of subject access requests? And do people have any surprises when they make such requests?

***Ms Brayshaw*:** I could not tell you the actual numbers. We have a steady trickle of subject access requests within the service. There is a very clear policy and procedure that we need to follow in response to that. And yes would be the answer, I do think that obviously some individuals … and they are free to challenge what is in that.

Q104. The Chairman: Have you received any complaints about potential falsifying of any records within the organisation?

***Ms Brayshaw*:** No, we have not.

Q105. Mr Boot: Well, we have heard evidence that maybe the record that you kept is different to the record that they assumed had been kept.

You said that there is a complaints procedure: if the data, when it is released, seems to contradict or be different from what they anticipated, what action can they take to have the record either changed or at least appealed against?

***Ms Brayshaw*:** They can make a complaint with regard to the accuracy of the information. What we experience when we have been in those circumstances is that quite often it is not necessarily a question of accuracy, it is a question of perception. And so the way that we have resolved those circumstances is to make it clear to the individuals that their perception and their view of those circumstances will sit alongside the professional view and information that is currently on the file as well. Where it is a clear inaccuracy we can change that, but obviously professional judgement will not always fit with an individual's …

Q106. Mr Boot: Who do they complain to?

***Ms Brayshaw*:** They complain to the Department.

Q107. Mr Boot: Right, so a judge and jury situation, then?

***Ms Brayshaw*:** No, the subject access request is dealt with separately. We have a dedicated individual who prepares those files and they are overseen by the information governance manager for the whole of the Department, so there is an independent oversee of that.

***Dr Couch*:** That is a right of the system. Anybody can ask for those.

Q108. Mr Boot: I realise that, but what I was trying to get to is if they find that the record does not accord to their recollection or their own notes, who do they actually …? Complaining to the same individuals who wrote the report, or in the same area, is not very independent, is it?

***Ms Brayshaw*:** No, but it would be managed by the information governance manager for the whole of the Department.

***Dr Couch*:** And this is where, to an extent – and obviously we are perfectly aware this is an issue of the moment with a motion before Tynwald Court next week – use of language becomes very difficult, doesn't it? 'Falsification' of records, 'altering' of records, 'not making' records –

when sometimes it can be that a person sees a record of a meeting and says, 'I disagree with what is being said there.' I suppose we ought to strive to allow, if they disagree completely, that their view is recorded with the minute.

There could be another challenge, which is, 'I am sure that *x* was said and has not been recorded,' so one could include an addendum.

And then I suppose the third category may be, 'I think that is a blatant untruth,' and we would have to run through our processes then to assess the validity of that.

A record, once made, is very difficult to delete. I think we would need to acknowledge that we had received a complaint, accepted the complaint, and then I suppose we would have to almost not so much redact but we would have to say that piece of the record must not be referred to again because it is inaccurate.

Q109. The Chairman: I may have picked this up wrong, and if I have I apologise, but I think when you were talking about perceptions in this matter you indicated that there might be quite a number. Are you saying there are quite a number of occasions when this situation has arisen?

***Ms Brayshaw*:** No, not in terms of being managed through a formal process. I suppose I would not be surprised that there can be difference of perception, given the nature of the work that we are doing.

Clearly, workers have to be accountable and responsible for what they record, and recording standards are important. Since we have had electronic records, which was end of 2009 when they were introduced, we have a clear process by which electronically we can track who has gone into the record, who has inputted on to the record, who has made any changes to the record and when; and every record that is inputted now is finalised, and therefore any change has to be an authorisation.

Since 2013, the electronic system we use is provided by a company called Liquid Logic. Its local name is Protocol and we have had a Protocol development manager in place since 2013. He runs regular random audits on information to check that everybody is complying with the standards that are required of them.

***Dr Couch*:** I think it is also worth, if you will forgive me, just mentioning that it may be the case that somebody has complained to the Department, a perfectly appropriate process has been run, may even include an independent view, and the complainant does not agree with the outcome and they continue to complain through other routes. That does not necessarily mean that the complaint was valid.

Q110. The Chairman: Are foster carers able to complain about the behaviour of social workers? Some of the people we heard from had made complaints; others seemed unaware that they were able to do so, or thought that making a complaint would be to their detriment in some way.

***Ms Brayshaw*:** Yes, they are is the short answer to that, and whether they complained through the fostering service or direct to the Department, that would be addressed as any other complaint.

Q111. The Speaker: Is this complaints process part of the information that is given initially to foster carers in information packs of any sort – if you are dissatisfied with this, that and the other, how you can complain or how they can deal with any concerns?

***Ms Brayshaw*:** Yes, they would be advised of that. Obviously, the role of a foster carer … there may be a number of areas, different natures of concern that they need to bring to somebody's attention, so they would be advised of the different processes available to them.

Q112. The Speaker: If they wanted specifically to make a complaint, would that process be in writing, in black and white format?

***Ms Brayshaw*:** It can be in any form, so I think the position at the moment, recognising the different ways that people communicate … whether it was via a telephone conversation confirming it was a complaint, an email, or in fact in writing.

Q113. The Speaker: No excuse for not knowing how to complain?

***Ms Brayshaw*:** No.

***Ms Hall*:** All foster carers are allocated a supervising social worker who makes regular visits to them. So, if they were unsure but felt uneasy or dissatisfied about something that had occurred that was still sitting with them, then that could be another route for them to say, 'Really, reflecting back, I am not happy about what happened a few weeks ago and I feel like I want to take it further – perhaps you could help me to do that.' That would be a legitimate role of that worker to assist them in making a complaint or just asking for clarification, or to do that on their behalf if they did not feel able to do so.

Q114. Mr Boot: I take it there would be an element there, though, of the present worker feeling some loyalty to their colleague?

***Ms Brayshaw*:** Not necessarily. It is a separate service – it is the commissioned service – and I think working with … What we try to instil in all workers across all the services is that they have got a responsibility, whether that is in respect of a colleague or otherwise.

***Dr Couch*:** And, to a degree, that is a further challenge in terms of assisting the Committee today, because we have a commissioned fostering service which is not the Department of Health and Social Care. We cannot be quite sure sometimes, with the questions you are putting to us, whether they are challenges about the Department's work or the work of that commissioned party.

Q115. The Chairman: Okay. What happens if you receive a complaint about a foster carer from another member of the community? We heard from people who felt their fostering and adoption prospects had been damaged because of delays in the handling of concerns raised with the Department by others.

***Ms Brayshaw*:** Well, that would depend on the nature of the complaint. If we received an allegation against a carer, then obviously, from our perspective, that would need to be looked at and investigated to determine whether any action needed to be taken to safeguard any child in placement with some … and there is a procedure and a process around how that would be managed. That would then connect with the fostering service, because any outcome of an inquiry or investigation of that nature would clearly impact on a decision as to whether it was appropriate for them to continue as a foster carer.

Q116. The Chairman: Given the kind of trauma around that kind of situation, are those kind of issues handled in a timely way so that any children affected can get back to some normality?

***Ms Brayshaw*:** Yes. They should be managed as any other child protection inquiry or allegation is undertaken. I think it would be fair to say that what we are aware of at the moment that needs to be addressed – and this is for all professionals, because it would be the same process that would apply if an allegation was made against any professional, not just a foster

carer – is that the knowledge of what that process involves and the consequences of that process are not well known amongst professionals generally, and that is something we need to address.

Q117. The Chairman: How do you make sure a person who has been complained about knows they have been complained about?

***Ms Brayshaw*:** There is an expectation that they should be informed, and again we have to be clear where has that complaint come in from, where is there an understanding of who should be managing it, and expectations of the Department on the service or the service on the Department. So we would need to be clear of the arrangements around that.

Q118. The Chairman: Just back to something I said a few minutes ago: how long approximately does it take for an allegation about a carer to be investigated?

***Ms Brayshaw*:** I think it would be very difficult to give a ball park figure on that. Obviously, if an inquiry is undertaken and found to be substantiated then you may be looking at a process that also includes a police process within that, which can take a period of time. So, really, when all the evidence is gathered, I would anticipate that a first position with regard to the information when it is first presented … If it is a serious allegation, the referral should be made straight away and there would be a response within 24 hours. I would expect to be in a position to make a judgement on that within 25 days.

The Chairman: Thank you.

Q119. Mr Boot: I think it alludes to the next question we have got, really. We have come across a couple of cases where a subsequent police report has resulted in no action – in other words, the allegations were false or not substantiated. Do you then expunge your records and remove that from the person's records?

***Ms Brayshaw*:** No.

Mr Boot: You don't?

***Ms Brayshaw*:** No, we don't.

Q120. Mr Boot: So that sits on the record, even though there may have been no action taken?

***Ms Brayshaw*:** We have a procedure around retention of records, and obviously those sorts of records are really important, so that would remain on the file.

I would also have to make a distinction that the outcome of a police investigation is not the outcome of an inquiry. A section 46 inquiry is about whether somebody is a risk to children, and evidence of prosecution is not the only evidence to be taken into account. So there may be, on the balance of probabilities, a professional judgement made that an individual is a risk to a child.

The areas of outcome in relation to allegations against professionals … There are four potential outcomes and it is really important in terms of the difference: you can have an allegation that is substantiated, which clearly speaks for itself; an allegation that is unsubstantiated is where it is neither proven or disproven, therefore it remains a very grey area, so you have to make a judgement on level of risk; you then have an outcome that is unfounded, where the evidence does not support the allegation made; and the fourth outcome is that it was

malicious. So we can actually distinguish the positions of professional judgement on allegations made against professionals.

Q121. Mr Boot: Are people made aware of this?

***Ms Brayshaw*:** Yes.

Q122. Mr Boot: The people we have seen … *[Inaudible]* to a police inquiry and nothing has happened, and then they have felt that Social Services had continued to pursue – which is probably what you are alluding to there (***Ms Brayshaw*:** Yes.) – for other reasons. I can accept that, but sometimes I do not think the individuals have been made very aware of why things are continuing.

***Ms Brayshaw*:** No, I would agree, and that links to my previous comment that it is not very well understood across *all* professionals. Yes.

Q123. The Chairman: How is the transition from fostering to adoption meant to work? We heard from some people who felt that the Department was not sensitive to the added significance of a pre-adoption placement.

***Ms Brayshaw*:** Right. I am struggling with the concept of transition. If the care plan for a child is adoption, then there is a clear procedure and process that needs to be followed, and I suppose within that is if the foster carer is to be considered as a potential adopter for that child then they go into a process any other prospective adopter would go into. The fact that they have been the foster carer for that child does not automatically assume that they should become the long-term adoptive carer for that child.

The reasons for that are that in looking at matching a child with an adoptive carer you have to look at the outcomes from over a period of time. You are looking at longevity. If you place a child with a foster carer initially, then a foster carer is a substitute carer and would assist a child moving on to whatever permanent arrangement is in place, so it cannot be presumed that a foster carer is automatically the right adoptive carer for a child. So it would –

Q124. Mr Boot: Do you take the child's views into consideration when you are looking at their future?

***Ms Brayshaw*:** If a child was of an age to take their views into account, yes.

Q125. Mr Boot: …? *[Inaudible]*

***Ms Brayshaw*:** Yes, we would. Well, again, it is a judgement based on age and understanding, but wherever possible we would seek the views of that child or young person.

The Chairman: Anything else?

Mr Speaker, anything you would like to ask?

Q126. The Speaker: Not on this subject, but could I ask a general question to Dr Couch in terms of the Department's legislative programme, in terms of what it might be thinking in developing children's services.

We have focused on the Department's role in the statutory services that you have to deliver. You will be well aware, of course, that there was, five or six years ago, intended to be a Children Bill, which, like the English Children Act 2004, was attempting to introduce the concept of early

intervention and child well-being as a threshold for delivering services. Of course, that was dropped.

At the moment, I am sure you are aware Scotland has introduced a policy of getting it right for every child, which is named person – health visitors, school teachers and so on taking some legal responsibility for a child's well-being, which is quite a radical concept when traditionally it was the family that primarily dealt with well-being.

Has the Department any thoughts of developing policy involving early intervention and a policy based on child well-being in order to intervene, rather than child protection meeting a need – any notions of that policy being worked up into legislation currently in the Department?

***Dr Couch*:** The very short answer would be with three letters, which is yes; obviously, it is immeasurably more complicated than that.

I think that, in terms of work with the Scottish Care Inspectorate, for example, who have recently been doing an update review, they are, we expect, going to make some recommendations about core national policies in respect of children, and those recommendations are likely to be that we have gaps in certain places, so I think they would be obliged, as a responsible service or series of agencies, to take account of those recommendations and to do something with them. So that is part of the answer to the question.

Whether things are more than a policy and become a legislative aspect I think is a secondary question, but it is likely … Almost as you were saying earlier with the Safeguarding Children Board, it is always better if you have got something where somebody – or some body, as in a legal body – needs to have authority to have a legal underpinning for that.

What we then face – and this would be a challenge for any chief executive or any service lead – is that you then have a sort of formula almost to apply, which is the capacity of your own Department to start to develop the legislation of policies. There is the capacity in the Attorney General's Chambers in drafting pieces of legislation. There is the capacity of the Branches of Tynwald to process legislation. And then I suppose, in terms of what we might have as our hit list of things that we would need to do – and there are several pieces of important legislation the Department needs to take forward – we have got the overlay of the Council of Ministers, which I think has to determine what it will sponsor in terms of priorities for any particular session of Tynwald. And sometimes you get bumped, and I think that we are all aware of that.

