



Education Committee

Oral evidence: [Mental health and well-being of looked after children](#), HC 481

Wednesday 13 January 2016

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Written evidence from witnesses:

- Dr Ananta Dave ([MHW0033](#))
- Matthew Brazier ([MHW0064](#))
- Barbara Herts ([MHW0025](#))
- Wendy Lobatto ([MHW0027](#))
- Alison O’Sullivan ([MHW0042](#))

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Members present: Neil Carmichael (Chair); Lucy Allan; Ian Austin; Marion Fellows; Lucy Frazer

Questions 68 - 120

Witnesses: **Professor Peter Fonagy**, National Clinical Adviser on Children and Young People’s Mental Health, NHS England, **Claire Bethel**, Deputy Director, Department of Health, **Dr Ananta Dave**, Consultant Child and Adolescent Psychiatrist, Dudley and Walsall Mental Health Partnership NHS Trust, and **Matthew Brazier**, National Lead for Looked-After Children, Ofsted, gave evidence.

Q68 Chair: Good morning and welcome to this session of our inquiry. It is great to see you here and thank you very much for coming. We will ask you to introduce yourselves

in a moment. We are going to start now formally in the public session and we hope to conclude this session by about 10.30 am or 10.45 am. I am just going to clarify the objectives of this session for viewers and others to be aware of as we go along and they are threefold: first, to determine the extent to which the Government's statutory guidance is being implemented and the impact of the recommendations of the Children and Young People's Mental Health and Well-Being Taskforce, known as the "Future in Mind" report. The second is to establish how effective Children and Adolescent Mental Health Services, CAMHS, are for looked-after children and care leavers because we have been hearing a lot about that already in this inquiry. The third is to scrutinise the methods used to assess children and young people with mental health needs as they enter care and the monitoring of care leavers. Both of those points were raised very clearly and frequently by people who had been through the care system when we had a private session at the very start of this process, so we are acutely aware of that particular area of inquiry.

Can I, first of all, ask you all just to say who you are and what you represent?

Dr Dave: I am Dr Ananta Dave. I am a Consultant Child and Adolescent Psychiatrist and I am representing the Royal College of Psychiatrists today.

Professor Fonagy: Hello, I am Peter Fonagy and I am National Clinical Adviser on Children and Young People's Mental Health for NHS England. I was also the Chair of the recent NICE guidance and attachment for looked-after children.

Matthew Brazier: Good morning, my name is Matthew Brazier and I am Ofsted's National Lead for Looked-After Children.

Claire Bethel: I am Claire Bethel from the Department of Health. I am the Deputy Director who has responsibility for children and young people's mental health and well-being and I was also closely involved in the work of the taskforce that produced the report "Future in Mind".

Q69 Chair: Okay, thank you all very much indeed. We will introduce ourselves as we go along but thank you. In the first evidence session of this inquiry we heard that CAMHS are turning looked-after children away for not fitting the criteria of having a diagnosed mental health problem. Do CAMHS provide consistent high quality care and support for looked-after children? Would you like to go first?

Dr Dave: Yes, I will. What we have seen is that good quality care is provided but it is patchy and not consistent. We have areas where there are well-commissioned and well-designed multi-disciplinary teams but they are not available easily. In those places where there is not that kind of care available, we have seen problems with issues of access, so that the criteria by which the CAMHS services operate might not work for the kind of presentations that the looked-after children come with, and the waiting times, especially for those children who have been referred out of their original placement authority, might be quite long, especially given some decisions around fundings have been reached and pressures on CAMHS services in the form of year-on-year cuts or cuts to social care and, therefore, the

loss of some staff who are trained, the increase in referrals and complexity of other kinds of mental health problems. These various issues have created problems of accessing the right kind of help in some CAMHS cases.

Q70 Chair: Can I just probe you on one aspect of my question, which is that it is about the criteria not being met in terms of diagnosed mental health problems? Is there not a need to look after criteria?

Dr Dave: That is happening and that is there in various recommendations, both in the “Future in Mind” taskforce, as well as the statutory guidance. There is research evidence to suggest that these have been barriers in the past. There are a range of papers published that talk about this problem. Where we see examples of good practice this has happened, where the criteria have been adjusted or where there is sensitivity to the needs of the looked-after children and their carers’ requests. There is an example of this happening but perhaps not as consistently as we would wish and there is an acknowledgement that this needs to happen consistently.

Professor Fonagy: I would certainly support everything that Ananta said, I think that is probably accurate. I would want to add though that we are probably at the brink of step-change in this regard, that up until now there has been silo-ing of services that has been distinctly unhelpful, particularly for children with complex needs, such as looked-after children. We have at the moment, with “Future in Mind”, a real opportunity for bringing services together because the principles that “Future in Mind” sets out are the integration of education, social care and health at the level of clinical commissioning groups and their key partners. This creates an absolutely ideal platform for dealing in a coherent way with the needs of children who are in care, who are being looked after.

If I just may make a specific point about this, Chair, these are children who have been, in many ways, let down by their circumstances, by fragmentation, where they could have expected coherence. If they are then confronted with a system that also is in conflict with itself—that is, in some ways, struggling with itself—it echoes an experience that they have had, that is distinctly unhelpful. For me, the coming together of these services and acting together models for them the intervention that they need and that is what “Future in Mind” has brought to the delivery of health care services, as well as education and social care services for these children.

Chair: Claire Bethel, would you like to comment?

