



Response to the DfES Consultation Paper:

“Care Matters: Transforming the lives of children & young people in care

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Introduction

The National Society for the Prevention of Cruelty to Children (NSPCC) is the UK's leading charity specialising in child protection and the prevention of cruelty to children. The NSPCC aims to end cruelty to children by seeking to influence legislation, policy, practice, attitudes and behaviours for the benefit of children and young people. This is achieved through a combination of service provision, lobbying, campaigning and public education.

The NSPCC believes that, given the will, most cruelty can be prevented. In order to achieve this, it is vital that all children, whatever their needs, have a range of services that are flexible and offer them support and protection. The NSPCC has more than 180 services in the UK and the Channel Islands. These services aim to:

- Prevent children being abused by working with parents and carers in vulnerable families to improve their knowledge and skills in safeguarding, and giving children and young people someone to turn to through ChildLine and our There4me.com online service.
- Protect vulnerable children and young people from abuse by providing direct services in a number of settings, including schools and young people's centres. We also protect them by providing Listening Services for adults to ensure they have someone to turn to with their concerns; by ensuring that abused children and young people are identified and effective action is taken to protect them, and by working with young people and adults who pose a risk to children and young people to reduce the risk of abuse.
- Help children and young people who have been abused overcome the effects of abuse and achieve their potential.

We set out below a summary of our key observations, together with further comments on a chapter-by-chapter basis. There are some issues on which we have chosen to comment that do not sit within the context of the set questions. This commentary follows our response to the consultation questions at page 21. Where the NSPCC does not explicitly comment on particular issues it may be taken that we do not consider that we have sufficient expertise in these areas to respond authoritatively.

SUMMARY

The NSPCC welcomes the publication of the Green Paper and the commitment of government to the care and well-being of children in care. We support the principle of shifting the balance between care and prevention and believe the aspirations of this paper can be fulfilled, but not without significant additional investment. Further, our experience indicates that there will always be a need for a state co-ordinated care system. If re-investing resources from that system into *'front end'* preventive work is to be achieved in a safe and sustainable manner, *'bridging'* funding must be found to support the shift.

63% of children and young people entering care do so for reasons of abuse or neglect. Our comments on this consultation document are based on our broad expertise in safeguarding children and promoting their welfare. This response has been particularly informed by our practice experience in the provision of a range of therapeutic interventions for abused children. We have also made extensive use of our experience in the provision of independent advocacy services and the co-ordination of independent visitor services. In addition, we have spoken to children and young people in care who currently use the services of the NSPCC; practitioners delivering those services and foster carers. Some of their testimonies appear below, and a detailed account of their thoughts and experiences can be found at Appendix 1: Supplementary Evidence, accompanying this response.

Therapeutic Services

As long ago as 1997, Sir William Utting (Department of Health, 1997) stated that *'Provision [of treatment for abused children] ... seems to depend upon haphazard awareness of need coinciding with the availability of scarce services. Abused children should in the eyes of the Review attract high priority for treatment from public funds.'* In 2004, Marian Stuart *et al* (Joseph Rowntree Foundation, 2004) found that *'Help and treatment for abused children is still inadequate. In particular, major improvements in the accessibility and quality of Children [sic] and Adolescent Mental Health Services (CAMHS) are needed.* Whilst Barnes, Wistow *et al* reveal a picture of improved but still patchy provision of CAMHS services (Department of Health & University of Durham, 2005).

Our experience is that CAMH services rarely work over the longer term with children who have been abused. Despite the acknowledged increase in CAMHS funding, resources at all tiers of provision remain stretched, and the associated thresholds for assessment too high. Children in the care system do not, typically, receive access to therapeutic help from CAMHS unless they are diagnosed with a mental health disorder. This is not necessarily an appropriate measurement when assessing a child's need for therapeutic support.

CASE STUDY

“He destroys everything in his sight. He self-harms, doesn’t sleep, doesn’t get on with other members of the family, isolates himself, needs 24 hours of supervision, he pulls his hair out, pulls his finger nails off .. CAMHS won’t work with him as he is not in a permanent placement. They see him to monitor his medication but do no one-to-one work ...”¹

Outcomes for children who have experienced abuse, whether inside or outside of the care system are consistently lower than for their peers. Children who have experienced abuse in very early childhood are known to perform less well and to complete their school careers earlier. The very manner of the assessment of success through the attainment of GCSEs is narrow and excluding and can, in many cases, contribute to a young person’s sense of failure.

CASE STUDY

“... I did my GCSEs but didn’t get the grades I would hope for. Maths wanted a C but I got an F instead, a bit disappointing, must admit I put my hopes a bit too high. RE F; Geography D; English F; History U; Science E or F ... I had friends who told me off and had a go at me then we would make up. It was a horrid bit.”²

Heath *et al* (1994) found that children taken into care who had experienced abuse or neglect were less likely to recover from their experiences than children in care for other reasons. “...even those foster children in long-term, settled placements in middle class environments fail to ‘escape from disadvantage’ a history of child abuse or neglect appears to have lasting effects. [t]he implication is that exceptional educational inputs are required.” The consultation paper is silent on the role of therapeutic interventions in enabling children and young people in care to achieve and develop - a surprising omission in light of the acknowledged fact (p.113) that 63% of children enter care as a result of abuse or neglect.