So, for example, there is work to do with children, there is work to do with improving Social Services legislation generally. We do have our National Health and Care Bill in the Branches now, so that is one that made the cut. We need to do a thorough review and an update of capacity legislation when people are not able to make decisions for their own care – that is an important one. We have got to update our deprivation of liberties legislation to do with things like mental health services etc.

So there is a whole sequence of things, and we will, as officers, try to prioritise and work with our Minister and our Department Members, and with Tynwald and the Council of Ministers to get those through.

Q127. The Speaker: Right, but there will be a legislative framework to any major new policy that involves the right to intervene and make early interventions into family life?

***Dr Couch*:** Well, I think there are two things, aren't there, Mr Rodan? I think one of them is to provide a service that gives early help for families and children; and then the other one, which I think is what you are alluding to, is the statutory obligation to intervene and give some form of early help. (**The Speaker:** Yes.) And I agree. Of course, as in the way I have described it, the statutory right to intervene would have to be underpinned by law.

Q128. The Speaker: Yes, so working, as we had intended to do a few years ago, to a policy of child well-being, child happiness and more nebulous concepts like that without this statutory

backing of a Children Act is something that you would seek to avoid? Any policy development that required legislation, the two would come together?

***Dr Couch*:** I think, again, as Ms Brayshaw said on a number of other things, there is a judgement to look at that. I think we have to be careful that we would not ask the drafters to start putting things in which you cannot otherwise define. I am perfectly aware that there are legal challenges in other jurisdictions to the concept of well-being – what does it mean is a tough one.

Q129. The Speaker: The five outcomes – that was discredited as a policy.

***Dr Couch*:** Yes. So, from my perspective – and you will be aware I am, I suppose, much more of a stickler, having come from a Treasury background – you should be able to look at a piece of law, interpret it easily in plain English and know what it is about. If you have got vague words it becomes difficult.

I will give you an example. Section 1 of the National Health Service Act says that this Department shall provide 'a comprehensive health service'. What does that mean?

The Speaker: Like the Education Act – they will 'deliver education'.

***Dr Couch*:** Yes, so policies may become law. The law needs to be explicit for everybody, both in terms of the people administering the law and the people who might be subject to it to understand it. That should be a principle of what we do.

The Speaker: It will avoid a lot of problems if that happens.

Thank you.

Q130. The Chairman: Is there anything you would like to tell us which we have not asked about?

***Ms Brayshaw*:** No, thank you.

The Chairman: On that basis, can I once again thank you very much for coming along today and being so prepared and so open to answer our questions.

Thank you very much.

***Dr Couch*:** Our pleasure, thank you.

The Chairman: We will now suspend this sitting for a few moments until we go to our next one.

The Committee adjourned at 3.40 p.m.

WRITTEN EVIDENCE

Appendix 1: Children and Families Division Annual Report 2014/15

Isle of Man Government
Reiltys Ellan Vannin

Children and Families Division

Annual Report 2014/15

A Day in the Life of …
Children and Families

Welcome

To the Children and Families Division's Fist Annual Report 2014/15

I am delighted to introduce this first Annual Report and to thank you for taking the time to read it.

The approach we have taken in this report is to take a day in the life of the Division to provide a snapshot of many of the activities happening day in and day out for children and families.

The responsibilities which we hold in children's social care (sometimes called the fourth emergency service) are immense. Alongside those responsibilities goes a true sense of accountability: accountability to the children and families who we serve; accountability to achieve outcomes for children and young people; accountability to staff and managers, to ensure that they have the skills, knowledge and experience to undertake their work efficiently and effectively; accountability to use the resources to obtain best value; and accountability to the Minister and MHKs who put their trust in the Division to meet their strategic and operational objectives.

We take these responsibilities and accountabilities seriously. This report takes you on a journey from first contact with the Division through the assessment processes to a time when there is greater involvement with us through Child in Need, Child Protection, Looked After Children and After Care arrangements. The report shows that we are constantly thinking about how we are doing our job and putting in place developments which will make a greater difference.

I welcome comments on our work including the format and approach of this First Annual Report which I commend to you

Deborah Brayshaw

Chief Social Worker

Director of Children's Social Care Services

May 2015

Contents

Introduction

This is the first Annual Report provided by the Children and Families Division, DHSC. It is aptly called "A Day in the Life of …Children and Families" The objective of this report is to give a real flavour of the work carried out on a daily basis by dedicated social work/social care staff, either working for government, or in our commissioned provider services.

First contact

When professionals (such as colleagues in health, education or police services) or individuals (such as parents, relatives or neighbours) wish to notify the Children and Families Division (C&F) of any issues about which they have concerns about, they make contact with the front door team – The Initial Response Team.

Every day, we have at least 66 calls including official contacts or referrals from concerned individuals or agencies

The top four referrers in 2014/15 were:

- Police: 31%
- Health (including A&E): 19%
- Parents/relatives: 19%
- Schools: 7%

The responses to contacts vary. Some referrers are provided with information, some are signposted on to other, more relevant services, some move into the more detailed work of C&F (becoming a confirmed referral) and others (which were provided to C&F for information only) are deemed to need no further action and closed.

Assessing need

Before we can support children and families we need to undertake an assessment of need. The assessments being carried out are either Initial Assessments or Core Assessments

Initial Assessments (IAs) are done to establish a quick understanding of the facts and issues in order to establish whether the child/family meets the threshold of intervention by C&F. Core Assessments (CAs) comprise of an in-depth assessment, which addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context.

Every day, we are carrying out between 5 and 6 formal assessments on children and young people and having dozens of discussions about them

Timescales are expected to be met for carrying out these assessments. In 2014/15:

- 87% of Initial Assessments were completed in timescales (against a target of 95%)
- 71% of Core Assessments were completed in timescales (against a target of 85%)

These targets are expected to be met in 2015/16.

Protecting Children

A key task for all children's social care services is to protect and safeguard children from potential or actual harm

Every day, we are protecting and safeguarding 52 children

There are a range of activities associated with the protection and safeguarding of children. These are: undertaking **strategy meetings**, when there is reasonable cause to suspect that children are suffering or likely to suffer significant harm; undertaking ***Section 46 Enquiries***, to determine whether action is required to safeguard and promote the welfare of the child or children who are the subject/s of the enquiries; initial and on-going ***Child Protection Conferences***, to ensure the child is safe and to prevent him or her from suffering further significant harm and to promote the child's health and

development; holding ***Core Group Meetings***, to develop and monitor the effectiveness of the plans and ensure that actions agreed are followed.

Every day there we hold around 7 Strategy Meetings, Section 46 Enquiries, CP Conferences or Core Group Meetings (1624 per year)

Children in Need

Sometimes an Initial or Core Assessment concludes that a package of support is needed for a child and/or the family. Under these circumstances a Chid in Need Plan is drawn up and implemented.

Every day, we are supporting 183 children via a Child in Need Plan

The plan identifies the developments needed, the support to be provided, the objectives of the support and the expected outcomes. The support the children receive includes:

- Direct 1-1 support for children and parent(s)
- Counselling support
- Advocacy
- Small group work (e.g. supporting improvements in parenting)
- Therapeutic support
- Specialised courses or individual programmes (e.g. behaviour management)
- Activity programmes
- Life skills training
- Communication training
- Preparation for independence

Children Looked After

Children who, for some reason, are not able to be cared for by their own parents come into care system managed by C&F. These children are classed as Looked After Children (LAC). The age ranges and numbers of children in care are:

Ages	Number
0 to 4 years	11
5 to 9 years	17
10 to 15 years	38
16 years plus	26

Fifty four of the children looked after (59%) are placed in foster care placements provided by Fostering First, a service commissioned by C&F. Twenty two children (24%) are placed in residential care settings provided by St Christopher's, a service also commissioned by C&F. The remainder are either placed with their parents (5) or with family and friends (2). This is often called kinship care. Two children are currently placed in specialist provision off-island.

Every day, we are caring for 92 Looked After Children

Activity associated with Looked After Children includes:

- Preparing Court reports
- Care Planning
- Placement meetings
- Statutory visits
- LAC Reviews
- Providing advocacy for the child
- Liaising with other professionals (e.g. health and education, youth justice)
- supporting placements (in foster care or residential settings)

Children Leaving Care

When children reach the age of 18, they officially leave the care of the department. Some choose to leave earlier than that age. C&F have a duty and responsibility to continue to support young people through college, university and hopefully into work. 42 care leavers are currently being supported. This number will rise over the next 2 years.

Every day, we are supporting 42 Care Leavers

Through commissioned services C&F provide:

- 2 homes for (semi) independent living
- A team of workers working with young people where they live to give support when and where they need it

Team around the School/Family Project

The Team around the School/Family (TSF) is the name given to the service delivery approach to assessing, making plans for, and reviewing outcomes of services provided to Children with Additional Needs. Schools in one part of Douglas (Ballakermeen) and Health Visitors in Ramsey can make referrals to the TSF Coordinator and following assessment, services are provided in response to need.

Every day, we are supporting 28 children through our TSF project

This service will be rolled out island-wide from September 2015 with a capacity to be supporting up to 250 children and young people at any one time.

Staffing

Every day, 230 staff members (approx.) in C&F and in our provider services are supporting and/or caring for children, young people and families

The C&F arrangements for managing and delivering services were changed in early April and May 2014. The intention of the Division was that through this change, we could create a reality of:

"Making every day count for children"

As a result of the changes made, we are of the view that:

1. The management task can be achieved without being over burdensome
2. Line management arrangements allow for high quality reflective, best practice supervision
3. Team structures encourage and enable collaborative working
4. Individuals within teams have caseloads which can be managed in a professional way using the theories, models, knowledge and skills of social work to truly make a difference to those children and families we serve and support
5. Due attention can be given to strategic responsibilities

Service Developments

Over the past year we have:

- ✓ Published our new commissioning intentions and by so doing have improved the balance of service delivery (more early intervention; less high cost residential provision; more services for children leaving care; and more intensive support for LAC in respect of their emotional health and well-being)
- ✓ Revamped and re-launched the Supporting Families Team
- ✓ Developed the concept of the Team Around the School (TAS) and developed a pilot project for DHSC and DECS
- ✓ Developed a project to revamp the 2 Children's Resource Centres for children with disabilities
- ✓ Created a partnership with Queens University Belfast to provide the Diploma/Masters in Applied Social Studies (Child Care Pathway) for C&F social workers/managers
- ✓ Provided all C&F managers with a ten part management development programme and created the C&F Leadership Framework
- ✓ Developed and delivered on the Divisional Plan
- ✓ Embedded the Quality Assurance and Performance Management (QAPM) Framework
- ✓ Undertaken reviews on:
  - Supervision

- Requests for commissioned services
- Contact: No Further Actions
- Managers and Team meetings

Resources and Finances

We are proud of our judicious use of the resources granted to us. The implementation of our commissioning intentions has enabled us to procure new and different services and, in 2014/15, contribute some of our savings into the overall DHSC pot.

Every day, we spend £43,753 supporting and/or caring for children, young people and families

Every day, we spend £5,330 on supporting children in foster care placements and £17,109 on children/young people in residential care (on island, off-island and in secure home accommodation)

Involving children, young people and parents

Feedback about the felt experiences of contact with C&F is regularly sought from parents, children and young people. This helps to improve our services over time.

The Division, through its Participation Officer supports the Voices in Participation (VIP) Council. This had small beginnings in 2008 but now has 30 young people regularly contributing to its work and activities. Council members:

- Have accredited qualifications for interviewing professionals for posts in the Division.
- Work with the Registration and Inspection Unit, helping inspectors to communicate with children in care
- Offer a VIP club group
- Organise and participate in the VIP Awards evening. (This year 87 professionals/MHKs attended
- Have made links with other similar groups in the UK

We have recently developed a new service user feedback strategy and process. An annual report will be produced from 2015/16 identifying the learning from this feedback and the changes made to service delivery.

The following quotes are from written feedback received after Child Protection Conferences and before LAC Reviews.

On Child Protection Conferences:

During Conference, I was patiently listened to and given a chance to speak

Parent, December 2014

I was nervous, but glad there are people who will look at our situation closely

Parent, October 2014

I would feel more comfortable if I got more accurate facts about situations for conference

Parent, June 2014

On LAC Reviews: what's gone well for you?

Getting into college; getting a job; getting great feedback from my tutor about my record of achievement; getting my IPad back (being trusted); making a new friend

Young Person July 2014

On LAC Reviews: what's gone badly for you?