Claire Bethel: Yes, I would and I would support what has been said before. If I could just put my hat on as a representative of the Task and Finish Group that looked at this specifically when we had the taskforce last year. This was a key point about children not meeting the diagnostic criteria for CAMHS and, as Dr Dave has said, there is huge variability in that. What we set out in the report is what we thought should happen, that we need a multi-

agency response, that if a looked-after child has a mental health problem it is not just a problem for CAMHS. It is a multi-agency response that is needed. We need better trained foster carers and so on. It is not just a CAMHS response that is needed. Also, one of the things that we said in the report is we need much better data because we don't know the situation very thoroughly. We can't answer the question as to how good the services are that are being provided, so we need far better data.

But, clearly, there is an awful lot that needs to be done to look at those—the hoops that children need to jump through before they are referred into CAMHS—to develop a far more flexible approach in the way that services are offered. We hope that the system that we are putting in place and that it has spelt out that the Local Transformation Plans will show what each area will do in order to deliver that, because every area is producing a Local Transformation Plan that will address the needs of vulnerable children generally and one hopes looked-after children specifically. That will be an ongoing process that we will then revisit over the next five years because we have put in place now a five-year transformation programme to address the very issues that you are raising, which are clearly very important.

Q71 Chair: Are we talking about significant changes and adjustments to statutory guidance?

Claire Bethel: Not necessarily I would say. As you know, the statutory health guidance for looked-after children came out the same month as the “Future in Mind” report and that updated the work that was done previously in 2009. If we need to revisit the statutory guidance, then obviously that is something we would consider. But, on the other hand, having looked at it very recently, I am not sure that it needs revision at this point. What is in it is right but what is needed is a good local response with agencies working together, which they are doing through the need to produce the Local Transformation Plan. We are very pleased that we have had a huge response to that. Every area submitted a Local Transformation Plan on time. They have all been assured and the funding has gone out from NHS England to every area. As you know, there has been the total of £1.4 billion additional funding. We very much hope that some of that will be used to improve outcomes for looked-after children. But the work that we are doing on things like data as well and putting in place a much better infrastructure are going to be just as crucial because otherwise, to be honest, under-investment is likely to continue because it won't be visible, and that is one of the things that the report pointed out.

Q72 Chair: The Health Select Committee, back in 2014 I think it was, thought that CAMHS was operating in—how did they put it?—a foggy situation or fog at least because of the lack of data. Is that situation improving or was it an unfair analysis in the first place? Would anyone like to comment? Dr Fonagy.

Professor Fonagy: I would not say it is unfair but it is a situation that is dramatically improving. Children and Young People’s Improved Access to Psychological Therapies has introduced a way of monitoring outcome and monitoring the activity that, once it is adopted across the country—at the moment 68% of the population are covered, going on to 100% by 2018—and becomes mainstream, as it is supposed to this month in the Mental Health Minimum Data Set, will see the situation dramatically improve. I would want to state that specifically in the case of looked-after children, long-term outcomes are poorly monitored and if you wanted to consider recommendations for this Committee, better monitoring of long-term outcomes for this population is of great importance. Some of the approaches that Children and Young People’s IAPT has taken to outcome monitoring may be helpful in this context.

Dr Dave: I agree with what is being said. Along with that, we are also collecting patient-recorded outcome measures that are becoming more prevalent. I am pleased that the mental health prevalence survey in children and young people has been announced and there is a commitment in the “Future in Mind” report to it on a five-yearly basis that will give us the information that we need. I think the last one was done over 10 years ago. Those developments are very laudable. Just as in commissioning, even for data, we need to work together in an integrated manner because the Department of Education is collecting very valuable data about the outcomes of children, what used to be called Special Educational Needs Plans, which are EHCPs now. We do have some interesting and useful data from the Department of Education. It is about collating it and using it for integrated commissioning and service provision.

Q73 Chair: Yes, because that touches upon the big question about agency co-operation, does it not, and that is something we will be probing later? But it is a critical part of this whole question, is it not? Just before we move on to another area of questioning, the young people who we talked to in private also talk about the cliff-edge problem and I am just going to ask straight off, do you think that CAMHS should be extended to people up to 25 years old?

Claire Bethel: It is obviously something that we looked at in the “Future in Mind” report, because the taskforce gave quite a lot of consideration to that point. NHS England have produced various specifications for transition and there have also been Government commitments under the previous coalition Government to improving transition. What I don’t think we want to do is put that on the statute books and make it a mandatory increase in the age from 18 to 25. We want to leave it for local determination but we are very interested and very pleased that there are a couple of areas in the country, Birmingham and Norfolk for example, that are now commissioning services from 0 to 25 and we will be interested to see what happens in those areas. We welcome that but I don’t think the Government would want to mandate that services for 18 to 25 do need to be provided by children’s services because

there are huge implications of that in terms of not just shifting the money but the workforce that would need to be considered.

Professor Fonagy: The recommendations of a report for NHS England, particularly on the issue of transition, was of the importance of flexibility in relation to clinical need. Linked to looked-after children, I can imagine a strong clinical justification for extending the age to 25 for individuals who had impermanence as one of their problems—not being able to stay put and be in the same setting for a more extended period, which may, in many instances, be desirable. I would not want to mandate it and I am sure that you would not either because there may be many children for whom that is distinctly unhelpful. The advice from NHS England on this has been quite good. You want to make it possible but you do not want to make it mandated.

Dr Dave: Yes, I agree with what is being said. The principles of 0 to 25 working, about flexibility and giving time for young people to make transition at a time when they feel ready and at a time when they feel ready to ask for help, are important but, we still need to give importance to a well-trained and informed workforce, whether the age range is 0 to 18 or 25. We still need people with those skill mixes to be present in the teams that are being commissioned.