¹ Transcript of part of an interview with a foster carer, with foster children using NSPCC services. January 2007

² Transcript of part of an interview with a NSPCC service user who is a young person in care. January 2007

CASE STUDY

“The emphasis is on education – but without mental health issues they won’t get that far. The ‘Life Outside School’ chapter? It all revolves around school!”

“Ideally you need a good assessment when a child first enters care to see their needs and engage in early intervention. This can be more effective than the work you do with older children and young people.”

“Substance misuse, violent relationships, teen pregnancy ... they’re all related to mental health ... feelings of self worth, lack of work with attachment and trauma ...”³

We believe this paper presents an unmatched opportunity for the Department for Education & Skills (DfES) in conjunction with the Department of Health (DH) to present their combined and funded expectations of both commissioners and providers, and that this paper does not currently do so.

Advocacy and the Independent Visitor Service

The United Nations Convention on the Rights of the Child (UNCRC) 1989, states at Article 12 that ‘... *the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly or through a representative or an appropriate body ...*’. We, therefore, welcome the proposal to reinvigorate the roles of independent visitor and independent advocate. *However*, the NSPCC has significant experience of acting in the role of independent advocate for children in care, and in co-ordinating independent visitors, and we wish to state in the strongest possible terms that the roles are not ones that could or should be merged.

Furthermore, children and young people in care must have direct access i.e. access without recourse to an intermediary, to the services of an independent advocate.

³

Transcripts taken from an interview with a consultant clinical psychologist working in a NSPCC Support Service. January 2007

CASE STUDY

“... we were doing complaints to get me contacts with my sisters because it would have been two years before I could get any contact. She (NSPCC advocate) put my points across and she helped fight with a lot of other stuff too. ... Even if people didn’t like it, she represented me ... whatever you say they will just do it, advise you, which I think is really good.”⁴

Finally, the independence of both roles must be rigorously guarded. We are aware of advocacy services that are provided ‘in-house’ by some Local Authorities. We believe that all advocacy should be externally commissioned and provided by a body with appropriate expertise, that is independent of the authority responsible for providing a child’s care.

CASE STUDY

This young person’s social worker put her in contact with an independent advocacy service:

If young children or teenagers can see something is going wrong ... they can get in touch with Voice for the Child in Care and they will come out and speak to them. If they want that happening – go for it. I can tell you it’s really helpful ‘cos it gets the weight off your mind. So, if you find there’s a problem with social services, or any problems – foster carers even – you can get in touch with them.⁵

⁴ Transcript of part of an interview with a NSPCC service user, who is a young person in care. January 2007

⁵ Transcript of part of an interview with a NSPCC service user, who is a young person in care. January 2007

Response to the Consultation Questions

(1) Chapter 1 – The Need for Reform

Are the elements we suggest for our ‘pledge’ the right ones?

In broad terms the NSPCC supports the model pledge and thinks that it covers some of the correct issues. Our comments are concerned with (a) issues of clarification and (b) omissions.

1.1 Clarification

It is not clear from the document whether a pledge for children in care is to be a generic national template, or something to be developed at local level.

1.1.1 **The NSPCC recommends that for pledges to be relevant, consistent and appropriate a national template should be developed, that includes scope for additional locally identified elements**, thereby enabling Children’s Services Authorities and associated partners to reflect local needs as identified by Local Strategic Partnerships (LSPs) and included in Local Area Agreements (LAAs).

1.1.2 In this context **we recommend that the revised and condensed Performance Assessment Framework (PAF), currently forming part of the consultation process for local government reform, should maintain a broad ‘basket’ of performance indicators (and associated sub-indicators) of direct relevance to the health and well-being of children and young people, and that at least one ‘stretch’ indicator should reflect the locally identified needs of children and young people in care.** It would be helpful for the revised PAF indicators to be developed alongside the Department of Health’s Commissioning Framework.

1.1.3 **We recommend the engagement of children and young people in care in developing pledges, and that this engagement should be representative of black and minority ethnic (BME) children and young people, the disabled and diverse faith groups within the given community.**

1.1.4 Finally, **we recommend that pledges must be ‘living’ documents, subject to regular review (at stated intervals), in order to reflect the diverse needs of a changing population.**

1.2 Omissions

1.2.1 In view of the acknowledged ‘.. *high incidence of mental health problems in the care population ...*’ (1.30) it is disappointing to note that the model pledge does not include appropriate, timely and sustained access to therapeutic services. This is a vital element of preventive and supportive services to children who have often been severely damaged by their pre-care experiences. **We recommend**

that the model pledge be amended to include a commitment to access to therapeutic services for all abused children, including children in care.