Some grades weren't good. Dad and Carers help me with revision

Young Person, June 2014

Argument with the family; stopped talking to them

Young Person, June 2014

On working with a Family Support Worker

After using the Outcomes Star, I realised for the first time that I did lots of stuff right, I wasn't rubbish and I could develop myself more. Thank you

Mother, October 2014

Next days

C&F are continuously looking to develop and improve services. This next year has an ambitious plan to put new things in place. These include the following:

1. **Single Assessment Framework:** this will replace the current process of undertaking initial and core assessments. it will be used by all departments and services involved with children and families from later on in 2015.
1. **Children with Disabilities:** From the Braddan Community Hub, we are expecting to provide a much wider range of services for disabled children and their families. This will include the provision of skills for living, improved communication, managing challenging behaviour and support for young people in transition and for independence.
2. **Introduce/embed Signs of Safety:** the evidence base of using the signs of safety approach to providing assessment of risk to children is strong. From its routes in USA is now used extensively in Australia and in parts of the UK. We wish to introduce this way of working as the preferred option for safeguarding children
3. **Greater focus on educational attainment for LAC:** at any one time there are up to 20% of LAC who are either on reduced timetables or not in mainstream schools at all. We wish to provide better coordination among the various providers, improve tracking and targeting, and to improve outcomes over time
4. **Early Help and Support** In September 2015 we are expecting to roll out our approach to providing early help and intervention. This is based on the Team around the School/Family Project (referred to elsewhere in this report). Five coordinators will be appointed to run this service
5. **Recruitment and Retention of Staff** We have put together an ambitious plan to attract social workers to our service and to keep them when they are here. This will be implemented in 2015/16

Key Performance Indicators (KPIs)

During 2014/15 we have been tracking what we call our set of Key Performance Indicators. Some of the targets are new and were set during the year so will be subject to change in 2015/16. Wherever possible we benchmark ourselves against English Local Authority measures (and adjust if and when necessary). Provided below is a table showing the 2014/15 out-turn figures against the targets set. There are also notes to some of the indicators.

Ref	Indicator	Target	2014/15 out-turn
1	Number of referrals per 1000 population	53.7	53.5
	Actual number	913	910
2	% of re-referrals in total referrals*	25%	39%
3	% referrals that become Initial Assessments	70%	74%
4	% Initial Assessments completed in 10 days	95%	88%
5	Initial Assessment to No Further Action	20%	31%
6	Section 46 Enquiries per 1000 population**	13.7	17
	Actual number **	233	292
7	Core Assessments per 1000 population***	–	28.1
	Actual number ***	–	478
9	% Core assessments completed in 35 days****	85%	69%
10	Number of CiN (incl Children with Disabilities) open cases	Up to 200	183
11	CP open cases per 1000 population	2.7 – 3.8	3.1
	Actual Number	45 – 64	53
12	LAC open cases per 1000 population	6.0	5.4
	Actual Number	90 – 102	92
13	% CiN Reviews on time	95%	62%

14	% CP Reviews on time*****		100%	**90%**
15	% LAC Reviews on time		100%	**89%**
16	% Supervisions due that were completed		100%	**83%**
17	% Pathway Plans in place		100%	**74%**
18	% children to permanence panel by second review		100%	**60%**
19	% children participating in or contributing to:	LAC Reviews	75%	**89%**
		CP Conferences	75%	**31%**
		CiN Reviews ******	75%	**9%**
20	Parents attending CP conferences		–	**85%**
22	Social Workers to have a caseload that accurately reflects their optimal capacity (as determined by experience, number of cases and complexity of work)		80%	**100%**

Notes to the KPIs:

1) The results are colour coded: **Green =** on target; **Amber =** we are satisfied that sufficient progress has been made during the year, or where robust plans are in place (even though the target may have not been met); **Red =** a target not being met or where further investigation is needed

2) These notes refer to specific indicators and are by way of explanation

*****

Re-referral rates have traditionally been high in Isle of Man. We are of the view that this is due, in part, to the previous lack of a comprehensive early help and prevention service. This, in turn, leads to referrals which were deemed not to meet the social care threshold to then being re-submitted. It is undoubtedly true also, that there are some referrals that could have been dealt with at the first time of asking. A piece of work is underway to understand this better. The 2014/15 out-turn shows a reduction in re-referrals of 10% on 2013/14.

**

The target quoted is the average for NW England in 2014. Within that average, there is variation from 7.2 per 1000 population and 40.4 per 1000 population. 35% of the local authorities in the NW England are within 2 points of Isle of Man out-turn figures. We will be keeping a close eye on the rates over the next year

***

Many local authorities have switched from their previous approach of providing Core Assessments to the Single Assessment Framework (SAF). This means that it is not appropriate to quote a target for 2014/15 as the comparative data is unreliable. C&F intend to introduce the SAF later in 2015.

****

The target of 85% of Core Assessments (CAs) being completed in timescales is internally generated. We have improved slightly on last year's out-turn, but there is some way to go. The England national average in 2014 was 73% of CAs in timescale, so not dissimilar to the Isle of Man out-turn.

*****

It would normally be expected that 100% of CP Review Conferences would be completed within timescales. On investigation, it was found that of the 15 Conferences held out of timescale, the main reasons were either unavailability of a chairperson or inability of the family to attend. On all occasions the delay was sanctioned by a senior manager.

******

During the past year, we have been resolving some issues in respect of recording CiN Reviews and, in particular, the recording of the participation, representation and/or attendance of children at CiN reviews. We believe that this is now working more effectively and we will be able to show significant improvement in this indicator over the next year.

A Collage of Pictures

Water sliding at Resource Centre

Paddle boats on a serene afternoon

Getting Creative

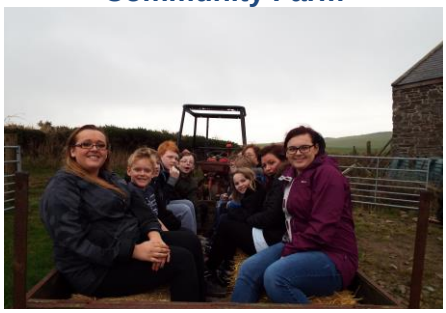
Look out – here come the swans

Forest Adventure

Preparing artwork for Thie Yn Lheihys

VIP Cub event

On the tractor at the Community Farm



Go Karting

Lazer Mayhem: ready to beat the Juggernaut

Voices in Participation Awards

The End

Appendix 2: Email dated 21st June 2015 from Tristram Llewellyn Jones

Sent: 21 June 2015 13:48:32
To: Jonathan King
Cc: Steve Rodan
Subject: Social Policy Committee

Dear Jonathan,

Maggie Mellon has forwarded me this academic paper which I suggest the Committee read before the session on 29 June:

Rethinking Child Protection Strategy: Learning from Trends
Dr Lauren Devine & Stephen Parker
March 2015
http://eprints.uwe.ac.uk/25258/1/Working%20paper%20-%20Rethinking%20child%20protection%20strategy%20-%20learning%20from%20trends.pdf

ABSTRACT:
This Working Paper is developed from the findings of the first Interim Report of the ESRC Transformative project, Rethinking Child Protection Strategy. It considers Child Protection and Safeguarding referral, investigation and outcome trend data. The trends are analysed on a number of measures in light of the available statistical data, covering the period since the implementation of the Children Act 1989. The trend data establishes that despite the increased cost, level of intrusion into private family life and surveillance of families there is no proportionate increase in the level of child abuse found in referred children. Although the number of children referred into the system has significantly increased, the number of cases where core abuse (physical and sexual abuse) is detected has dropped. In addition, the ratio of referrals to registrations has significantly fallen year on year. This is not adequately explained by the rise in early intervention for families as targeted early intervention occurs following the assessment stage. The paper concludes there are a number of policy questions to be addressed.

later on . . .

Commentators such as Wrennall and Anderson et al argue that the current framework furthers collective government s e-Government agenda in relation to data collection and retention in respect of all children in the form of databases, and by extensive and intrusive assessments. Concerns have been raised that practices are unlawful, or at least have the potential to be so, as they operate on the fringes of acceptable intrusion into private life. Research findings raise concerns that this is causing undue harm and distress to families. In addition to the obvious concern that this system overload could cause some children to be missed , and left in a dangerous situation, there is also growing concern from a number of voluntary organisations, MPs and Peers that this is facilitating referrals amounting to unfounded allegations, and also referrals which are being made at too low a level. This type of referral may be pursued to the detriment of families using already overstretched resources. This issue requires further research to ascertain the depth and scale of the problem.

It appears that the concerns about over referral are now confirmed by the numbers.

Kind regards,

Tristram

Tristram

Appendix 3: Submission dated 13th October 2015 from Dr David Foreman, with the author's CV and the questions asked by the Committee

WRITTEN ANSWERS TO SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

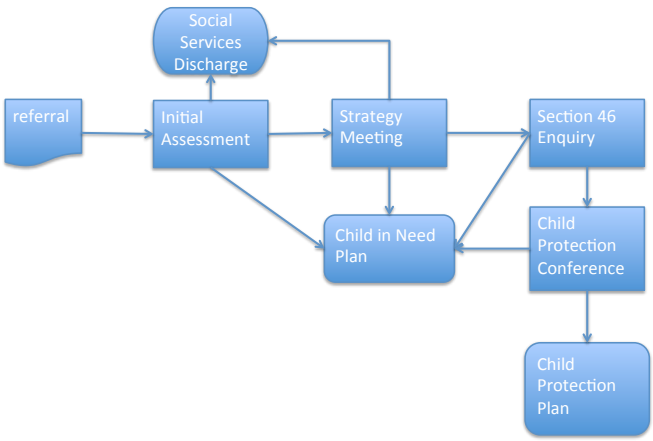
Thank you for inviting me to respond to your Committee. I attach my Curriculum Vitae. You will see that I am not a qualified Social Worker, and both my research and my practice have been concerned with Child and Adolescent Psychiatry. My CV shows that I have worked at the interface between Social Services and Child and Adolescent Mental Health, particularly in relation to child protection. I have also served as Consultant to the Isle of Man Government in Public Mental Health, as well as in Child and Adolescent Psychiatry, and have published on them both. My answers should be interpreted in the light of this experience.

For ease of reference, I follow the structure of the document listing the questions. I summarise each question in a heading, and provide my answer beneath.

COMPARATIVE SOCIAL SERVICES' ACTIVITY FIGURES FOR THE ISLE OF MAN AND ENGLAND

On inspection of the figure at paragraph 23, page 8 of the Social Affairs Report (SAR), these figures do not seem to have been clearly presented to the committee. I provide a simplified flow chart for the Island's Child Protection procedure in Figure 1 below.

FIGURE 1: SIMPLIFIED FLOW CHART OF ISLE OF MAN CHILD PROTECTION PROCEDURE



It can be seen that the referral pathway is different to that implied in the SAR: significant harm is not assessed following a completed assessment of need.

INTERPRETATION OF ENGLISH AND ISLE OF MAN SOCIAL SERVICES DATA (QUESTION 1)

I have reanalysed the data provided in appendix 2 of the SAR. In both the Isle of Man and England, a child is defined as an age-range from 0-17 years, and I note that the social work activity figures included in the appendix have not had their age-range further qualified. I have therefore adjusted the census populations reported in appendix 2 to a 0-17 age-range. With this definition, The Isle of Man 2011 Census identifies 17,088 children, and the UK 2011 census 11,336,960 for England.

a) **Referrals**. In England, a referral is defined as "… a request for services to be provided by children's social care and is in respect of a child who is currently not assessed to be in need" (1). The equivalent definition for the Isle of Man is provided in the SAR at paragraph 29, page 9. For effective comparison, the number of English referrals should therefore be compared with the sum of Manx "referrals" and "contacts", as both meet the English definition. Approximately 188 per thousand children were referred (by English criteria) on the Isle of Man; while in England 53 per thousand were referred, making Isle of Man referrals approximately 3.6 times higher than English referrals over the same period. This difference is highly unlikely to be a chance finding (probability (p)<.001).

b) **Need**. The English definition of a child in need is "… one who has been assessed by children's social care to be in need of services" (1). The identification of need takes place at the initial assessment, which follows the referral. On the Isle of Man, from the descriptions given at paragraph 29, an assessment of need appears to take place in determining whether a "contact" should proceed to a "referral", and the "initial assessment" which follows "referral" is "statutory": the Isle of Man have thus introduced at least one, and possibly two more filters than England. Consistent with the use of additional screening, the rates for need identified by Social Services are, for the Isle of Man, 12 per 1000 children, while for England the comparable rate is 35 per 1000 children. Thus, despite the 3.6-fold higher rate of referrals to Social Services, need is only identified at 34% of English rates (p<.001).

c) **Initial assessments**. In addition to the differences already discussed, comparative inspection of the Isle of Man guidelines (2) and current English guidelines (3) identifies an additional important difference. The Isle of Man guidance advises: "This will ensure that appropriate decisions can be made about whether or not the child is a child in need *and* at risk of significant harm." The equivalent English guidance is: "to decide whether the child is a child in need (section 17) *and/or* is suffering or likely to suffer significant harm (section 47)". Thus, the initial assessment refers to different populations, so any comparison between the reported rates of initial assessment is uninterpretable.

d) **Section 46/47 Child Abuse Enquiries**. These investigations serve the same purposes in English and Manx Law, to determine if there is a risk of "significant harm". These are analysed as proportions of referrals, because the rate of initial referrals (including contacts) is so much higher on the Isle of Man. The proportion of referrals leading to a Section 46 Enquiry (Isle of Man) was 8%, while that leading to a Section 47 Enquiry (England) was 4% (p<.001).