Chair: Thank you very much for those answers. We are going to move on to Lucy Allan who is going to be talking about initial assessment.

Q74 Lucy Allan: I was quite taken, Professor, with your comments about children coming into care and the way in which it is inevitably quite a traumatic process. One of the things that we heard from Ofsted was that local authorities were failing to do initial assessments and not using the Strengths and Difficulty Questionnaires in a way that had a maximum impact. I am just wondering if in fact any member of the panel would like to address why these initial assessments are not being carried out and how the Strengths and Difficulty Questionnaires can be improved and have a better level of effectiveness. Perhaps, Matthew, you would like to comment on that?

Matthew Brazier: Yes. We are not convinced it is the content or the template of the SDQs and whether there is a problem with the screening at all. There may be a sense among some areas that the use of SDQs is an administrative task around counting figures, rather than at all to help practitioners and services to think about how they can benefit looked-after children and how they can understand their overall needs. It may be an issue of raising awareness, one of training, one of making sure that it is integrated within the planning processes rather than investing a lot of time and resources in rethinking something that is generally thought to be an effective screening tool. We have seen examples where it has worked very well to help local authorities to consider what children need.

Q75 Lucy Allan: Is there an argument that any child coming into care is going to need a level of therapeutic support, rather than collecting data and doing lots of assessments and asking whether they need some higher level support? Any child coming into care is going to have to get to reconcile themselves to that loss and trauma that they have experienced and it is just a natural consequence of their situation and needs some form of therapeutic support to be automatically acceptable.

Dr Dave: I am not quite sure you can say that every child coming into care will automatically need therapeutic support. The right placement can itself be very enabling and promote the resilience and the mental health and well-being that is required. It does need a robust assessment. Coming to the SDQ as a tool, it is a screening tool that works well at a population level to look at the general level of need. For the SDQ to be effective in its role, first, it does need to be triangulated with information. The SDQ itself can be given to the carers, and young people, as well as teachers. Many times the SDQ is collected by one person from the carer but perhaps the triangulation does not take place. After it has been collected the data has to be interpreted in terms of either needing further assessment or signposting to the right agency and there might be a need for collecting it at regular intervals to see what the patterns are. If we look at it as to what it realistically can do, and think of it as a screening tool rather than as an assessment tool or the only thing that is required for assessment, it can then be used as a starting point, provided it is well triangulated and it is used, not just collected but used, to signpost and then look for the right—the assessment is very important after the SDQ.

Q76 Lucy Allan: Screening and monitoring and data collecting is all well and good, it is how you then use that data. As you say, if it just uses a tick-box exercise it is some other thing that we have to do as an initial part of a process. When do we then take the next step and deliver that therapeutic support? I do not know, Claire, if you have anything—

Claire Bethel: Yes. Again, this is just something that the Task and Finish Group on vulnerable groups looked at specifically. One of the things that the group concluded was that even though by definition every child coming into care will have undergone an extremely traumatic transition, they do not all need direct intervention from specialist mental health services, certainly at that point. Although something like half of those children will have some underlying mental health problem, it is not just for CAMHS to sort that out. As I say, what is needed is a multi-agency response and what the report said was that frontline workers should be able to access support, depending on the child's needs, and need to be sufficiently skilled in order to do so. That involves skilling up foster carers, residential care home workers and so on. I don't know if you are familiar with the KEEP Project. The KEEP Project is a national programme and I visited one site on Monday this week in Leeds where they are training the foster carers efficiently as to what to look out for, as the foster children might develop problems. They might not manifest themselves immediately as they come into care but later on. We need an ongoing ability to assess those children. The annual screen or six-monthly screen for young children should enable that at least to take place and should trigger a referral for a more comprehensive assessment for those children who need it.

Professor Fonagy: If I could just add to that because you raise an enormously important point. But it is important also to bear in mind that even if a mental health assessment flags up a mental health problem, so-called, it is not necessarily the case that mental health is the best avenue to deal with that problem. The problem may be a secondary consequence of some other difficulties that they have, whether those difficulties are decision making about placement or a need for better support for foster carers. The important point about mental health interventions is that they carry a certain risk and to assume that they carry no risk is probably wrong. In the United States, where referral to mental health services is very common, 12% of children in foster care are on antipsychotic medication, on risperidone.

We do not want that to replicate that here because for children, controlling their aggression may not be best achieved by prescription. But, equally, even as an intervention for an assumed trauma—as, for example, in the King’s Cross fire, a trauma debriefing was mandated for all victims and that actually led to an increase in post-traumatic stress disorder, rather than a decrease. People have tremendous capacities to deal with these problems themselves. Mandating an intervention risks undermining that capacity, so we are very cautious about mandating therapeutic care for many of these children. An appropriate multi-disciplinary multi-agency assessment that indicates a genuine mental health problem should trigger a genuine mental health intervention. The category of being looked after or even coming into care should not take away from the child the potential, their capacity for self-reliance, for independence, which we know from long-term follow-up studies, is what probably, if anything, marks out those who succeed after long-term care from those who do not.

Lucy Allan: That is a very interesting point, thank you.

Q77 Ian Austin: Quite a bit of the evidence that we got expressed concern about the extent of co-operation at a local level, so I am interested in asking you some questions about that. The statutory guidance says that local authorities, CCGs, the NHS and Public Health England should all be co-operating to commission health services. I am interested in to what extent there is co-operation on the ground? What is hindering the development of better co-operation? Whose job is it to monitor the implementation of the statutory guidance? To what extent is it being monitored? I would be interested in hearing your thoughts on some of those issues. I don’t know who wants to kick off.