- 1.2.2 We note the absence of a pledge for carers and/or residential workers, and **recommend that an appropriate commitment towards support and training should form part of the generic national template.**
- 1.2.3 Whilst education is a dominant theme in the paper, this is not reflected within the model pledge. **We recommend the inclusion of a pledge that measures attainment.** This should not be an absolute measurement, but based on the principle of *'value added'*, thereby enabling the very different circumstances and experiences of children and young people entering and leaving care to be reflected.

(2) Chapter 2 - Children on the edge of care

- 2.1 We are concerned at the lack of attention to very vulnerable groups of children: runaways; unaccompanied minors and young offenders are disproportionately represented in the cared-for community. Further, children and young people are particularly vulnerable to sexual exploitation whilst in care, from external influences and/or by sexually harming children and young people themselves.
- 2.2 We welcome, in principle, the proposed establishment of a National Centre for Excellence in Children's & Family Services, but strongly recommend that this should exist alongside and not replace the Social Care Institute for Excellence and the Centre for Excellence in Residential Child Care. We believe, if it were to replace these bodies, it could have the effect of diluting focus on specialist child and residential care services.

Q. What more can be done to reassert the responsibility of parents and help them to fulfil those responsibilities?

- 2.3 There will always be a need for a well-functioning, adequately funded care system to look after those children who cannot be cared for by their family. Nevertheless, the NSPCC wholly endorses the principle of working towards an increase in the number of children supported in families. We are, however, conscious of long-standing resource issues which have (a) failed to provide children in need with support beyond the context of universal services, and have (b) as a result too often left children inappropriately in an abusive family environment. We believe additional investment is required to extend the support presently available for vulnerable children, and that this will not only reassert the responsibility of parents but will also go some way towards helping them to fulfil those responsibilities.

2.4 The NSPCC welcomes the demonstration pilots that have been set up to test a model of intensive parenting support delivered via health visitors and community midwives. We are, however, concerned that current pressures within the health service may result in insufficient resources (both fiscal and human) to deliver a robust and consistent model across England and Wales.

2.5 The NSPCC also welcomes the renewed emphasis on parenting support, as outlined in the RESPECT Action Plan (The Home Office). We do not, however, agree that the proposed sanctions outlined in the Action Plan are appropriate, and would suggest that the introduction of housing benefit sanctions, combined with the ultimate power of eviction has the potential to result in children being inappropriately subject to care proceedings. This does not seem consistent with the aims of the consultation paper.

Q. What more could be done to support links between adult's and children's services particularly in relation to substance misuse and mental health support?

2.6 We welcome the acknowledgement that links between children's and adults' services need to be improved. **We recommend that all children and young people who are cared for by adults with a known mental health condition and/or substance or alcohol misuse issues be automatically assessed according to the multi-agency Common Assessment Framework (CAF).**

2.7 We recognise that this may present medical and nursing professionals with potentially conflicting legislation, and we therefore further **recommend that consideration should be given to the provision of guidance for medical and nursing professionals about the circumstances and process for sharing otherwise confidential information.**

2.8 We welcome the government's recognition of the '*... very high incidence of parental mental health problems in the families of children at risk of coming into care.*' together with acknowledgement of the need for the '*... commissioning strategies of adult social care services and Primary Care Trusts [to] respond to the needs of vulnerable parents.*' However, it is far from clear how such a response might be adequately framed or funded. We are concerned that without adequate *protected* funding to support these proposals they are unlikely to result in purposeful practice.

Q. What more could be done to support family and friends' carers?

2.9 The NSPCC believes it is right and proper that all possible care options should be explored before a child is taken into care, and we broadly welcome proposals to expand the family group conferencing model. We also believe that family and friends' carers would be encouraged to come forward if (a) their entitlement to financial support was a clear and unequivocal right and (b) where necessary, due consideration were given to issues around potential aggression or violence from birth parents or other family members. In our experience it is not unusual for family and friends' carers to be confronted with such behaviour. This is damaging, not only to the children but also to carer(s), who, having made themselves vulnerable in the best interests of the child, are too often not well supported in their efforts. **We recommend that rigorous risk assessment is undertaken wherever family or friends' carers come forward (or are sought), that includes a risk analysis and an agreed procedure for multi agency responses where and when appropriate.**

(3) Chapter 3 – The role of the corporate parent

Q. Would a social care practice model help give social workers more freedom to support children?

3.1 The NSPCC believes there is much to be welcomed in the development of social care practices, including the empowerment of social workers through independence; scope for the development of specialist teams and the potential for the development of multi-disciplinary teams. We are, however, mindful of the possible unintended consequences of such a model, which might include:

3.1.1 A further loss of able and experienced social workers from local authorities;

3.1.2 The potential for practices to retain unused funds as '*profit*', with the possible associated consequences of inappropriate rehabilitation or placement for adoption;

3.1.3 The problems associated with maintaining consistent assessment thresholds both between teams and across boundaries.

3.1.4 If they are introduced, we recommend that the multi-agency dimension of social care practices is ensured through legislation.