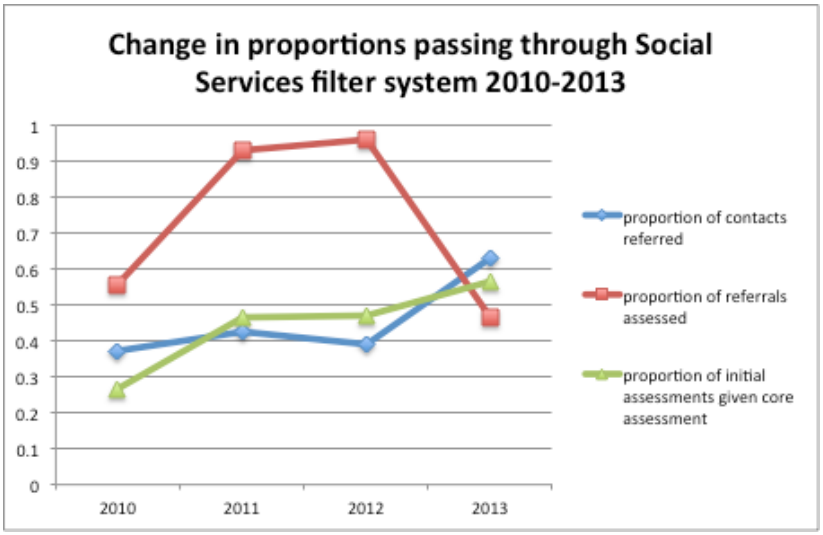
e) **Children on Child Protection Register**. Unfortunately, Appendix 2 does not report the number of Case Conferences following a Section 46 (Manx) Enquiry, so I cannot compare this stage of the procedure. Despite the change in population estimates

used, I also found no difference when the population rates of registration were compared: 3.5 per 1000 children for the Isle of Man, and 3.8 per 1000 children for England.

TREND ANALYSIS

Unfortunately, "core assessments" can be carried out both as part of abuse and more general social services investigations, and cannot therefore simply be regarded as Section 46 investigations. So, the trend data at paragraph 27, page 9 is not directly comparable to the cross-sectional data just discussed. While this data shows considerable year-to-year variation, there was no significant overall trend in absolute numbers of contacts, referrals, initial or core assessments. However, highly significant trends could be detected in the ratio of referrals to contacts ($p<.001$), initial assessments to referrals ($p<.001$), and core assessments to initial assessments ($p<.001$).

A chart showing how the proportions changed is provided below



COMMENTARY

The comparative data found

1. Total referrals to Social Services were around 3.6 times higher than England
2. Identification of children in need was 66% lower than England, associated with additional referral filters in use on the Isle of Man.
3. The proportion of referrals leading to a Section 46 Enquiry for Significant Harm was double that of England.
4. Child protection registrations were similar to the UK, as a proportion of the population.

The time trend data found

5. There were no overall trends in absolute numbers at any level of referral or assessment.
6. There were significant trends in the relative proportions of different levels of referral and assessment, which formed the filter system mentioned at 2 above.

7. These trends followed a generally upward direction, with however a sharp reduction in the proportion of referrals assessed between 2012 and 2013, associated with an accelerating trend in the proportion of both contacts referred, and initial assessments given core assessments.

This data fits a hypothesis that Social Services is attempting to ration service delivery to children in need, while preserving services for children at risk of significant harm. Findings 2 and 4 above, taken together, are likely direct consequences of such rationing. Finding 1 can be understood as referring agencies' response to such rationing: as these are counts of referrals, some children may be referred more than once. Finding 3 may be Social Services' response to Finding 1; a Section 46 Enquiry will both conclusively dismiss referring agencies' concerns if incorrect, and its narrower focus (on significant harm) may well lead to reduced sensitivity in detecting more general need. Consistent with this view, the figure at paragraph 23 SAR indicates at least some cases with no identified need were subjected to a Section 46 Inquiry.

This hypothesis also implies a "vicious circle", with rejection of children following abortive Section 46 Enquiries leading to more strenuous attempts by referring professionals to get Social Services engaged. This accounts for the very high levels of referral found, particularly as this might reflect repeated referral of the same children following prior rejection by Social Services. Finding 7 may illustrate this: while (probably as a result of concerns expressed then) the proportions of referrals assessed dropped sharply between 2012 and 2013, and the associated proportion of assessments proceeding to core assessments increased, as might be expected by more effective filtering, this was also associated with a sharp increase in the proportion of contacts being assessed, implying more assessment effort was needed to demonstrate, to referrers, that further progress was unnecessary. Findings 5 and 6, taken together, suggest that Social Services is struggling to reorganise its referral pathways and filters to manage this pressure, despite the underlying need remaining unchanged.

SHOULD THE UK AVERAGE RATE BE A TARGET FOR THE ISLE OF MAN? (QUESTIONS 2 & 8)

The close similarity in proportions between Manx and English Child Protection Registrations suggests that the English average is a useful benchmark, as registrations report children who have been thoroughly assessed, either in England or on the Isle of Man, using similar policies, procedures and assessment tools, by similarly trained workers. However, not only is there wide regional variation across the United Kingdom for a range of abuse-related variables, but also the Isle of Man itself varies, according to topic, in the degree to which it resembles the United Kingdom or its components. Comparative matching between the UK and the Isle of Man should be contingent upon topic, and is therefore beyond the scope of this answer.

WHY ARE REFERRALS HIGHER THAN THE ENGLISH AVERAGE? (QUESTION 3)

This is discussed at heading "commentary" above, as part of a threshold-rationing hypothesis. English research I have undertaken suggests that rationing through threshold manipulation may be informal, implicit, and occurs without clear awareness in individual practitioners: it is thus hard to detect by interviewing front-line workers. While I believe the explanation given is the most plausible, it nonetheless is inferred, and others may find

alternative explanations. If there is significant, unresolvable disagreement with this interpretation of the findings, further research may be needed to establish a reason.

IMPACT ON FAMILIES, CHILDREN IN NEED, THE ECONOMY, AND SOCIAL SERVICES ACTIVITY

WHAT IS THE IMPACT OF EXCESS "SIGNIFICANT HARM" INVESTIGATIONS ON FAMILIES (QUESTIONS 4-6)

There is remarkably little published research on the negative aspects of child protection investigations on families. Possible risks (which I and others have observed) include

I. Increased family discord and potential family breakdown. In the most severe cases, this could lead to illness or death in family members (4)
II. Bullying of adults or children in the family. This may be relevant on the Isle of Man, where confidentiality is harder to maintain, given the increased likelihood, in a small population, of workers living close to their clients, and having multiple roles. More generally, the oppressive nature of child protection assessments can be mitigated if Social Workers are experienced as competent, communicate positively, and offer practical or emotional help (5)
III. Loss of family income, either through the time demands of the investigation itself, or loss of employment resulting from it
IV. Increased suspicion of family by professionals (6)
V. Reduced sensitivity to abuse by professionals, due to increased numbers of negative investigations and information overload (7)
VI. Failure to adequately address need that is not related to significant harm because
    a. Section 46/47 investigations focus on significant harm, leading to "mission creep" even if the original referral was a disguised referral for need, as discussed above, as well as their high threshold operating to prevent need-only cases moving into the service. This is discussed above.
    b. Such investigations are resource-intensive, leaving fewer resources to address other needs. This may apply at the service level, as well as with individual families.

ARE CASES STILL BEING MISSED? (QUESTION 7 & 13)

This issue is discussed at length in Eileen Munro's Report to the English Government (8). Any system that succeeds in preventing all cases of child abuse will inevitably result in a significant number of cases where children are falsely identified as being abused. Likewise, a system that avoids ever making false accusations against families will inevitably miss a significant number of genuine abuse cases. Detection systems therefore seek to strike a balance, to achieve the smallest overall number of misidentifications.

There is a literature on false reporting of child abuse, which most frequently happens in relation to contested divorce proceedings. The legal management of this is beyond my expertise. To date, however, there seems to be no published information on the impact of the Irish legislation upon the detection of Child Abuse.

GREATER EMPHASIS ON THE AGENCY OF FIRST INSTANCE

As Social Services' identification of children in need is 66% lower than the English average, it seems likely that the agencies of first instance (referring agencies), which are all based on English models, are already stretched to, or beyond their limits in managing social care issues among their clients. Social Services' rationing is thus the driver of the over-referral that it seeks to manage. This is of course, a corollary of the threshold-rationing hypothesis discussed at heading "commentary" above. It thus seems likely that greater emphasis on the agency on first instance would need to be associated with appropriate training and resourcing of those agencies, beyond what would be expected in the UK.

INTER-AGENCY PROCEDURAL GUIDANCE (QUESTIONS 9-11)

If the threshold-rationing hypothesis is correct, then current procedural guidance is being distorted in the resource competition between referring agencies and Social Services. It seems likely that re-writing the guidance as suggested, without dealing with threshold-rationing, will simply lead to a different set of procedural distortions. I would suggest

- Making a clear separation between needs assessment and assessment for significant harm at outset, with clear numerical criteria for both, expressed as maxima and minima, based on English benchmarks.
- Define and agree, across all referring agencies, thresholds for need sufficient to trigger Social Services intervention.
- Separate the budget for Child Protection from the more general Social Services budget, so it receives sufficient finance without cannibalising other services.

MANX-BASED LEGISLATION (QUESTION 12)

In the longer term, there could be considerable benefit in employing Manx-based legislation, particularly in the context of increasingly devolved legislation across the British Isles. However, much Social Care and Health legislation is developed from an infrastructure of health and social care intelligence, interpreted by expert working parties. My review of Public Mental Health on the Isle of Man identified significant (if correctible) weaknesses in the former, while the Island may not be able to readily access pools of relevant expertise, which are more available in England and, to a lesser extent, Scotland and Wales. Thus, for the time being, importing legislation developed elsewhere may be prudent. International assessments of best practice are available (9) which could serve as a basis for future legislation, while appropriate infrastructure is developed to allow effective evaluation of legislative interventions.

HOW MUCH DIFFERENCE COULD IT MAKE IF WE HAD A BETTER COMPLAINTS PROCESS (QUESTION 14)

In the business world and healthcare, it is accepted that there is a clear relationship between high quality customer relationships and high quality service delivery (10). Arguably, Social Services, like healthcare, can be considered to be a form of (monopoly) service industry, where the Government, rather than its customers pays the fee for service. Much of the difficulty in maintaining effective on-going child protection for children can be

considered in terms of maintaining relationships that are valued by the children and their families. Social Services' clientele is likely to experience threshold-rationing as a game of "pass the parcel" between disinterested agencies, seriously damaging their engagement, and significantly delaying interventions to help them. Effective feedback and interaction between Social Workers, their prospective and current clients about service quality and desirability could directly counter some of these deleterious effects, as well as reducing stigma, improving the public profile of the Service, increasing efficiency and aiding early intervention.

REFERENCES

1. Department for Education. Characteristics of children in need in England: year ending March 2012 - Publications - GOV.UK [Internet]. [cited 2015 Jun 21]. Available from: https://www.gov.uk/government/statistics/characteristics-of-children-in-need-in-england-year-ending-march-2012

2. Protecting Children Board. 3.3 Initial Assessments [Internet]. [cited 2015 Jun 20]. Available from: http://www.proceduresonline.com/iom/scb/chapters/p_init_assess.html

3. Working together to safeguard children. Chapter 1: Assessing need and providing help [Internet]. 2015 [cited 2015 Jun 20]. Available from: http://www.workingtogetheronline.co.uk/chapters/chapter_one.html#processess_individual

4. Alcohol killed mother Sally Clark. BBC [Internet]. 2007 Nov 7 [cited 2015 Sep 11]; Available from: http://news.bbc.co.uk/1/hi/england/essex/7082411.stm

5. Schreiber JC, Fuller T, Paceley MS. Engagement in child protective services: Parent perceptions of worker skills. Child Youth Serv Rev. 2013 Apr;35(4):707–15.

6. Milner J. A disappearing act: the differing career paths of fathers and mothers in child protection investigations. Crit Soc Policy. 1993 Oct 1;13(38):48–63.

7. Munro E. Common errors of reasoning in child protection work. Child Abuse Negl. 1999;23(8):745–58.

8. Munro E. The Munro review of child protection. Pt. 1, A systems analysis. 2011 [cited 2014 Dec 10]; Available from: http://dera.ioe.ac.uk/11434/1/TheMunroReviewofChildProtection-Part%20one.pdf

9. Mattar M, Marchenko S. 100 Best Practices in Child Protection [Internet]. 2013 [cited 2015 Jun 20]. Report No.: 46781. Available from: http://www.protectionproject.org/wp-content/uploads/2014/01/Best-Practices-in-Child-Protection-2013.pdf

10. Gallan AS, Jarvis CB, Brown SW, Bitner MJ. Customer positivity and participation in services: an empirical test in a health care context. J Acad Mark Sci. 2012 Jul 13;41(3):338–56.

Curriculum Vitae:

David Martin Foreman.

DAVID MARTIN FOREMAN

PERSONAL DETAILS

- DOB 11.2.1955
- Residence:
- Tel
- Married with three children.