Claire Bethel: As I say, the statutory guidance came out in March and it reinforced a lot of what had been in the previous guidance. But the guidance that came out in August from NHS England about the transformation programme for mental health reinforced quite a lot of those principles that you are alluding to about collaboration between agencies and co-operation. By requiring them all to put in place and develop a Local Transformation Plan for mental health that covered vulnerable groups, that meant that they had to work together and that included schools, CCGs, local authorities and so on. Clearly, the commissioning profile

that comes is very complex, as there are four different groups of commissioners, but that has reinforced what is in the guidance.

The assurance process that has been put in place for that has been very robust for this year. It is going to be different for next year, as it will be mainstreamed into the existing assurance processes, but this year there has been a very robust assurance by NHS England regional teams. They have looked specifically at whether there is collaboration, co-operation, joint plans, joint commissioning and so on. While that is not specific to monitoring the guidance for looked-after children, it will include looking at that multi-agency working. I do feel that if we can get it right for looked-after children we can get it right for all children, since they are among the most vulnerable.

Q78 Ian Austin: Right. But the Royal College said local implementation was patchy, do you agree—

Dr Dave: Those conversations are still happening, evolving and developing because I know, for example, in the local area where I work, Dudley and Walsall, people have met locally, and the Local Transformation Plans are in the process of being finalised. The draft has been announced and some of them have been firmed up. It is an evolving picture. People are having those conversations as—

Ian Austin: But it has been almost a year, has it not?

Dr Dave: Yes, but—

Ian Austin: But if the guidance came out in March and the stuff has only just been drafted—

Dr Dave: I think, partly, it also reflects the changes that have been happening in terms of loss of workforce, change of local leadership, change of Government and so on, things that have been outside their control. But I know that in many areas those local conversations have taken place and some of the plans have been implemented and some of them are in the process of being implemented a year on. The structures are in place to monitor, in terms of not only the needs analysis that would have taken place before the commissioning but also the health and well-being boards that would look at how these plans are being implemented, the commissioning networks that would provide the assurance. The processes are in place. The networks are in place. In terms of fully implementing everything that has been agreed, that is evolving and happening. But I know that those local conversations are happening.

Matthew Brazier: What we have seen, as we have provided in our written evidence already, that there is too often just a lack of specifics. The guidance does talk about the need to address the needs of looked-after children and care leavers but too often what we are seeing in Joint Strategic Needs Assessments and the Health and Well-being Strategies is that either they are not present or the detail is lacking. What we are keen to see is that Local

Transformation Plans can draw local areas to become more specific about looked-after children and care leavers, to say exactly what they need to do and exactly who is going to take responsibility. We welcome the idea that there will be lead responsibility identified to pull all these things together because we think that has been lacking.

Q79 Ian Austin: How varied is performance between the areas that are working most effectively together and the areas that—

Matthew Brazier: Like most of the things we talk about, we will say that it is variable. We see some good practice, for example, we have mentioned Leeds already—they get two mentions this morning—and there is Stoke-on-Trent we have seen where there has been some good strong focus on looked-after children and care leavers where they have been able to meet—

Q80 Ian Austin: What have been the factors though? What is it that has resulted in particularly good practice in some places? What has been lacking in the areas where that has not happened?

Matthew Brazier: There is a variety of reasons. Like our colleague says here that stability and leadership can make a difference, the competing priorities. It would be disingenuous not to talk about the financial constraints that a lot of local authorities are working under.

Ian Austin: But that shouldn't affect professionals in local authorities and the local CCG working together effectively. That is pretty basic.

Matthew Brazier: No, not at all. It has always been something that we want to focus on. We expect to see it where we visit and, as I say, we hope to see it in future and we hope that the Local Transformation Plans can help drive improvement.

Professor Fonagy: I think it is important to point out that this is not happening in isolation. The advice about integration has been around for 20 years, but I think it has been quite difficult to implement because of split budgets, and because of a whole range of difficulties that had impacted directly on the capacity of individuals on the ground to deliver an integrated service. There have been some services that have a history of integration—and these have really taken off—associated with the new statutory guidance. I think where there has not been a history it will take longer, and it is a five-year process.

I think we are in a better position than we have ever been, as far as I am concerned, in the history of this particular issue, but much more broadly in the history of child mental health, of there being an understanding, a willingness on the part of all concerned, that mental health issues are not going to be simply resolved by mental health services alone. What needs to happen is an integration of education, of social care and of mental health working together

solving each individual case. It is looking at the clinical needs of each individual case and at what level—particularly with looked-after children, with the multiple levels of determination, the multiple levels of causality—that that particular case is best addressed. That is a new way of working. You will have to give a little bit of time for that to happen because the professionals involved have been working in a particular way for some time. I think what we have now is a shared purpose, an agreement, a philosophy that everyone has bought into of common purpose, joined up thinking about outcomes, joined up thinking about information and data sharing. That is to my mind historically new. It will take a little time to bed down but I think groups such as looked-after children—I think all children, particularly vulnerable children—will benefit from it tremendously. We are looking at one or two years but it will lead to better outcomes.

Q81 Ian Austin: Can I ask whose role is it to spread the best practice, to take the examples from Leeds or Stoke or wherever, and to get places that are not doing this as effectively? Who does that? How does that happen?

Matthew Brazier: The Department does a good deal of work. I am sure they can answer that.