Q. Should the independent visitor role be revitalised and renamed as Independent Advocate to introduce advocacy as a key element of the role?

3.2 Our practice professionals have told us *unequivocally* that **these roles must remain separate and distinct** for the following reasons:

3.2.1 Advocacy is a formal professional role for which individuals are trained and for which a particular expert knowledge is required.

3.2.2 The services of an advocate are likely to be required episodically, as they will work with and represent a child on particular issues. An advocate's role is to present the child's view (whether or not it is one which they endorse), regardless of the challenge it may represent to the corporate parent.

3.2.3 The independent visitor is neither a formal nor a professional role, and these are the qualities for which it is valued. The role is essentially to act as a consistent and supportive presence in a child's life and in particular throughout their time in care.

3.2.4 Independent visitors are primarily a friend for the child in care. In this capacity they may find themselves *advising* the child. This may involve a rudimentary level of advocacy but, importantly, this is not a formal element of the role. Many able independent visitors would not wish to extend the scope of their task and will be lost to children in care if expected to do so. Furthermore, research indicates that children and young people value '*...the fact that independent visitors [are] unpaid volunteers who [make] time to be with them*' (NSPCC, 2000 pp 64). Extending the scope of the role is likely, then, to compromise its primary purpose. That the demand for independent visitors is ill-matched by an adequate supply is neither a reason nor a recommendation for subsuming this service into the role of advocate. On the contrary, we would suggest there is a pressing need to examine how independent visitor services can be enhanced and expanded.

3.2.5 Advocacy services must be available to all children in care *without* recourse to their corporate parent or other statutory service. This is consistent with Article 12 of the UN Convention on the Rights of the Child. Most children and young people will have access to formal and informal advice and support, either through their parents, who will strive to represent their best interests, or through relationships with trusted others in whom they can confide confidentially. Children in care may not have access to similar formal or informal networks. All children in care must, therefore, be made aware of their right to advocacy. They must not be expected to justify or explain their reasons for seeking independent advocacy as this is likely to discourage them from accessing the service. The independent visitor may prove invaluable in obtaining such services for a child without recourse to statutory channels.

- 3.2.6 In the absence of a universally available independent visitor resource, a dedicated Listening Service with linked 'sign-posting' channels, should be available and drawn to the attention of children and young people when they enter care.

3.3 Listening Services

- 3.3.1 *The Line* was established in 1999 by *ChildLine*, as a dedicated listening service for young people living away from home. It is offered as a separate number from the core service as the volume of calls to *ChildLine*'s generic service made it problematic for these particularly vulnerable children and young people to speak to a counsellor. The purpose of *The Line* is to offer the opportunity to children and young people in care to speak confidentially about their problems. It offers ongoing supportive contact wherever possible, with the intention of providing some continuity for children and young people living in unstable and unpredictable circumstances, and particularly those experiencing multiple changes of placement. Callers receive an average of five counselling sessions, though their number is not limited.

CASE STUDY

Julie is 15 years old. She came into the care system because her mum takes drugs and her step dad would physically abuse her. She regularly runs away from her current home. 'I have problems with the staff, they make me angry and I lash out and kick out'. She has trouble coping with her anger and feels no one understands. She has been put on behaviour reports at school. 'They never listen to me or believe what I'm saying. I often lose it and bang my head against the wall'. Sometimes she goes to her mother's home even though she has been banned from visiting. She has a history of self-harming, drinking alcohol and smoking cannabis. 'I've thought about throwing myself under a car or off a bridge. Cutting makes me feel better ... I just want to be normal.'

- 3.3.2 Volunteers receive extra training to enable them to deal confidently with the kinds of issues likely to be raised in these calls. Although *The Line* is still available, in recent years it has been less well publicised and as a result, less well used, largely due to lack of sufficient funds. Calls from children and young people in care are now, typically, handled at the *ChildLine* call centres.

CASE STUDY

Alex is 13 years old. He has been in the care system for 10 years. He recently moved from his previous foster home where he was based for the last four months. He like it there and is distressed that he was made to leave. 'It's like I'm torn and trapped.' He gets bullied in the care home. 'People are being horrible. They call me names, chase me and throw things at me.' The staff in the children's home upset him after telling his teachers personal things about him. 'No-one has a right to tell anyone. I don't want to go back to school now.' He feels isolated and wants to live with a family that will care for and love him. 'I've been dumped here and forgotten about. Sometimes I just want to end it all.'