Current Appointments

From 12th August 2014 Medically Qualified Member, the Mental Health Review Tribunal, Isle of Man
From 2nd February 2014 Consultant to Keys Group (Provider of residential accommodation for looked after children)
From 28th June 2002 Visiting Senior Lecturer in Child and Adolescent Psychiatry, Institute of Psychiatry at the Maudsley

Formerly

From November 2012 –December 2013 Consultant to Isle of Man Government in Service Development
From 28th July 2010 – 23rd July 2013 Executive Director, Isle of Man Longitudinal Study of Parents and Children (MELSPAC) (Data transferred to ALSPAC for archiving)
From 8th September 2008 – 8th September 2012 Visiting Professor in the Department of Health and Social Care, Royal Holloway, University of London (fixed term appointment, extended to maximum allowed)
http://www.rhul.ac.uk/Health-and-Socialcare/About-Us/Foreman.html
From 18th September 2006-30th April 2012 (retired) Consultant in Child and Adolescent Psychiatry to the Isle of Man Government
From 5th June 2002-15th Sept 2006 Consultant in Child and Adolescent Psychiatry, Berkshire Mental Health Trust
From 26th Sept 2003-March 2006 Health Services Research Fellow to the University of Reading
Locum Consultant in Child and Adolescent Psychiatry, Plymouth Mental Health Trust March 2002 to May 2002.
Locum Consultant in Child and Adolescent Psychiatry, South Derbyshire Mental Health Trust August 2001 to February 2002.
Consultant/Senior Lecturer in Child and Adolescent Psychiatry to Combined Healthcare NHS Trust and Keele University December 1987 to April 2001.

Qualifications

MB ChB(Bristol) 1978

MSc(Manchester) 1988

MRCPsych 1983

FRCPsych 2003

FRCPCH 2004

Referees

1. Dr Tim Byrne, Clinical Director, Mental Health Administration, Nobles' Hospital, Strang, Braddan, Isle of Man IM4 4RF, United Kingdom. Email:
2. Professor E Taylor, Department of Child and Adolescent Psychiatry, Institute of Psychiatry at the Maudsley, King's College London, de Crespigny Park, London SE5 8AF, United Kingdom. Email:
3. Professor Nicky Best, Head, Statistical Innovation Group, Quantitative Sciences (UK)RD Projects Clinical Platforms & Sciences, GSK, Stockley Park West, 1-3 Ironbridge Road, Uxbridge, Middlesex, UB11 1BT, United Kingdom.

SUMMARY

Previous Consultant Experience

- From September 2006- April 2012 (retired) Consultant in Child and Adolescent Psychiatry to the Isle of Man Government
- Consultant in Child and Adolescent Psychiatry, Berkshire Mental Health Trust, May 2002
- Locum Consultant in Child and Adolescent Psychiatry, Plymouth Mental Health Trust, March 2002
- Locum Consultant in Child and Adolescent Psychiatry, South Derbyshire Health Trust, August 2001
- Appointed Consultant/Senior Research Fellow to Keele and North Staffordshire Health Authority December 1987
- Consultant in Charge: Wall Lane House Adolescent Unit 1993-1994

Other Positions Held

- CAP Faculty representative on Perinatal Faculty Executive, April 2014-date
- Faculty representative on Minimum CAMHS dataset, July 2012 to date
- Member, RCPsych Child and Adolescent Psychiatry Faculty committee, term commencing June 2011
- Member, RCPCH committee on Factitious Illness and Injury 2006-2012
- External examiner in psychiatry, Makerere University, Kampala, Uganda, May 2006
- Member, Royal College of Psychiatrists Westminster Parliamentary Liaison Subcommittee, 2003-2007
- CAMHS lead for Information Technology, Berkshire Mental Health NHS Trust 2003
- Member, Bracknell Forest ACPC 2002
- Visiting Consultant in Child and Adolescent Psychiatry, Makerere University, Kampala, Uganda, October 2001
- Honorary Consultant to Kings College Hospital, February 2001
- Chair of Education Committee, Department of Psychiatry, Keele University 1999
- Workshop member, International Study of Postnatal Depression 1998
- Consultant to Price Waterhouse Cooper on Questionnaire Design 1998
- Member of Discretionary Points Committee, 1997
- Examiner to the Royal College of Psychiatrists (Part II) 1996
- Visiting Consultant to Icelandic Child and Adolescent Psychiatry on introduction and use of ICD-10 1996.
- Member, Regional Audit Subcommittee of Consultants' Advisory Committee
- External Assessor, Irwin Unit (Young People's Unit) Birmingham.
- Founding Member, National Committee Member and Local Representative, Royal College of Psychiatry Special Interest Group in Philosophy and Medical Ethics.
- Member, Royal College of Psychiatrists' working party on postnatal mental illness 1992.
- Member, Staffordshire County ACPC, including Education & Training and Policies & Procedures Subcommittees.
- Senior Organizer for the Royal College of Psychiatrists' Part 1 M.R.C.Psych 1989-1991.

- Approved Trainer for Senior Registrars (now called Specialist Trainees)

Other Achievements

- Identified current collapse in preschool child psychiatry, engaging RCPsych faculty committee to address this (ongoing)
- Initiated and collaborated in development of methodology for evidence-based diagnosis of rare types of child abuse (ongoing)
- Collected case series of more than 300 online assessments of CAMHS patients in UK CAMHS 2006-12
- Developed nurse-led ADHD clinic with prescribing 2006-12
- Trainer in Development and Well-Being Assessment 2006
- Initiated multi-agency Integrated Care Pathway for behaviour disorders including ADHD 2004-5
- Piloted nurse-led ADHD clinic 2004
- Organised East Berkshire Hyperactivity Clinic Prevalence Audit 2004
- Invited to submit draft of Child-Friendly Mental Health Inititiative to Child Advocacy International 2001
- Organised and evaluated a greater than threefold improvement in the detection of hyperkinesis in child psychiatry clinics 1998.
- Co-developer of "Goodfore", a general computer engine for the administration of questionnaires and interviews 1998.
- Invited to prepare RCPsych response to working party on child consent 1997.
- Prevention of removal of Social Workers from Child and Adolescent Psychiatry Teams across Staffordshire 1996.
- Prize for best presentation, North Staffordshire Medical Institute Research Innovations Conference, February 1996.
- Co-developer of Senior Registrar (SpR) research fair, Birmingham 1996.
- Managed waiting list initiative 1995-6.
- Running service (with adolescent unit) for 475,000 people when sole consultant 1993/4.
- Development of ethical guidelines for covert video surveillance of suspected Munchausen Syndrome by Proxy 1993.
- Co-Author, Staffordshire ACPC Child Protection Guidelines (responsible for Child & Adolescent Psychiatry advice) 1992+.
- Exposure of 'Pindown' Malpractice 1991.
- Co-Founder and Vice-President of 'GRASP' (Staffordshire-based charity for social support to children with Asperger's Syndrome) 1990.
- Creation of Senior Registrar/Lecturer Post 1988-91.
- Creation of Regional Senior Lecturer Research Club 1990
- Development of Research Methods Course at Keele University 1990
- Development of Developmental Psychiatry Course (combining Learning Disability and Child Psychiatry 1989

PUBLICATIONS (INCLUDING 'IN PRESS')	67
GRANT INCOME	£143,554
CONFERENCE PRESENTATIONS	45
CONFERENCES ORGANIZED/CONVENED	7

ASSESSOR TO 9 JOURNALS AND THE WELLCOME TRUST

ACADEMIC CURRICULUM.

Publications

JOURNAL ARTICLES

1. FOREMAN D.M., Goodyer I.M. "Salivary Cortisol Hypersecretion in Juvenile Depression." Journal of Child Psychology & Psychiatry 1988;29(3):311-20.

2. FOREMAN D.M. "The Ethical Use of Paradoxical Interventions in Psychotherapy" Journal of Medical Ethics 1990;16(4):200-5.

3. FOREMAN D.M. "Guidelines for Organized Abuse" Community Care 1993;947:10.

4. FOREMAN D.M., Farsides C "Ethical use of covert videoing techniques in detecting Munchausen syndrome by proxy." British Medical Journal 1993;307:611-13.

5. FOREMAN D.M. "The Royal College of Psychiatrists Philosophy Group - a brief history of ideas." Psychiatric Bulletin 1993;17:675-676.

6. Henshaw C., Belcher J., Cox J.L., FOREMAN D.M., O'Brien P.M.S. "An Experimental Model for Premenstrual Syndrome." Neuropsychopharmacology 1993;9(2s):71s.

7. Dover S.J., Leahy A., FOREMAN D.M. "Parental psychiatry disorder: clinical prevalence and effects on default from treatment." Child: Care Health & Development 1994;20:137-43.

8. FOREMAN D.M. "Philosophy and Psychiatry" Psychiatric Bulletin 1994;18(5):308.

9. Graham P.J., FOREMAN D.M. 'An ethical dilemma in Child and Adolescent Psychiatry.' Psychiatric Bulletin 1995;19:84-86.

10. Henshaw C., FOREMAN D.M., O'Brien P.M.S., Belcher J., Cox J.L. 'A longitudinal study of postnatal dysphoria.' Journal of Psychosomatic Obstetrics and Gynaecology 1995;16:65s.

11. FOREMAN D.M., Thambirajah M. 'Conduct disorder, enuresis and specific developmental delays in two types of encopresis: a case-note study of 63 boys.' European Child and Adolescent Psychiatry 1996;5:33-37.

12. Hacking S., FOREMAN D.M., Belcher J. 'The descriptive assessment of psychiatric art. A new way of quantifying paintings by psychiatric patients.' Journal of Nervous and Mental Disease 1996;184:425-430.

13. Mann, J., FOREMAN, D.M. 'Homo-erotomania for a delusional parent: Erotomania with Capgras and Fregoli syndromes in a young male with learning difficulties.' Journal of Intellectual Disability Research 1996;40:275-278.

14. Henshaw C., FOREMAN D.M., Belcher J., Cox J., O'Brien P.M.S. 'Can one induce premenstrual symptomatology in women with prior hysterectomy and bilateral oophorectomy?' Journal of Psychosomatic Obstetrics and Gynaecology 1996;17:21-28.

15. Henshaw C., FOREMAN D.M., O'Brien S., Cox J. "Are women with severe blues at increased risk of postpartum depression?" European Psychiatry 1996;11(4):288s.

16. FOREMAN D.M., Dover S., Hill A.B. 'Emotional and semantic priming as a measure of information processing in young people with school refusal: a research note.' Journal of Child Psychology and Psychiatry 1997;38:855-860.

17. FOREMAN DM 'Myths, Mysticism and Madness at the End of Time: Predicting Mental Health and Behaviour around the Millennium.' In: Smith, M Dowd, C (eds) 'The Year 2000 and Healthcare Computing.' Health Informatics Journal, Sheffield Academic Press, 1997;3/4:205-210.

18. FOREMAN DM 'Maternal Mental Illness, Child Psychopathology and Mother-Child Interaction: Implications for Treatment.' Advances in Psychiatric Treatment 1998;4:135-43.

19. Adesida A, FOREMAN DM "A Support Group for Parents of Children Diagnosed with the Hyperkinetic Disorders: An Empowerment Model." Clinical Child Psychology and Psychiatry 1999;4:567-578

20. FOREMAN DM "The Family Rule: A framework for obtaining consent for medical interventions from children." Journal of Medical Ethics 1999;25:491-496

21. FOREMAN DM "The Family Rule: A response to Alderson." Journal of Medical Ethics 1999;25:499-500.

22. Paul M, FOREMAN DM, Kent L "Outpatient Clinic Attendance: Consent from Young People: Ethical Aspects and Practical Considerations" Clinical Child Psychology and Psychiatry 2000;5:203-12

23. FOREMAN DM, Hanna M "How Long can a Waiting List be? The Impact of Waiting Time on Intention to Attend Child and Adolescent Psychiatric Clinics" Bulletin of the Royal College of Psychiatrists 2000;24:211-213.

24. Hacking S, FOREMAN DM "The Descriptive Assessment of Psychiatric Art (DAPA): Update and further research." Journal of Nervous and Mental Disease 2000;188:525-529

25. FOREMAN DM "Infant Psychiatry: its scope, coherence and clinical utility" Israel Journal of Psychiatry 2000;37:165-177

26. McGuire R, Berg I, McKenzie I, Wright B, FOREMAN DM, Chandiramani K "Have the cross-informant syndromes of the CBCL any practical value in identifying grouped ICD-10 diagnoses" European Child and Adolescent Psychiatry 2001;9:263-70

27. FOREMAN DM "General Practitioners and Child and Adolescent Psychiatry: Awareness and training of the new commissioners." Bulletin of the Royal College of Psychiatrists 2001;25:101-104

28. FOREMAN DM, Foreman D, Prendergast M, Minty B "Is clinic prevalence of ICD-10 hyperkinesis underestimated: Impact of increasing awareness by a questionnaire." European Child and Adolescent Psychiatry 2001;10:130-134.