Claire Bethel: Yes, certainly. One thing that I think the Committee will be interested in is the fact that NHS England have commissioned an analysis of the Local Transformation Plans, and that will be both quantitative and qualitative, and we expect that to be available in March this year. That will include an analysis thematically of how well Local Transformation Plans cover the needs of looked-after children, so I think you will find that really interesting. We are looking forward to that, so I think that will give us some information.

We will also be setting up various sites for putting various toolkits in place, and so on, not only with colleagues in NHS England but DfE, with whom we are working. This is more or less a joint programme. We are working very closely with DfE. We will showcase examples of practice on that website, publicising what various areas are trying so that they do not have to reinvent the wheel.

Professor Fonagy: If I could answer your question directly. NHS England is funding strategic clinical networks directly to perform exactly that task. There are a number of initiatives but, in addition to that, there are master classes of the Children and Young People's Improving Access to Psychological Therapies collaborative, and also informing, helping. There is a great deal of support that is out there and there are specific support teams to ensure that less advanced services will catch up with the more advanced ones.

Matthew Brazier: Ofsted also has a responsibility. We obviously share good practice through our reports. We run a series of Getting to Good seminars for local authorities, where we discuss what is required to become good. We undertake thematic inspections. We did a

thematic inspection on effective leadership—we published that recently—and we have a good practice website where we put good practice examples as well.

Dr Dave: I would like to say that it is also important not to forget the role of the young people, and the carers themselves, in assuring the quality of services and holding people to account. I think part of the commissioning, training and support is about enabling them to do that, to carry out that role more effectively. I think the other thing that the “Future in Mind” report has done, along with the statutory guidance, especially the “Future in Mind”, is about bringing voluntary third sector and public statutory agencies together. So I think in every local area these conversations are increasingly happening, not only between statutory agencies but also with the third sector.

Q82 Ian Austin: Very briefly, what about when children move? I mean that is all about collaboration in a sort of locality but when young people are moving from one local authority to another what about collaboration? What can be done to make that transition smoother and easier for them, and less disruptive to their care?

Dr Dave: Sure. I think one of the things that needs to happen is information sharing in a timely manner. That has been brought up in the reports. So the information needs to follow the child in a timely way. If the child is transferred in a crisis, for example, it needs to happen within a few days, or if it happens in a planned manner, it needs to go along with the child, so it is currently about everybody being aware of their roles in various CCGs, the GP practices, and health and social care, being aware of the guidance and their roles. It is partly about information-sharing happening and there being no barriers to this, and partly about the constant checking, checks and balances that are in place to make sure, through the independent IROs reviewing the looked-after child care plan, the health checks and so on, so at these various natural points in a looked-after child’s journey there should be these constant monitoring points to see whether this has happened. So I think there are ways of achieving it, although it might not always be happening.

Q83 Chair: Thank you. That is a good line of questioning. That is quite interesting. Matthew Brazier, the “Future in Mind” report recommended that the Care Quality Commission and yourselves, Ofsted, work together to develop a joint cross inspectorate. How are things getting on?

Matthew Brazier: Pretty well we think. We have been committed to taking a joint approach for a long time. We have a longstanding relationship with the Care Quality Commission, which goes back to the safeguarding looked-after children inspections before the current framework. We have undertaken thematic inspections together. The Committee may know about the joint targeted area inspections that have just started, which CQC and Ofsted are working together on along with HMI Probation and HMI Constabulary. That has been piloted. We will be publishing the framework imminently for future joint targeted area

inspections. These are deep dive inspections where we look at a particular area of practice, which we and the sector think is of significant importance, that we need to understand better and learn from.

The next joint targeted area inspection will be on the theme of child sexual exploitation but, clearly, the mental health and the emotional well-being of looked-after children as well as well-being might be the kind of area that such an inspection might look at in the future. We will consult with the sector to talk to them about what we should be prioritising for future work, but we are in a good place to be able to move that kind of joint work forward.

Q84 Chair: In one of your observations following Ian's questions, you talked about the leadership of local authorities and how you are offering training and so on. Where are your main concerns about leadership within local authorities and what kind of accountability mechanism, other than your own involvement as an inspection organisation, would you like to see?

Matthew Brazier: When we talked about leadership we talked about it being strong leadership at all levels. We are not just talking about Directors of Children's Services, we are talking about shared accountability and we are talking about effective succession training, but one of the key themes that we have raised a lot is about stability of leadership. We see that often the response to poor inspections can often be a further change of leadership, which isn't always necessarily the best response. It may be in local circumstances but it might not always be the best response to a difficult or challenging inspection outcome.

I suppose it would be difficult to say this is exactly the type of accountability we would like to see. It really depends on local circumstances, but what we would not want to see is a kneejerk response to those kinds of difficulties. There are only a finite number of people who might be willing to become Directors of Children's Services and everybody at every level needs support and training in the work that they do.

Q85 Chair: Thank you. Do you think there is scope for reviewing Ofsted's role in assessing school-based support for mental health and well-being?

Matthew Brazier: I don't think there is scope for reviewing it at the moment. I think we do look at the emotional well-being of looked-after children and support services when we inspect schools. We have implemented—probably you will know—a new common inspection framework, so across all our inspection remits we will look at emotional well-being and we will look at the sort of work that schools can do. When we talk about that we are looking beyond access to specialist services, about how schools equip pupils to be resilient, to understand risk and to build good, positive relationships with each other. We think we have the framework to do it. We have a new judgment in that area, so we can tell a good and accurate story of progress in schools. It will be something that we will be keeping a

close eye on and about monitoring how we implement that framework over the next few months, but we think we are in a good position to be able to tell an accurate story about progress.