- 3.3.3 In 2005-2006 *ChildLine* counselled 1046 children about their experiences of the care system. A further 1675 children who were counselled about other things went on to talk about being in care, either currently or in the past. The issues of concern to these children include: bullying; maltreatment and disregard of diversity whilst in care; mental health problems such as suicidal feelings; post-traumatic stress following abuse; eating disorders and self-harm; sexual exploitation through prostitution; pregnancy and sexual health; bullying, home-sickness and drug abuse in educational boarding establishments. Ten per cent of the 1936 children who called *ChildLine* about running away were in care.
- 3.3.4 We do not know how many other children in care may have sought help from *ChildLine* but were unable to get through or did not reveal their domestic circumstances.
- 3.3.5 **The NSPCC recommends that government should fund a dedicated listening service that forms part of the statutory provision of services for children and young people in care, and that the availability of such a service should be actively brought to the attention of children and young people when they enter care.** Listening services should be easy to access, have the capacity to provide sustained and confidential counselling services where appropriate, and offer developed expertise in the problems and issues confronting children and young people in care. Listening services should be able to make direct referrals to independent advocates where appropriate and when consent is given.

(4) Chapter 4 – Ensuring children are in the right placements

- 4.1 We agree that a successful placement is the most important factor in enabling children in care to flourish. Loving care, continuity and stability are essential factors to any child's well-being, and more so to a child who has felt their want and may in addition, have suffered further abuse.
- 4.2 However, we believe the proposals in this chapter are not under-pinned by a practice-based understanding of the barriers to successful, sustainable placements and therefore a clear understanding of how these might be overcome, for example:
- 4.2.1 The level of damage a child or young person is likely to have sustained when entering care is not reflected;
- 4.2.2 Children entering care are not on a 'level playing-field'. Current outcome measurements are too orthodox, too blunt and too narrow, for example the focus on GCSEs as a measure of educational attainment. A more complex measurement, of a more diverse range of functions should be developed (the *value added* element mentioned above). Thus, the success of care placements could be more appropriately assessed on a range of issues reflecting a child's *progress* as well as final outcomes in social as well as educational attainments.

Q. Should a tiered approach to fostering be developed? If so, should this be underpinned by a formal qualifications framework?

- 4.3 We welcome the government's commitment to increasing placement choice. It is essential that the status, support and pay of carers are increased. A national tiered model of placement types, with an associated qualifications framework, is to be welcomed, and is already operated in some local authorities. However, introducing a tiered system of care could have unintended negative consequences. A system would, therefore, need to be developed that:
- 4.3.1 Retains a care model which values experience *as an suitable alternative* to academic qualifications;
- 4.3.2 Does not stigmatise and/or label children who are in particular care-tiers, as a Tier 1, 2 or 3 child;
- 4.3.3 Does not move a child inappropriately from a successful placement because of positive progress; either because of non-availability of particular tiers of care or because of costs.

- 4.4 The paper also needs to address the issue of retention as well as recruitment; of support as well as training of foster carers. The proposed tiered system is likely to go some way to addressing this. However these issues, in particular retention, need to be given a greater focus.
- 4.5 In some cases independent agencies have set a good example of the way to run a service which increases the number of carers. There are, however, difficulties associated with a mixed economy of care. For example, a child placed with relatively expensive independent carers due to lack of a local authority placement, may be moved to a local authority placement when one becomes available for purely financial reasons (Sergeant, 2006, pp 18-19). In addition there is anecdotal evidence that independent agencies may be less willing to challenge their carers where this is necessary and appropriate in relation to the care they are providing.
- 4.6 Traditionally, recruitment by local authorities has been based on local campaigns, with little communication of good practice nationally or even regionally. **We recommend that an ongoing, centrally funded national fostering campaign is developed, with which local authorities can engage in such a way as to reflect local and/or demographic needs.**
- 4.7 Including foster carers in the *Homebuy* scheme is a good and practical suggestion but wholly inadequate as the sole mechanism for encouraging foster carers to come forward.
- 4.8 Retention is as important as recruitment. Many dedicated local authority foster carers are lost to the independent sector where they often receive higher levels of support for themselves and for the children for whom they care. This, together with a level of payment that recognises their skill and expertise, is a crucial element in retaining foster carers.
- 4.9 Multi agency support is also crucial, for children and carers alike. In addition to higher rates of pay, the better independent fostering agencies provide their own play therapists, consultant psychologists etc., as well as a high degree of direct support. It is essential that CAMHS services are available and that these are centred on and able to follow the child. We do not, for example, believe it is fair or appropriate for a child or young person to lose their place on a CAMHS (or indeed any other service) waiting list because they move across administrative boundaries, and a child in care is particularly vulnerable to this circumstance.
- Q. How can we increase placement choice without increasing financial burdens on the system?**
- 4.10 **The NSPCC does not believe this is possible. However, we regard this expenditure as an *investment* in one of the most vulnerable groups in society rather than a *burden* on the system.**