29. Hacking S, FOREMAN DM "Psychopathology in paintings: A meta-analysis of studies using paintings of psychiatric patients" British Journal of Medical Psychology 2001;74:35-45

30. Gudmundsson O, Prendergast M, FOREMAN DM, Cowley, S "Outcome of Pseudoseizures in Children and Adolescents: A Six Year Survival Analysis." Developmental Medicine and Child Neurology 2001;43:547-551

31. FOREMAN DM, Henshaw C "Objectivity and subjectivity in postnatally depressed mothers' perceptions of their infants" Child Psychiatry and Human Development 2002; 32:263-75.
32. FOREMAN DM, Foreman D, Minty EB "How should we measure social disadvantage in clinic settings" European Child and Adolescent Psychiatry. 2003;12:308-12
33. Henshaw C., FOREMAN D.M., O'Brien, S., Cox, J "Severe postnatal blues and subsequent postpartum depression." Psychosomatic Obstetrics and Gynaecology 2004;25(3-4):267-272
34. FOREMAN DM, Foreman D, Minty EB. "The association between hyperkinesis and parenting breakdown in clinic populations." Archives of Disease in Childhood 2005;90:245-248
35. FOREMAN DM "Detecting Fabricated or Induced Illness in Children" British Medical Journal 2005;331:978-979
36. FOREMAN DM. "Attention Deficit Hyperactivity Disorder: Legal And Ethical Aspects." Archives of Disease in Childhood (Invited submission): 2006;91:192-194
37. FOREMAN DM. Beedie A, Kapuge R "Clinic Assessment For Methylphenidate Maintenance Therapy In Secondary Care: Are Parental Questionnaires Useful?" Psychiatric Bulletin 2006;30:406-409
38. Madge N, FOREMAN DM, Baksh F "Starving in the midst of plenty? A study of training needs for child and adolescent mental health service delivery in primary care." Clinical Child Psychology and Psychiatry 2008;13:463-478.
39. FOREMAN DM, Williams J "Medical law and the protection of children" British Medical Journal 2008;337:a1380
40. FOREMAN DM, Ford T "Assessing the diagnostic accuracy of the identification of hyperkinetic disorders following the introduction of government guidelines in England" Child and Adolescent Psychiatry and Mental Health 2008;2:32 doi:10.1186/1753-2000-2-32
41. FOREMAN DM, Morton S, Ford T "Exploring the clinical utility of the Development And Well-Being Assessment (DAWBA) in the detection of hyperkinetic disorders and associated diagnoses in clinical practice" Journal of Child Psychology, Psychiatry and Allied Disciplines 2009;50:460-470
42. FOREMAN DM, "The Impact of Governmental Guidance on the Time Taken to Receive a Prescription for Medication for ADHD in England" Child and Adolescent Psychiatry and Mental Health 2009; DOI: 10.1111/j.1475-3588.2009.00526.x
43. FOREMAN DM, Morton S "Nurse-delivered and doctor-delivered care in an attention deficit hyperactivity disorder follow-up clinic: a comparative study using propensity score matching" Journal of Advanced Nursing 2011;67:1341-48
44. FOREMAN D.M. "Other medications of use in ADHD" Cutting Edge Psychiatry in Practice 2012;2:46-50
45. FOREMAN D.M. "Ethics and values in the prescription of drugs for ADHD" Cutting Edge Psychiatry in Practice 2012;2:64-67
46. Best, N; Ashby, D; Dunstan, F; FOREMAN, DM; McIntosh, Neil "A Bayesian approach to complex clinical diagnoses: a case study in child abuse" Journal of the Royal Statistical Society A 2013;176:53-96

47. FOREMAN D.M. "Psychiatry in Public Mental Health: Easy to Say, but Harder to Achieve." British Journal of Psychiatry 2015: in press.

48. FOREMAN D.M., Best N., Dunstan F., McIntosh N., Ashby, D. "Improving Child Protection by integrating research evidence and clinical experience." International Journal of Law, Policy and the Family 2015: accepted

49. FOREMAN D.M. "The Psychiatry of 0-4 Children" Advances in Psychiatric Treatment 2015: invited submission

BOOK CHAPTERS

1. FOREMAN D.M. "Beyond the Edinburgh Postnatal Rating Scale: other rating scales and standardised interviews of use in assessing disturbed parents and their children." In : Cox J., Holden J. (eds) "Perinatal Psychiatry: use and misuse of the Edinburgh Postnatal Depression Scale." Gaskell: London, 1994:199-215.

2. Watson M., FOREMAN D.M. "Diminishing the Impact of the Puerperal Neuroses: towards an expressive psychotherapy useful in a community setting." In : Cox J., Holden J. (eds) "Perinatal Psychiatry: use and misuse of the Edinburgh Postnatal Depression Scale." Gaskell: London, 1994:233-247.

3. FOREMAN DM "Sam Mason" (commentary) in: Dickenson DL, Fulford KWM "In Two Minds: a casebook of psychiatric ethics" 2001 Oxford: Oxford Medical Publications, 274-276

4. FOREMAN DM "Ethical and Legal Aspects of the Psychiatric Care of Adolescents" in: Gowers S (Ed) Clinical Practice in Adolescent Psychiatry. 2001 London: Arnold, 277-299

5. FOREMAN DM "Law and ethics in the management of chldren and adolescents." In: Gowers S (Ed) "Clinics in Child and Adolescent Psychiatry (2ND Ed)" Gaskell 2005;90-101

6. FOREMAN DM. "Common Psychosocial problems in Childhood: Diagnosis and treatment" in: Bannon M., Carter. "Practical Paediatric Problems in Primary Care." 2007; Oxford University Press:Oxford, 513-528.

7. FOREMAN DM. "Ethics and Legal Issues" in: Bannon M., Carter. "Practical Paediatric Problems in Primary Care." 2007; Oxford University Press:Oxford, 543-554.

8. FOREMAN D.M. "The Psychiatry of 0-4 Children" in: "Clinical Topics in Child and Adolescent Psychiatry." Ed. Huhline-Jackson, S., Gaskell, 2014.

CONFERENCE PROCEEDINGS

1. FOREMAN D.M. "The Use of A Salivary Collection Procedure to Facilitate a Single Case Design: Salivary Progesterone Levels and Elated Mood in a 14 Year Old Girl - A Case of Periodic Psychosis of Puberty?" In: Kirschbaum C. et al (eds) "Proceedings of the 2nd European Symposium on Hormone & Drug Assessment in Saliva: Perspectives for Basic Research and Clinical Practice." Basle: Huber, 1991.

2. FOREMAN D.M., Hackney M., Cox J.L. 'Postnatal depression in the community; Impact on the family and strategies for treatment.' In: Asanova N (Ed) 'Proceedings of the First International Conference on Maternal and Child Mental Health.' Moscow: Institute for Child Psychotherapy and Psychoanalysis, 1996.

3. FOREMAN D.M, Grundy F, Lees S. 'Sex, Age and the Desirability of Computers.' Proceedings of 6th International IFIP conference on Women, Work and Computerisation. Bonn, May 1997.

4. Rogers J, FOREMAN DM, Harper P "Bracknell's Multi-agency ICP for Children with behaviour problems aged 4 to 11" In: Gray J "Conference Report: Poster presentations at the annual Integrated Care Pathways 2007 conference in London" Journal of Integrated Care Pathways 2007;11:71-92

PUBLISHED REPORTS

1. Cox J., Kumar C., Oates M., FOREMAN D.M., Anderson H. "Report of the General Psychiatry Section Working Party on Post-Natal Mental Illness." Psychiatric Bulletin 1992;16:519-22.

2. FOREMAN, DM "Children's Consent to Treatment" (1997) This was a report prepared for the Faculty of Child and Adolescent Psychiatry of the Royal College of Psychiatrists, that was submitted as evidence to the BMA Committee on Children's Consent. BMJ books published the book arising from this "Consent, rights and choices in health care for children and young people" in January 2001.

LETTERS

1. FOREMAN D.M. "Liaison between Child Psychiatry and Social Services' Staff" British Medical Journal 1991;(letter) 303(6793):60.

2. FOREMAN DM, Thambirajah, MS Re: 'Encopresis and sexual abuse in a sample of boys in residential treatment' (letter) Child Abuse and Neglect 1998;22:337.

3. FOREMAN DM "Covert Video Surveillance" (Letter) Archives of Disease in Childhood 2000;82:336.

4. FOREMAN DM "The distinction between mental and physical illness" (letter) British Journal of Psychiatry 2001;179:462.

Conference Presentations.

1. FOREMAN D.M. "The Use of A Salivary Collection Procedure to Facilitate a Single Case Design" 2nd European Symposium on Drugs & Hormones in Saliva 1990.

2. FOREMAN D.M. "The Impact of Postnatal vs Non-Postnatal Depression on New Babies and their Older Siblings: a Controlled Study." Child Psychiatry Research Society, 1990.

3. FOREMAN D.M., Hackney M. "Parent/Baby Interaction and Implications for Therapy." at 'Prevention of Depression after Childbirth', Marce Society, 1991.

4. FOREMAN D.M., Wolton A. "Premenstrual Syndrome in Teenagers: implications for LLPDD." Dept of Obstetrics & Gynaecology Conference 'Premenstrual Tension.' Keele, 1991.

5. FOREMAN D.M. 'Liaison Child Psychiatry in a Child Development Centre' Royal College Senior Registrar Training Day in Liaison Child and Adolescent Psychiatry, Manchester, 1991.

6. Dover S., FOREMAN D.M., Hill A. "Investigation of Semantic Memory Networks in Emotionally Disordered Children." 9th Congress of the European Society for Child and Adolescent Psychiatry, 1991.

7. FOREMAN D.M., Hackney M., Cox J.L. "The Impact of Treated Postnatal Depression on the Development of New Babies and their Older Siblings: Preliminary Results from a Controlled Study." Marc' Society, 1992.

8. Henshaw C, FOREMAN D.M., Belcher J., O'Brien P.M.S., "An experimental model for premenstrual syndrome.' 1st Annual Conference on Reproductive Psychological Medicine, NSMI 1992.

9. Hacking, S., FOREMAN, D.M., Barrett K. "Aspects of Research in Art Therapy." Theoretical Advances in Art Therapy, 1993.

10. Henshaw C, FOREMAN D.M., Belcher J., O'Brien P.M.S., "An experimental model for premenstrual syndrome.' Blair Bell Gynaecological Research Society, Birmingham 1993.

11. Henshaw C, FOREMAN D.M., Belcher J., O'Brien P.M.S., "An experimental model for premenstrual syndrome.' Poster: 1st International Congress on Hormones, the Brain and Neuropsychopharmacology, Rhodes, 1993.

12. FOREMAN D.M. "Parents with Mental Illness - Impact on Children." Patients as Parents, Keele, April, 1994.

13. Henshaw C, FOREMAN D.M., Belcher J., O'Brien P.M.S., "An experimental model for premenstrual syndrome.' Royal College of Psychiatrists Midland Division Meeting, April 1994.

14. Dover S.J., Leahy A., FOREMAN D.M. "Parental psychiatric disorder among attenders at a child psychiatric clinic: Prevalence and default from treatment." RCPsych Annual Meeting, Cork, July 1994.

15. FOREMAN D.M., Hackney M., Cox J.L. "In what way does postnatal depression affect older children?" RCPsych Annual Meeting, Cork, July 1994.

16. Henshaw C., O'Brien P.M.S., FOREMAN D.M., Cox J.L., Belcher J. "An experimental model for premenstrual syndrome." RCPsych Annual Meeting, Cork, July 1994.

17. FOREMAN D.M. "Child Sexual Abuse: A practical problem in need of an ethical solution." 2nd European Conference: Association of Child Psychology, Psychiatry and Allied Disciplines, Winchester, Sept 1994.

18. Hackney M., FOREMAN D.M., Cox J.L. "Postnatal Depression and Child Development: Impact on Siblings." Marce Society, Cambridge, Sept 1994.

19. FOREMAN D.M. "Maternal Depression: Impact on Young Children." Depression through the Life Cycle. Royal College of Psychiatrists and Keele University, October 1994.

20. Henshaw C., Cox J.L., FOREMAN D.M., O'Brien P.M.S., Belcher J. "Postnatal blues – an early warning sign? A longitudinal study of postnatal dysphoria." Depression through the Life Cycle, Royal College of Psychiatrists and Keele University, Stoke-on-Trent, October 1994.

21. FOREMAN D.M., Hackney M., Cox J.L. 'Postnatal depression in the community; Impact on the family and strategies for treatment.' First International Conference on Maternal and Child Mental Health, Moscow, May 1995.

22. Henshaw C., FOREMAN D.M., 'A longitudinal study of postnatal dysphoria.' 11th international conference on Psychosomatic Obstetrics and Gynaecology, May 1995.

23. FOREMAN, D.M. 'The definition of Child Sexual Abuse: Evaluation and Description.' First International Conference on Philosophy and Mental Health, Benalmedina, February 1996.

24. Hacking, S., FOREMAN, D.M., Belcher J. 'The descriptive assessment of psychiatric art. A new way of quantifying paintings by psychiatric patients.' Prize for best presentation, North Staffordshire Medical Institute Research Innovations Conference, February 1996.

25. Henshaw C., FOREMAN D.M., O'Brien, S., Cox, J 'Are women with severe blues at risk of postpartum depression?' AEP/Royal College of Psychiatrists Annual Meeting, London, July 1996.

26. Henshaw C., FOREMAN D.M., O'Brien, S., Cox, J 'Are women with severe blues at risk of postpartum depression?' Biennial Meeting of the Marce Society, London,September 1996.

27. FOREMAN D.M., Grundy F, Lees S. 'Sex, Age and the Desirability of Computers.' 6th International IFIP conference on Women, Work and Computerisation.' Bonn, May 1997.

28. Henshaw C., FOREMAN D.M., O'Brien, S., Cox, J 'Are women with severe blues at risk of postpartum depression?' 1st Meeting of the Australasian Marce Society, Brisbane, June 1997

29. FOREMAN D.M., Henshaw C., Jeffries S., Barnett B. 'Objectivity and subjectivity in postnatally depressed mothers' perceptions of their infants.' 2nd Internation Conference on Maternal and Child Mental Health - Recovery from trauma. Moscow, 2-6th June 1997.