Q86 Chair: The National Association of Head Teachers, NAHT, have been talking about the need to offer more training to teachers in connection with mental health. Do you think that is something that should be done? I can see Professor Fonagy is certainly agreeing.

Matthew Brazier: Yes. I think, to be honest, if you asked about anybody who is involved in the care of vulnerable children I think they all need appropriate training suitable to their responsibilities. As I understand it, there will be a framework, initial teacher training, for example, where the priorities are given to them to make sure that teachers do understand child development and will be able to respond to children's needs accurately and the same goes for head teachers, so I would say it is a given.

Professor Fonagy: I very much concur but I would want to stress that, in this particular context, there is agreed risk and also an opportunity for teachers to benefit from understanding problems that arise in relation to disrupted attachment and the disorganisation of attachment. In the NICE guidance development group that I chaired, one of the recommendations that we identified was in relation to training teachers to be more aware of the attachment issues, which can manifest as disruptive behaviour in the class on the part of a young person who feels that this is the way that they will get noticed, this is the way that they will get attention, whereas a young person who has a more typical background in development in an attachment context, would anticipate good behaviour to result in attention. The expectations they have developed are that, unless they act up, unless they play up, nobody will pay the attention that we all feel that we deserve and that we biologically need. Putting training in place in attachment and attachment-related issues for the entire system would bring better understanding, but also mental health literacy could benefit looked-after children and other vulnerable groups.

Q87 Chair: Thank you. One last question before we move on to Lucy's issue. There is of course an alternative view, which is that you would have a specialist teacher or a specialist provision in a school or for a group of schools. Is that something you have been thinking about?

Professor Fonagy: I think one of the parts of the policy is to have a teacher identified in each school who understands Child and Adolescent Mental Health Services better, who is better trained to deal with issues. Among their skills could be a specific skill to deal with looked-after children. I am always very cautious about trying to put too much responsibility on one person. Looked-after children, actually corporate parenting, is all of our responsibility. It is not just the responsibility of a particular teacher and then we can discard. What corporate

parenting means in my mind is the state is looking after these children. We are all responsible for them. We should all look out for them.

Chair: Thank you. Lucy, counselling services and training of staff specifically?

Q88 Lucy Frazer: Yes, that leads in very nicely. So we know that half of mental health problems begin before people are 14 and that school is a great place for children to receive mental health advice. Professor, you talked about the integration of education and mental health. The Children's Commissioner told the Committee that all schools should have counselling services, so, do you agree with that?

Professor Fonagy: I think that currently, in NHS England, we are working very closely with counsellors and with the professional association of counsellors, BACP, to try to develop counselling training that would meet that particular brief. I want to make two points, which I want to be very clear about, particularly in relation to looked-after children. I think that every looked-after child has the right to expect support in making sense of their situation. I think it is not something that you or I normally would be confronted with.

There is a wonderful section, which I commend to your attention, of the 2010 NICE guidance, E5, where young people's experience of being in care is more comprehensively and more fully described than anywhere else I have seen. A couple of points that they make very clearly involve the extent to which they require support in making sense of a very confusing situation, and I think they have a right to that. But whether counsellors are appropriately trained to do that is an open question, and that is something that a recommendation from you could perhaps assist with.

The second issue is that, in relation to substantive mental health disorders, counselling is not evidence-based, so to recommend blanket counselling as if this is going to solve the problem of substantive mental health disorders, whether they are attachment difficulties or another kind, is probably optimistic. They require tailored treatment that is specified appropriately for them in NICE guidance. Counsellors should be in a position to signpost, to be trained up to provide evidence-based appropriate intervention and, in terms of parity of esteem, I think it is important that these young people who often feel stigmatised, and children who are confused, get the support that they require in relation to their experiences.

Q89 Lucy Frazer: Should that counsellor who is providing the signposting—I am hearing that it is not the only solution, and there are a plethora of solutions that need to be offered—be in the school?

Professor Fonagy: I think that is certainly a very powerful part of the "Future in Mind" report and, in current policy, the integration of education and mental health is probably the big step change in mental health provision that is going to arrive in this country. It is going way, way beyond looked-after children. It is hard to achieve that. It is a complex

issue. I think it would be irresponsible of me to give off-the-cuff answers in relation to that. It is something that is being intensively worked on and the integration of an educational programme, a training programme, for teachers—and specifically mental health literate teachers and those working in mental health—to understand each other’s difficulties and problems is, I think, what is going to make a massive difference to children and young people in this country.

Lucy Frazer: Claire, do you want to come in?

Claire Bethel: Could I just answer that? I think Professor Fonagy is alluding to the pilots that we have going at the moment—and I am not sure if you know about those—whereby we are trying to put a single point of contact in a school who faces a single point of contact in the mental health services locally. So, a little bit like the role of a SENCO, I suppose. Indeed, it may well be the SENCO. We are piloting that in a number of areas.

The training is being provided as we speak, so that is being rolled out across the pilot sites, and the point is to try to improve access to services but also to try to work out which children need specialist healthcare, which can be dealt with more appropriately by a voluntary sector organisation, which are really in trouble.

At the moment there are schools that are referring many, many children to CAMHS, where those referrals are rejected because CAMHS say either they are not the sort of children who they can help or there are issues about the quality of the referral. Schools are allowed to make direct referrals. What we want is a much more streamlined approach where schools know the sort of services that are available locally and what can be provided in the school, because there are clearly a number of organisations like, for example, Place to Be—if I may mention one—who are working with 230 schools to provide some of those services in-house. I think the single point of contact pilot, which will be evaluated, will give us a much better feel for how effective such a system will be.