(5) Chapter 5 – A First Class Education

- 5.1 The NSPCC broadly welcomes the content of this chapter, and in particular a new power for local authorities to direct schools to admit children in care. However, these powers should include Academies and Trust schools which are neither implicitly nor explicitly included at present.
- 5.2 We have some concerns about the proposed use of boarding provision for children in care, particularly in the contexts of: stigma; vulnerability to institutional abuse; educational stability in relation to on-going funding; and out-of-school care. The current pilots will no doubt go some way to responding to these concerns, but we would wish to register our interest in any further consultation that may take place around this specific issue.
- 5.3 The function and purpose of Personal Education Plans (PEPs) needs to be clarified and re-invigorated. Our experiences with children in the care system indicate that too often children neither know *what* a PEP is, nor that they *have* a PEP and they are rarely involved in or consulted over their PEP reviews.
- Q. How might the role of the Designated Teacher for children in care be strengthened further?**
- 5.4 The NSPCC is aware that the role of Designated Teacher (DT) is not always welcomed. Anecdotal reports tell us that children in care feel it *'identifies'* them as being in some way *'other'*. There is a need for DTs to be sensitive to the stigma of being in care, whether this is actual or perceived. This is an issue which should be addressed by provision of and access to multi-agency training.
- 5.5 There also needs to be absolute clarity around the roles of the Designated Teacher for child protection and the Designated Teacher for children in care. These designated roles are quite different, in terms of both the issues and the framework with which the different DTs must be familiar, and there are separate training requirements for each of the roles. Self-evidently the needs of a small village primary school will be significantly different to those of a large inner-city comprehensive. There may be instances where one teacher can occupy a dual role, but as a general principle **we would recommend that the roles are filled by separate individuals.** Explicit guidance pertaining to the role of the DT for children in care and relating to the size and nature of the establishment should be considered.
- 5.6 The Designated Teacher role is typically undertaken by an individual with a particular interest in safeguarding over and above his/her pedagogic function. Too often it is a role shunned by senior staff, and its difficult and sensitive nature is not wholly appreciated by governors.

5.7 **We recommend that consideration be given to:**

5.7.1 **Placing head teachers under a statutory duty to release DTs for a minimum of one (1) day's training or eight (8) hours each academic year;**

5.7.2 **How this statutory duty might be extended to private sector providers;**

5.7.3 **Developing an accredited training package, which DTs are obliged to attend, comprising an initial 'foundation' module(s) with additional incremental modules;**

5.7.4 **The provision of an annual fiscal increment to teachers undertaking the role of DT.**

Q. How would a 'virtual headteacher' best raise standards for children in care?

5.8 We welcome the principle of the 'virtual head teacher' and in particular the suggestion that they will act as key links for the dissemination of good practice, the provision of professional leadership for DTs and as champions for driving performance. We look forward to the opportunity of commenting on the outcomes of the pilot schemes. Consideration should be given to the ways in which 'virtual head teachers' might link with Local Safeguarding Children Boards, for example through Training Sub-Committees, where there would be value in sharing their learning and experience, particularly of good practice in schools.

Q. What more can be done to reinforce the educational role of the carer?

5.9 We wish to register our concerns at the phrasing of this question. In asking what more can be done to reinforce the *educational* role of the carer, the paper is perilously close to valuing education in terms of scholarship alone. We believe carers have a pedagogic role, which, when matching is successful, is of wider and greater value than solely academic achievement, whilst being a prime motivator in its attainment.

5.10 We refer to our response at paragraph 4.2.2, which for ease we reproduce here:

Children entering care are not on a 'level playing-field'. Current outcome measurements are too orthodox, too blunt and too narrow, for example the focus on GCSEs as a measure of educational attainment. A more complex measurement, of a more diverse range of functions should be developed (the *value added* element mentioned above). Thus, the success of care placements could be more appropriately assessed on a range of issues reflecting a child's *progress* as well as final outcomes in social as well as educational attainments.

(6) Chapter 6 – Life Outside School

6.1 In principle there is much to be welcomed in this chapter. Notwithstanding, we have significant concerns.

Q. Have we set out the right features in the comprehensive model of healthcare for children in care?

6.2 Yes, the features in the comprehensive model of healthcare are correct, *however*, we must express the gravest concerns about this model being comprehensively implemented. We make the following comments:

6.2.1 We are surprised that the paper has not embraced the *Every Child Matters* programme – where *'be healthy'* heads the five outcomes.

6.2.2 In view of the well documented fiscal challenges facing the Department of Health, we have no confidence that guidance from the Department for Skills & Education (DfES) will be embraced by the Department of Health (DH) without clear and *protected* funding to meet associated costs.

6.2.3 We are disappointed at the lack of emphasis placed on health, and particularly mental health issues, despite early acknowledgement (1.30) in the paper that *'63% of children in care are there as a result of abuse or neglect, [and] it is likely that the high incidence of mental health problems in the care population, and the high frequency of placement breakdown, is in many cases a result of pre-care experiences.'*

6.2.4 The physical and mental well-being of children in care is a fundamental feature of successful outcomes. Without self-esteem, confidence and the appropriate coping mechanisms to help children overcome their pre-care experiences positive results for some of our most damaged children will continue to be compromised.

6.2.5 Overall this chapter offers very little by way of acknowledgement of the need for therapeutic interventions to deal with a child's experiences before entering care, or instances of being abused whilst in care. Although there is a focus on the over representation of care leavers in socially excluded groups there is no acknowledgement of other symptomatic responses characterised by, for example: post traumatic stress disorder; self-harm and suicide; substance abuse; eating disorders; mental health problems; poor concentration or nightmares. There is, in addition, no reference to the particular vulnerabilities and needs of the disabled child, despite the fact that disabled children are at greater risk of abuse.