30. FOREMAN, D.M. 'Consent in Children: A protective factor in preventing institutionalised abuse.' 2nd Internation Conference on Maternal and Child Mental Health - Recovery from trauma. Moscow, 2-6th June 1997.

31. Paul M, FOREMAN DM, Kent L 'Who is Consenting in Child and Adolescent Psychiatry' Annual Residential Conference of Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists, September 1997.

32. Gudmunsson O, Prendergast M, Cowley C, FOREMAN DM "Outcome of pseudoseizures in children and adolescents at Birmingham Children's Hospital." Pseudoseizures in Children and Adolescents: MacKeith Meetings, Royal Society of Medicine, November 1997.

33. FOREMAN D.M., Henshaw C., Jeffries S., Barnett B. 'Objectivity and subjectivity in postnatally depressed mothers' perceptions of their infants.' International Conference on Synthesis of Psychopharmacology and Psychotherapy, Geneva, October 1999.

34. Hacking S., FOREMAN DM "Psychopathology in paintings: A meta-analysis of studies using paintings of psychiatric patients" "Meta-analysis" UC Berkeley-Stanford, March 2000

35. FOREMAN, DM "Maternal mental illness and mother-child relationships" 6th World Congress on "Innovations in Psychiatry – 2000" London, April 2000.

36. Hacking S., FOREMAN DM . "Presentation of the DAPA: Method and Research." Sciences and the Arts Conference, Arts Bridge, UC Irvine CA, May 2000

37. Hacking S., FOREMAN DM . "Presentation of the DAPA: Method and Research." (poster) Annual psychology faculty research conference UC Davis, June 2000

38. FOREMAN DM, Foreman D, Prendergast M, Minty B. "Is clinic prevalence of ICD-10 hyperkinesis underestimated? The impact of increasing awareness by a questionnaire screen in a UK clinic." Royal College of Psychiatrists Annual Meeting, Edinburgh, July 2000

39. Foreman D, FOREMAN DM "Parent-training in primary and secondary care." (Poster) Royal College of Psychiatrists Annual Meeting, Edinburgh, July 2000

40. Henshaw C, FOREMAN DM, Cox JL, O'Brien S "Blues and Postnatal Depression" Marce Society, Manchester, September 2000

41. FOREMAN DM, Henshaw C "Objectivity and subjectivity in postnatally depressed mothers' perceptions of their infants" Marce Society, Manchester, September 2000.

42. Henshaw C, FOREMAN DM "Postpartum blues: a risk factor for postpartum depression" 1st World Congress on Women's Mental Health, Berlin, March 2001.

43. FOREMAN DM, Foreman D, Minty BM "Does hyperkinesis promote parenting breakdown in clinic populations." Berkshire study day on looked after children, Wexham Park, Januray 2003

44. Henshaw C, FOREMAN DM "Mood disturbance early in the puerperium." Marce Society International Biennial Scientific Meeting, Oxford: Sept 2004

45. FOREMAN DM ""The diagnosis of ADHD in the community: where next after NICE?" Royal College of Psychiatrists Faculty of Child and Adolescent Psychiatry, Liverpool : Sept 2008

46. Best, N; Ashby, D; Dunstan, F; FOREMAN, DM; McIntosh, Neil "A Bayesian approach to complex clinical diagnoses: a case study in child abuse" Read Paper at the Royal Statistical Society London 2012

47. Henshaw C., FOREMAN DM., Cox, JL "Longitudinal follow-up of postpartum blues and depression" Marce Society Paris 2012

Grants Obtained

£46,339 from the Mental Health Foundation to make a controlled comparison of the effects of postnatal & non-postnatal maternal depression on children. (Grant held concurrently with Professor J.L. Cox, Keele University) 1989

£5,006 from the North Staffordshire Medical Institute for equipment to record interactions between mothers and children. (Held concurrently with Professor J.L. Cox, Keele University) 1990.

£21,459 from University of Keele to study the relationship between progesterone levels and premenstrual syndrome in a wide age-range. (Concurrently held with Professors J.L. Cox & P.M.S. O'Brien, Keele University) 1990.

£10,000 from the North Staffordshire Medical Institute to investigate the phenomenology of artwork produced by psychiatric patients 1994.

£450 travel grant from British Council Moscow for presentations at 2nd Internaltional Conference on Maternal and Child Mental Health.

£20,000 from Berkshire Mental Health NHS Trust to undertake an audit of the relation between true and administrative prevalence of hyperactivity in referrals to CAMHS.2004

£20,000 from Reading University with Health Service Research Fellowship to develop an electronic Care Programme Approach for CAMHS 2003

£20,000 Unrestricted Educational Grant from Lilly Pharmaceuticals to develop and evaluate a nurse-led hyperactivity follow-up medication clinic. 2004

£300 travel grant from Janssen-Cilag sponsoring visit as External Examiner in Psychiatry to Makerere University, Uganda. 2006

£1168 grant from Royal College of Psychiatrists for assessment of rate of change in service activity in 0-4 children, 2014

Conferences Organized or Convened

Organizer of Royal College of Psychiatrists' Child and Adolescent Psychiatry Subsection Day Meeting 1989.

Convenor at Royal College of Psychiatrists Philosophy Special Interest Group Anglo-American Conference 1991.

Convenor at Royal College of Psychiatrists Philosophy Special Interest Group Residential Conference 1993.
Organizer of 'Parents as Patients' Conference, Keele University, 1994.
Organiser of Royal College of Psychiatrists Philosophy Special Interest Group Residential Conference 1995.
Convenor of First International Conference on Philosophy and Mental Health, Benalmedina, February 1996.

Organiser, Staffordshire ACPC Study Day on Emotional Abuse, 1996.

Courses Run

DEVELOPMENTAL PSYCHIATRY COURSE. An innovative course I developed, integrating Child and Adolescent Psychiatry with Mental Handicap within the organizing principle of Developmental Psychopathology, which also allowed the teaching of these two subspecialities to be related to General Psychiatry. The course was both part of the teaching for the Membership Examinations of the Royal College of Psychiatrists and a module in the M.Sc. in General Psychiatry at the University of Keele.

RESEARCH METHODS COURSE. This course was one of the first Medical Research Methods Courses to include "hands-on" computer training in statistical analysis, as well as outside speakers giving demonstrations of their methods. As with the Developmental Psychiatry Course, it formed both part of the M.R.C.Psych Course and the M.Sc. course.

RESEARCH CLUB for Senior Registrars (now SpRs) in Child and Adolescent Psychiatry on the Birmingham Rotation. As well as offering supervision and guidance for trainees in their research, it also encouraged them to form research groupings amonst themselves, with pairs or more collaborating on a single project. This significantly improved their completion rate. I also organised (later with Professor Vostanis) an annual research fair where they could present their work to senior colleagues across the region.

OVERSEAS CONSULTANCIES. The first, in Iceland in 1996, involved teaching both the use of ICD-10 and a semi-structured assessment form to all members of the Icelanding CAMHS service. The second, in 2001, involved training local health workers and doctors in Uganda in assessment and treatment in Child and Adolescent Psychiatry as part of an ongoing collaboration between Keele and Makere Universities, involving both the Tropical Health and Education Trust, and Child Advocacy International.

Postgraduate Students

- Ph.D. 2
- M.Sc. & M.Phil. 4
- Diploma 1

Assessor (Grants, Articles and Book Reviews)

- Journal of Medical Ethics
- Journal of Child Psychology and Psychiatry
- Child and Adolescent Mental Health
- British Journal of Psychiatry
- British Journal of Medical Psychology
- Developmental Medicine and Child Neurology
- Child Abuse and Neglect
- Archives of Disease in Childhood
- Pediatrics
- Wellcome Trust
- Acta Paediatrica
- ESRC
- Journal of Telemedicine
- Social Psychiatry and Psychiatric Epidemiology

Membership of Learned Societies

- Royal College of Psychiatrists' Philosophy Special Interest Group.
- Association of Child Psychology, Psychiatry and Allied Disciplines.
- Child Psychiatry Research Society.
- Paediatric Psychopharmacology Group
- Royal Society of Medicine

Degrees & Professional Qualifications

- M.B., Ch.B. Bristol University 1978
- M.R.C.Psych. 1983
- M.Sc. (Advanced Studies in Psychiatry) Manchester University 1988. Thesis title: 'Salivary Cortisol Hypersecretion in Juvenile Depression.'
- FRCPsych 2003
- FRCPCH 2004

CLINICAL CURRICULUM.

Training Posts

Position	Firm	Speciality	Placement	From	To
House Surgeon	Messrs. Jewers, Johnson & Meikle	General Surgery	Dorset County Hospital	Aug 1978	Feb 1979
House Physician	Dr. Roberts	Chest Medicine	Ham Green Hospital, Bristol	Feb 1979	May 1979
House Physician	Dr. Burston	Geriatrics	Ham Green Hospital, Bristol	May 1979	Aug 1979
Senior House Officer	Dr. G. Bennet	General Psychiatry	Susan Britton Wills Unit, Bristol	Aug 1979	Feb 1980
Senior House Officer	Dr. O. Russell	General Psychiatry & Learning Disability	Susan Britton Wills Unit, Bristol	Feb 1980	Aug 1980
		Manchester Registrar Training Rotation			
Senior House Officer	Prof. Goldberg, Drs. Creed & Szabadi	General Psychiatry	Withington Hospital, Manchester	Aug 1980	Feb 1981
Senior House Officer	Dr. S. Benjamin	General Psychiatry	Gaskell House, Manchester	Feb 1981	Aug 1981
Senior House Officer	Dr. E. Owens	Alcohol Abuse	Alcohol Px Unit, Prestwich Hospital	Aug 1981	Feb 1982
Senior House Officer	Dr. P. Wells	Adolescent Psychiatry	Young People's Unit, Macclesfield	Feb 1982	Aug 1982
Senior House Officer	Drs. R. Hobson & S. Seaton	Psychotherapy	Gaskell House, Manchester	Aug 1982	Feb 1983
Registrar	Dr. G. Hay	General Psychiatry	Withington Hospital, Manchester	Feb 1983	Aug 1983

Manchester Senior Registrar Rotation: Child & Adolescent Psychiatry

Senior Registrar	Prof. D. Taylor & Dr. I. Goodyer	Child and Adolescent Psychiatry and Child Neurodisability	Royal Manchester Children's Hospital	Aug 1983	Feb 1985
Senior Registrar"	Drs. I. Goodyer & S. Leslie	Child and Adolescent Psychiatry (inpatients)	Booth Hall Children's Hospital"	Feb 1985	Mar 1986
Senior Registrar	Dr. P. Wells	Adolescent Psychiatry	Young People's Unit, Macclesfield	Mar 1986	Dec 1987

Senior Posts

Consultant and Senior Lecturer in Child and Adolescent Psychiatry, Combined Healthcare NHS Trust and Keele University, December 1987 to April 2001

Locum Consultant in Child and Adolescent Psychiatry, South Derbyshire Health Authority, from August 2001 to February 2002

Locum Consultant in Child and Adolescent Psychiatry, Plymouth Mental Health Trust, March 2002 to May 2002

Consultant in Child and Adolescent Psychiatry, Berkshire Mental Health NHS Trust, June 2002 to Sept 2006

Consultant in Child and Adolescent Psychiatry, Isle of Man Government, Sept 2006

Visiting Senior Lecturer in Child and Adolescent Psychiatry, Institute of Psychiatry at the Maudsley, June 2002

Health Services Research Fellow to the University of Reading September 2003-March 2006

Consultant in Child and Adolescent Psychiatry to the Isle of Man Government September 2006-April 2012

Visiting Professor in Child and Adolescent Psychiatry, Dept of Social Care, Royal Holloway University London, September 2008-Sept 2012

Service Development

On my initiative, the first Senior Registrar Post in North Staffordshire was established 1988, and converted to a Lecturer Post (Keele) by 1991.

Though 4 Consultant posts were funded, the posts were fully filled in 1988 and 1989 only. Between March 1993 and August 1994 I was sole consultant in Child and Adolescent Psychiatry for a Health District of 475,000; running a community service, an adolescent unit, and training junior doctors in Child & Adolescent Psychiatry. This was achieved by training Social Workers and Senior Nurses to make ICD-10 diagnoses and treatment formulations under supervision, using a semi-structured interview schedule I designed. These professionals then headed small, fluid therapy teams under the overall direction of myself and the Lecturer in post. Satisfaction with the service this provided was reflected in a continuing increase in referrals despite the reduction in Consultant numbers and a growing waiting list, an

ECR rate five times the average for the Trust, and a commitment by the Purchasers to develop the adolescent unit from a 5-day unit to a 7-day unit. This enabled the recruitment of a second Consultant for the Adolescent Unit in 1994, and a third Consultant in the Community in September 1995. I had helped train both these Consultants.