Q90 Lucy Frazer: Is the single point of contact a specialist?

Claire Bethel: No. The single point of contact will be a teacher, probably, or as I say a bit like a SENCO. Training is being provided but not very high level training. It is about them being able to reach out.

Lucy Frazer: It is a current teacher or a new teacher?

Claire Bethel: No, no, a current teacher.

Lucy Frazer: Why would it not be a specialist?

Claire Bethel: Well, because it is up to the school how they choose to do that, in the way that a SENCO isn’t necessarily a specialist. They may need additional training but it is

about enabling them to know what is available locally and how to engage with CAMHS, because I think part of the problem is that relationship has not always worked very effectively. They do not know who to talk to. There are multiple routes into local services, so the point is if you have a single point of contact—as “Future in Mind” recommended—in both organisations, who speak to each other and have far closer communication and better information sharing, that that will be helpful for all children.

Q91 Lucy Frazer: I can see the benefit of that and I go into a lot of schools. I went into one last week and I said, “Should you all be trained in mental health?” and the head mistress looked at me as if I was crazy. She said, “We have enough on our plate”. They have to deliver the curriculum, and so are we placing an additional burden on teachers? Obviously it is important that they recognise attachment and can do what they can, but is there a space for a specialist, someone new in the system, not imposing on a teacher additional burdens of what is, essentially, an extremely important role in identifying mental health issues early on?

Claire Bethel: In my view, no. I am hoping that the pilot will, once evaluated, show that this is an effective means of delivering services, in the same way that the SENCO system I think seems to work reasonably well within schools. What I have found in talking to schools is that an awful lot of them are using pupil premiums, and so on, to buy in known services to work with organisations like Place to Be and other organisations, and indeed with statutory mental health trusts, for example, I have been to a school where they use something called CUES-Ed, which is a wonderful system of a whole-class teaching led by a psychologist from a mental health trust who teaches them about mindfulness, about resilience, about how the brain works, and the children absolutely love it. It has been very well evaluated, and that is being provided by statutory services but using the pupil premium.

Dr Dave: I agree with that. To make it practical and implementable, I think we have to realise the role of staff within schools. It is about promoting resilience and mental health well-being, early identification and signposting. I do not think the role would be about providing specialist interventions within schools. I think that would need a robust assessment and then delivered by specialists as required.

The other thing also is about listening to young people themselves. For them talking to somebody in school is one of a range of places where they can talk to people. Some young people feel that school might not be the best place because of confidentiality issues, so it needs to be a range of places. They need to have somebody in school they can go to to talk about their worries. It also needs to be available in other non-stigmatising, easily accessible places where they can go to appropriate staff and talk about their concerns. So, school has a role but it is not the only place where these concerns can be picked up and signposted from.

Q92 Lucy Frazer: Are you all suggesting there should be one teacher? Obviously we will get on to general teacher training in a minute, but for this sort of specialist

signposting there should be one teacher, a non-specialist, who is just a teacher, who is the point of contact? Are you all in agreement? I think Claire is in agreement with that. Dr Davy?

Dr Dave: There should be a point of contact. I think that would be useful to know somebody who is a point of contact but the whole burden of identifying it should not be on that person. That person should be collating the information and then having conversations with other agencies and supporting staff, but they shouldn't be the only person whom young people can come to.

Matthew Brazier: While I would agree with what colleagues have said, it does not preclude other teachers in that school having similar skills and knowledge in that area. I guess one of the roles of the single point of contact would be about building capacity, about sharing their skills and enhancing knowledge so that people are generally sensitive and able to refer appropriately to the same single contact.

Professor Fonagy: I think it is really about knowing the system. So much of the difficulty of the past has been about there being poor information available about what to do, what is the best thing to do. If the best thing that a teacher can advise a young person is to go to Accident and Emergency in order to be seen, that is not a good situation and they need to be sufficiently empowered to know what useful advice they can give, what systems are available, at an early stage, to support self-help, to support resilience, as Mr Brazier put it. There is a lot that we can do that may change entire scenarios that schools and mental health services sometimes find themselves in. It is closer working that I think the single point of contact will achieve.

Q93 Lucy Frazer: How much is it costing in your pilot for this?

Claire Bethel: £3.5 million.

Lucy Frazer: For each individual school?

Claire Bethel: That is divided by 20 areas but it is reaching a number of schools. My maths isn't quite good enough to work that out.

Q94 Lucy Frazer: Who should pay for that?

Claire Bethel: It is split between the Department for Education and NHS England. It is a short term pilot coming to an end now, and the Anna Freud Centre are providing the training. Head teachers are engaging in that training, and then there will be a bit more detailed training for the actual practitioners or teachers who have been appointed to act as single point of contact. Thank you. I have just been told it is £3,500 per school. £32,000 per CCG, so I hope that is helpful.

Q95 Lucy Frazer: If we have initial teacher training for general teachers to understand attachment, what do we do about those teachers who are already teaching? Should they undergo some supplemental professional continuing development?

Professor Fonagy: What NICE guidance recommended was a whole school approach. I think there is justification for the entire school becoming more attachment aware. The evidence that I am familiar with, on the whole, supports the view that school-wide interventions work better than trying simply to identify particular individuals who are then responsible for “attachment” in their school. For the culture of the school to be more accepting of attachment issues is part of the solution. Certainly that is what NICE guidance—

Q96 Lucy Frazer: Very briefly, we have attachment, what are the other things that should be in the teacher training? Just very briefly because I am conscious of the time.