6.2.6 In recognising the greater and more complex needs of the child in care (6.2), the paper focuses solely on the physical health of the individual and/or the need to address the higher incidence of teenage pregnancy in this group of young women. There is no reference to emotional health and well-being, nor to the impact of abuse and neglect and the extent to which

this might be ameliorated by the provision of timely, and where necessary, sustained therapeutic support.

- 6.2.7 The acknowledgement that *'[C]hildren also need help to avoid the risk of damaging behaviour, which can result from their experiences before or after entering care ...'* (6.5) is confined to the context of substance abuse and/or criminal behaviour.
- 6.2.8 Whilst we agree that access to leisure and recreation activities (6.7) is valuable, it is unlikely on its own to make a significant contribution to the improvement of mental and emotional health. In short, we do not believe that a child or young person will be empowered to enjoy or achieve unless their mental and emotional needs have been appropriately assessed and responded to. Currently, this may not be at a level that attracts the support of CAMH services, thereby leaving children who might benefit from some form of therapeutic support with needs that are frequently unmet.
- 6.2.9 We welcome reference at paragraph 6.18 to the *'... particularly acute mental health problems and emotional and behavioural difficulties'* typically experienced by children entering the care system. However, paragraphs 6.19-6.20 refer to an extensive set of guidance including the Department of Health's *Promoting the Health of Looked After Children (2002)* and *The National Service Framework for Children, Young People & Maternity Services*, whilst remaining vague about the services that are needed and will be provided for children in the care system.
- 6.2.10 Furthermore, little or no reference is made to children and young people who have experienced sexual abuse. "The majority of children who have been sexually abused do not have a psychiatric condition, but they do need help in making sense of what has happened to them." (Palmer, 2005), yet without a psychiatric diagnosis children are unlikely to receive support from CAMH Services.
- 6.2.11 **In line with the Improvement & Development Agency (I&DeA) Local Area Agreement (LAA) Toolkit and in the absence of robust CAMHS performance indicators, we recommend that agencies in partnership are required to develop 'stretch' targets, that measure the *impact* of service improvements, at least one of which should report on CAMHS-based therapeutic support for children in the care system.**
- 6.2.12 We wholly support the principle of each child in care having a named health professional to ensure their needs are being met, but we are not clear what role and purpose the named health professional might fulfil which is not currently fulfilled by the co-ordinator (DoH, 2002, paragraph 8.5). We have some concerns that the proposed number of professionals with particular responsibilities may lead to confusion. In particular, we are unclear of the relationship between the named health professional, the named or designated doctor/nurse and the developing role of lead professional.

- 6.2.13 We are unclear as to the status and process of the basic annual health assessment referred to at 6.2, including dental check-ups. *'Feedback from young people confirms that they find the current system unhelpful. A health care system based on annual "medical" is seen as stigmatising and impersonal – and without recognisable outcomes for them.'* (Department of Health, 2002). Nothing that we have subsequently heard from children and young people themselves disabuses us of this view, nor are we clear from the paper how this might change.
- 6.2.14 We are concerned at the proposed introduction of routine screening for substance abuse. Screening, by its nature, is unlikely to promote a supportive or trusting relationship between a child and corporate parent, and is inconsistent with the United Nations Convention on the Rights of the Child (UNCRC, 1989) which states at Article 16.1 *'No child shall be subjected to arbitrary or unlawful interference with his or her privacy ...'*.
- 6.2.15 Finally, the NSPCC's recent response to the *Call for Evidence: DfES/HM Treasury Joint Policy Review on Children and Young People* (September 2006) is also apposite. A copy of this paper can be made available on request, and we would draw particular attention to content at pages 16-18 concerning the need for therapeutic services for maltreated children.

(7) Chapter 7 – The Transition to Adult Life

Q. Should young people be allowed to remain with their foster families up to the age of 21, including when a young person is at university?

7.1 In general we support the proposals set out at 7.10. Where foster placements have been successful and supportive it would seem counter-productive to disrupt them precipitately and/or as a young person enters further or higher education. Indeed, we would go further and suggest that:

7.1.1 Leaving-care arrangements need to be responsive to need. The average age for a young person leaving the parental home is 25. In early adulthood young people will often live independently for a time and return home for a time. Usually this is an option a young person is able to exercise. This option should be open to young people in the care system, so that they too can move in and out of 'adulthood' and be supported in the same way as their peers.

Q. What is the best way of ensuring dedicated supported accommodation for young people making the transition to adulthood?

7.2 The proposal at 7.13 is also to be welcomed. We would take this opportunity to reiterate our recommendation in response to the National Minimum Standards consultation on fostering allowances. The level of the national minimum allowance must not result in foster carers suffering hardship as a result of caring

for a child. This may also go some way towards addressing problems of recruitment and retention whilst providing the high quality care that looked after children and young people so badly need.