The chronic shortage of senior medical staff led to a need to re-organise services specifically to reduce waiting times in 1995/6. However, the only additional staff that could be recruited were generic therapists with general psychotherapeutic skills, and little previous experience with children, while the assessment-trained staff were already fully stretched. Accordingly, the Child Behaviour Check-List was used as a screening instrument to identify uncomplicated cases of conduct and emotional disorder. I developed a training course to adapt their skills to basic work with children, and also trained them to use the Child General Adaptation Scale as a measure of progress. They then undertook initial therapeutic work with children identified as suitable for them, passing them on for more detailed assessments either at their own request, or if they failed to make progress either on supervision or CGAS scores. The use of the CBCL led to a greater than threefold mprovement in the pick-up rate of hyperactivity. All this work has now been published in peer-reviewed journals. I developed a hyperactivity clinic, involving drug maintenance, a parent support group, parent training groups, teaching and Occupational Therapy support. Both the assessment process and the parental support goup associated with the clinic have been published in peer-reviewed journals.

Following my move to Berkshire Mental Health Trust, I developed a multiagency plan for CAMHS that allowed CAMHS access to vacant posts in other agencies. My intervention led to the establishment of a network of Webster-Stratton parenting groups run by the Behaviour Education Support Team of the Bracknell Local Authority: at the time the only successful establishment of such groups in East Berkshire. I also planned, and have successfully piloted, the development of a multiagency integrated care pathway for behaviour disorders in children, supported by Lilly Pharmaceuticals, which has now been published, making use of structured assessment tools including the Strengths and Difficulties Questionnaire (SDQ), Development and Well-Being Assessment (DAWBA) and the CGAS. As team leader, I was successful in encouraging my team to develop both a cognitive-behaviour therapy clinic and a systemic family therapy clinic, both of which engage professionals from other agencies not otherwise involved in CAMHS. The clinics interacted, and it was planned to derive a handbook from their teaching practices. We were also able to pilot a mother and baby clinic for under 2s.

After my move to the Isle of Man in September 2006, I implemented the use of the Strengths and Difficulties Questionnaire as a preliminary screening tool for mental health referrals to specialist CAMHS, the Development and Well-Being Assessment as a structured validated assessment for common child psychiatric disorders, potentially extensible to primary care, and the 3Di as a standard, validated assessment for autism, on the Island. This contributed to shortening of waiting times, and an increase in the detection of comorbid diagnoses, as well as increasing the engagement of non-medical team members in the diagnostic process. I collected a case series of more than 300 DAWBAs, which might allow investigation of the impact of its routine use upon service activity and treatment effectiveness, by comparison with previous and parallel service activity data. I have also trained and supervised a nurse prescriber, who now runs a clinic for ADHD on the island, allowing replication and extension of my previous publication on this.

Extending Clinical Practice.

In 1989 I obtained formal training in Portage.

In 1990 I helped found GRASP, a charity whose purpose was to improve the social lives of young people with Asperger's Syndrome. It ran a social club for them, and other youngsters with difficulty in communication and socialisation, in Stafford.

In 1990 and 1991 I worked with Mr. Kevin Williams (Solicitor) to expose 'Pindown' in Staffordshire Social Services. This was a form of institutionalised child abuse in Staffordshire Children's Homes, where the victims (typically a teenaged child) were placed in solitary confinement for extended periods of time, sometimes extending to weeks. A particularly insidious aspect of the abuse was that it was introduced to the largely untrained staff within the homes as a form of milieu therapy, using psychotherapeutic language. Apart from undertaking the first psychiatric report on a 'Pindown' victim, my role involved me giving psychiatric advice on 'Pindown' both to Mr. Williams and to the subsequent inquiry (Levy & Kahane 1991). The results of this inquiry have been nationally adopted as part of the guidance for good practice in Children's Homes.

In 1992 I contributed to the development of the local ACPC guidelines for good practice in child protection.

In 1993 I, with Dr Farsides (then of the Department of Philosophy, Keele University), developed a philosophical basis for the ethical use of Covert Video Surveillance in Munchausen Syndrome by Proxy. This now informs local and national guidelines.

I was asked to prepare the Royal College advice to the BMA working group on consent in children, in 1997.

In 1997 I developed a sceening system for ADHD, employing questionnaires that markedly improved its detection in children with behaviour disorders attending my clinic. While the increase in detected cases was initially met with disbelief and hostility from my colleagues, UK diagnoses have now risen in line with my findings, and the use of questionnaires to support diagnosis of ADHD has been adopted as part of good practice guidelines issued by the National Institute of Clinical Excellence

I worked with Professor Robert Goodman, of the Institute of Psychiatry to develop computerised assessment techniques in Child and Adolescent Psychiatry in 1998-9. I have since been trained in two computerised interviews: the Development and Well-Being Assessment (DAWBA: a general tool for use in primary and secondary care), and the 3di (a structured assessment for autism and related disorders). I can train for both DAWBA administration and evaluation.

I obtained formal training in Webster-Stratton parent and child behaviour management programmes in 1999.

I have been frequently used as an expert witness in difficult cases, including instruction from the Official Solicitor before that office was devolved to the Children and Family Court Advice and Support Service (CAFCASS). I have provided opinions on contested Private Law cases, contested Care Orders which have reached the High Court, Wardship cases both before and after the introduction of the Children Act in 1991, determination of residency and contact when one parent has killed the other, evaluation of the likelihood of abuse following interview, risk assessment and psychiatric assessment of both abused and abusers, including assessment of harm for damages. I have been used by Local Authorities and Solicitors extending from Bristol, London, through the Midlands, to Lincolnshire and the Isle of Man. I have also been an invited lecturer to judges, solicitors and magistrates on Child and Adolescent Psychiatry. I have been asked to provide second opinions on videotapes of children interviewed for evidence of child sexual abuse. I have been asked to compare the performance of NHS and private adolescent units for West Midlands Regional Health Authority, as a trustworthy second opinion in the face of a hostile press campaign.

My work on Pindown, Munchausen Syndrome by Proxy, and ADHD has attracted Press attention. I have appeared on television, and discussed these issues on both local and national radio regarding the two former. Though I received adverse publicity from my challenge to the low detection rate of ADHD typical of the UK before 1999, my identification of a link between hyperactivity and parenting breakdown was featured, positively, in the Daily Telegraph and Children Now.

In East Berkshire, I initiated a CAMHS implementation and strategy group extending across Health, Education and Social Services, which provided the managerial infrastructure for the innovations and service developments I introduced. I organised and published an audit of clinic prevalence of hyperactivity across East Berkshire, planned and supervised an audit of hyperactivity control in our Methyl Phenidate follow-up clinic (now published) and also initiated & helped publish a multi-agency audit of CAMHS capacity, which has identified significant unused CAMHS capacity in primary care. In my role as CAMHS lead for IT there, I continued to develop the electronic assessment of patients in collaboration with Professor Goodman (making use of the Development and Well-Being Assessment DAWBA), and piloted the use of such assessments in primary care as part of a multi-agency Integrated Care Pathway in behaviour disorders. I piloted a nurse-led service for hyperactivity using modern assessment tools as part of the Integrated Care Pathway, and have planned, managed and funded a controlled audit of its effectiveness, which has been presented and published.

After arriving in the Isle of Man, I also acquired training in, and begun helping to establish the Childhood Experience of Care and Abuse (CECA), and the Attachment Style Interview (ASI), as additional assessments to develop an agreed multi-agency package of assessment and treatment between CAMHS, Educattion and Social Services. These tools were being brought to the Island by the St Christopher's charity, as a means of supporting care workers for Looked After Children. Following training, I collaborated in developing normative data for the CECA, and have helped introduce the Strengths and Difficulties Questionnaire as an additional diagnostic tool in St Christopher's programme. I have established the equivalence of doctors and nurses in the ADHD clinic for assessment and treatment

Following retirement from my clinical post, the government of the Isle of Man asked me to prepare plans for the development of all mental health services across the Island. This has been completed, and is now awaiting implementation: I have been requested to give oral evidence on it to Tynwald (the Manx Parliament) this June. This report highlights the importance of the mental health of 0-4 year olds in a public health context. The Child and Adolescent Faculty Executive of the Royal College of Psychiatrists asked me to review the current state of services for 0-4 year old children in England: I have identified significant withdrawal by English Child Psychiatrists from the assessment and treatment of this group of children. I have also significantly contributed to evidence submitted to the UK parliament relating to this group of children, including aspects of their epidemiology, assessment needs, treatments, economic implications, and the importance of this age-range in the prevention of the long-term effects of abuse and neglect.

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

Children's social services

Oral evidence on 29th June 2015

Topics for discussion

We concluded in our Report that in 2012 the number of children in the Isle of Man in need of protection was about the same as the English average on a per capita basis, but the numbers of referrals, assessments and inquiries were proportionately higher. We went on to conclude that since 2012 there had been an increase in the number of instances where an agency approaches Children and Families Services in a case where an assessment is not needed.

[1.] Do you share our assessment of the published figures for the Isle of Man?

[2.] How much do referral rates vary between different local authority areas in the UK? Should we regard the UK average rate as a target for the Isle of Man?

[3.] Many of our teachers, police and social workers come to us from England. Our child protection guidance is based on English models. What reasons could there be for our rate of needless referrals being higher than the English average?

We concluded in our Report that over-referral is a serious issue because of its direct adverse impact on families needlessly subject to the attention of social services, its indirect impact on children in need and at risk of harm, and its cost to the taxpayer.

[4.] What is your view of the impact of needless referrals on families who are needlessly investigated, including any impact on the health of the families concerned? Please would you illustrate this from your experience.

[5.] Do you think that the impact of a needless referral on a family is likely to be worse in a small community where we live in a goldfish bowl and everyone knows – or expects to know – everyone else's business?

[6.] What is your view of the impact of needless referrals on professionals whose caseload is thereby inflated? Does it result in genuine cases being missed, like needles in a haystack? Please would you illustrate this from your experience.

[7.] We understand that England has moved on from the "Every Child Matters" agenda. Have things improved or are cases still being missed?

[8.] What is the latest position in Scotland?

We recommended in our Report that, in our inter-agency child protection procedures, greater prominence should be given to the importance of concerns being dealt with where possible by the agency of first instance and only referred to social services where necessary.

[9.] Do you share our concerns about the prominence of “If in doubt refer” in our procedures? Do the equivalent documents in the UK use this form of words?

[10.] How can we help people working in “agencies of first instance” to know when to refer a case to social services, and when not to?

[11.] Can this issue be addressed by inter-agency procedural guidance alone? If not, what more do we need?

[12.] The Isle of Man has the ability to make its own legislation. Can we turn this to our advantage in the area of child protection by coming up with our own legislative solutions, or would we be better to continue following UK (specifically, English) models?

[13.] Would a ‘false reporting’ offence like they have in Ireland help? Has any consideration been given to creating such an offence the UK? What are the pros and cons?

[14.] How much difference would it make if we had a better complaints process?

Appendix 4: Email dated 25th May 2016 from Deborah Brayshaw, Chief Social Worker, Children and Families Division

From: Brayshaw, Deborah
Sent: 25 May 2016 17:40:04
To: Jonathan King
Cc: Couch, Malcolm
Subject: RE: Children and Families initial and core assessments

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Dear Jonathan

My apologies for the delay in providing the attached information, but the table is now complete. It has been completed with the **finalised** figures for Initial and Core Assessments for the last 3 years. You will note that I have adjusted the figure for Referrals for the year 2014/15 provided at Social Affairs Policy Review Committee on 13 April 2016 (highlighted in red). The difference (only 3 more) is accounted for by an error made when the report was run for our attendance at SAPRC. The report parameters inadvertently excluded one 'department' on our system, this has been corrected so the figure of 910 tallies with that within our Annual Report. Please accept our apologies for that error.

With regards to comparison to figures provided in response to Tynwald Questions you will note that the figure provided for Written Answer in October 2015 covered the period 01/08/2014 – 31/7/2015 and the figures within the table are 1 April 2014 – 31 March 2015 therefore the time frames covered are different.

The figures for 2013/14 (2201 and 1414 respectively for Contacts and Referrals) differ slightly from that provided in October 2014 to Tynwald when providing the data for the reporting period 01/04/2013 – 31/03/2014 which were 2198 (3 less than provided to SAPRC) and 1385 (29 less than provided to SAPRC). We have changed our reporting regime in that we now run a **finalised** 'year-end' total directly from the electronic case management system, whereas, in 2014 a monthly spreadsheet was maintained and the information produced by tallying up the monthly totals. Running the year-end report on the system now, as we did for the SAPRC data, produces slightly different result from that provided from the monthly spreadsheets as it accounts for anything outstanding that had been completed within the whole time frame. This method is the more accurate one.

I hope this information is sufficient for the Committee but please revert if there are any further points of clarity required.

Thanks you

Debbie Brayshaw
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Children and Families

Source: oral evidence to SAPRC 13th April 2016, QQ24-26

Total Received/Completed	2013/14	2014/15	2015/16
Contacts	2,201	1,590	1,638
Referrals	1,414	910 (was incorrectly 907)	986
Initial Assessments	646	627	794
Core assessments	366	478	591

From: Jonathan King
Sent: 04 May 2016 12:21
To: Brayshaw, Deborah
Subject: Children and Families initial and core assessments

Dear Deborah

In your oral evidence to the Social Affairs Policy Review Committee last month you provided up-to-date figures for contacts and referrals in the last three years (see attached). The Committee will wish to compare these with the figures which have been given in answer to Tynwald Questions in recent years.

Please would you be able to provide the Committee with figures for the last three years on initial assessments and core assessments, i.e. to fill in the blanks in the attached table? Thank you.

Jonathan

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