- 7.3 Whilst we welcome the proposed additional sum for Child Trust Funds for children and young people in care, we feel that £100 for each year spent in care is too low and will in no measure address the financial hardship experienced by too many young people on leaving care. Nor does it address the experiences of many children and young people whose experience of care is episodic.

(8) Chapter 8 – Making the system work

- 8.1 The NSPCC is committed to listening to the voice of the child, we therefore warmly welcome the proposed introduction of Children-in-Care Councils with direct links to their corporate parents via the Director of Children’s Services.
- 8.2 With regard to the measurement of key outcomes, we would reiterate our earlier call for more complex measurements, of a more diverse range of functions to enable the success of care placements to be more appropriately assessed on a range of issues reflecting a child’s *progress* as well as outcomes in social as well as educational attainments.

General Comments

1. Detailed discussion is out-with the scope of this response, however, the NSPCC wishes it to be noted that we are concerned in principle at the implicit distinction being made between children in care and unaccompanied asylum-seeking children (1.26). The reason(s) for this may become clear when the forthcoming Green Paper on Asylum Seeking Children is published. However, given the disproportionate likelihood of unaccompanied children entering the care system it is not intuitively clear why they should be excluded from this consultation. We would suggest that the provision of independent, culturally empathetic services is a key element in representing the best interests of *all* children-in-care, not least unaccompanied minors.
2. The NSPCC believes examination and evaluation of the provision of a social pedagogic model of care (Cameron, 2004; Jackson, 2006) would be timely and appropriate in the context of both foster care placements *and* within residential care settings. We therefore welcome the brief acknowledgement of this model in chapter 4.
3. The NSPCC is concerned at the implicit acknowledgement that children are not presently receiving a consistent standard of education (1.39). Furthermore, we would suggest that the attachment by some foster carers of little importance to schooling is largely associated with inappropriate and/or inadequately supported placements in which carers find their efforts diverted into managing behaviour (the causes of which are not being addressed) rather than encouraging academic attainment.
4. The NSPCC broadly concurs with the view that accountability mechanisms are limited. It is, then, particularly disappointing that this document is not a cross-departmental publication.

Conclusion

In summary, we welcome the government's reinvigorated commitment to the lives and futures of children and young people in care. We also welcome the opportunity to respond to this guidance. A summary of our recommendations is reproduced below:

The Pledge

1. We recommend the development of a national template, with scope for additional locally identified elements.
2. We recommend that pledges should be developed in consultation with children and young people in care, reflecting an appropriate balance of black and minority ethnic and faith communities and the disabled.
3. We recommend that pledges should be subject to regular review (at stated intervals).
4. We recommend that pledges should make a stated commitment to access to therapeutic services for all abused children, including children in care.
5. We recommend that pledges should make a stated commitment to support and training for carers and residential workers.
6. We recommend the inclusion of a pledge that measures attainment.
7. We recommend that the revised and condensed Local Authority Performance Assessment Framework (PAF) should maintain a broad 'basket' of performance indicators and associated sub-indicators of direct relevance to the health and well being of children and young people. There should be a requirement for at least one 'stretch' indicator to reflect locally identified needs for children in care.
8. We recommend that all children and young people who are cared for by adults with a known mental health condition and/or substance or alcohol misuse issues be automatically assessed according to the multi-agency Common Assessment Framework.
9. We recommend that consideration should be given to the provision of guidance for medical and nursing professionals working in adult services (and who may not, therefore, be familiar with the principal of *best interests*) about the circumstances and process for sharing otherwise confidential information.
10. We recommend that if they are adopted the multi-agency dimension of social care practices is ensured through legislation.

11. We recommend that the independent visitor service is maintained and that an examination of how to encourage and enhance the role is undertaken.
12. We recommend that advocates are maintained as a separate and distinct role from that of independent visitor. Advocates should be independent of the local authority (or other local authority commissioned provider).
13. We recommend the provision of a centrally funded, independently provided, dedicated listening service for children and young people in care.
14. We recommend an ongoing, centrally funded national fostering campaign is developed.
15. We recommend that consideration be given to placing head-teachers under a statutory duty to release Designated Teachers for a minimum of one (1) day's or eight (8) hours training each academic year.
16. We recommend that consideration is given to extending this duty to private sector providers.
17. We recommend that an accredited training package for Designated Teachers is developed.
18. We recommend that the role of Designated Teacher should be acknowledged by the provision of a dedicated salary increment.
19. We recommend that agencies in partnership are required to develop 'stretch' targets that measure the impact of service improvements, at least one of which should report on CAMHS-based therapeutic support for children in care.

20. We recommend that where a child or young person in care experiences a placement move that shifts them across administrative boundaries, and where a child or young person has been successfully assessed for health services for which they have been placed on a waiting list, they have the right to at the very least maintain their position on that list, or to improve it.

For further information on any of the comments please contact :

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