Dr Dave: I think looked-after children, as other young people, can have a range. They can have emotional and behavioural problems to do with conduct problems, impulsivity, emotion dysregulation, self-harm behaviours, specific learning difficulties. There is a range: your trauma-related problems and common mental health conditions, along with severe mental conditions. There are a range of things that may need to be looked out for, which teachers and staff within school need to be aware of. Attachment as you said, is one of them, attachment-related problems, but these are the other areas that they need to look at.

Claire Bethel: Can I just add that the Government developed something called MindEd, which was developed with the Royal Colleges, and it is a fantastic learning tool aimed at people with a reading age of 10 and above; it is aimed at anybody working with children, from school dinner ladies to teachers to Scout leaders, everybody, and DfE is doing some extra work to do something similar for parents. But MindEd has been very widely used across the system, particularly by school staff, and it gives you a very dedicated module to each of the areas that Dr Dave has just mentioned and is very good and evidenced-based.

Q97 Lucy Frazer: Finally, if you could make one change to improve the provision of mental health support for looked-after children, what would it be?

Dr Dave: In keeping with the spirit of fostering hope and recovery for young people, I would say let us learn from areas of good practice and use that to have very informed commissioning of provision, with highly skilled and trained staff who put children’s voices at the centre of those services.

Professor Fonagy: A very personal suggestion: we currently have designated doctors, who are usually paediatricians; we have designated nurses for looked-after children. We do not have a designated mental health professional. I think maybe we could consider having someone in the system who is there to co-ordinate mental health input for looked-after children, who can identify genuine mental health needs, who is aware of alternative care pathways, who can oversee mental health literacy and training and has a perspective of

mental health and holds that perspective in a powerful way. I feel that the real problem of looked-after children was very clearly voiced in E5 of the 2010 guidance, “Who loves me, and if no one loves me, why should I love myself?” Someone who has the child’s experience in mind in that way and the way that it impacts on the rest of their experience would, I think, be of true value, because ultimately what looked-after children need and what they deserve is a system that is mindful, which has their mind and their experience in mind.

Matthew Brazier: I am going to cheat a bit as well: I could easily say just one aspect. I think if there is one change or one major development, it is about the need to be really ambitious for looked-after children, and the sort of aspirations that the Professor is talking about, the need for a whole system approach to this cannot be overstated. All aspects of practice contribute to good emotional health, so whatever work we are talking about—whether that is around good matching of children to foster carers or effective recruitment strategy for foster carers, good life story work to help children understand their histories—everything will contribute to good emotional well-being, so we have to have a real whole system approach to this, rather than just think this one aspect will be the solution. It might be part of the solution, but it will not be all of it.

Claire Bethel: I would devise a clear care pathway—which is what we said in our Task and Finish Group report—for looked-after children, so they are able to access care in a much more flexible way than they are now, not just in the clinical setting, and that also professionals working with the child will be able to access specialist care much more flexibly than they are now, rather than having to go through very complex referral procedures and not always getting the help that they need, so that foster carers, teachers and so on can access specialist help for looked-after children without necessarily the child seeing the psychiatrist or whatever.

Chair: Thank you very much for those very good answers. I think they are going to help our report enormously, so I am very grateful to you. Thank you.

Examination of Witnesses

Witnesses: **Barbara Herts**, Director for Integrated Commissioning and Vulnerable People, Essex County Council, **Wendy Lobatto**, Service Manager, First Step, Tavistock and Portman NHS Foundation Trust, and **Alison O’Sullivan**, President, Association of Directors of Children’s Services, gave evidence.

Q98 Chair: Welcome to the second session of our inquiry. I think you were all in the audience before, so you know what we are looking at and you know that our themes are as I described at the beginning, so could you just say who you are and where you are from, Barbara?

Barbara Herts: I am Barbara Herts. I am Director for Integrated Commissioning at Essex County Council and I chair our Collaborative Commissioning Forum for all children in Essex.

Chair: Thank you. Wendy?

Wendy Lobatto: I am Wendy Lobatto. I am the Service Manager of First Step, which is a psychological health screening and assessment service for looked-after children in Haringey.

Chair: Alison?

Alison O'Sullivan: Hello, I am Alison O'Sullivan and I am the President of the Association of Directors of Children's Services. We have in our membership 1,500 of the leaders in Children's Services, including all 152 local authorities and the new Children's Trust chief executives.

Q99 Chair: Thank you very much. To Barbara and Wendy, I am going to be asking about First Step in Haringey, and Essex County Council have adapted their mental health services specifically for looked-after children. What steps have you taken to improve your services to this vulnerable group? Barbara.

Barbara Herts: What we have done is we decided in 2014 that we were going to integrate our services across social care, health and education, so we went into a collaborative commissioning agreement across seven CCGs and three local authorities. Essentially, we recommissioned our services to bring together an early prevention, early identification approach, very much linked to our social care offer for vulnerable children and young people. We were pleased that in our collaborative commissioning that we were able to pool our budgets. We have very successfully pooled budgets with our clinical commissioning group colleagues and I oversee that budget, which means that we can operate flexibly and meet the needs of vulnerable children and young people in Essex. I think the previous system of having a lot of fragmentation and different organisational boundaries let our vulnerable children and young people down and now it means that we can bring that budget together, particularly with our health colleagues, and get that clinical expertise and use the additional monies much more flexibly and responsibly.

Chair: Wendy, do you have any comments?

Wendy Lobatto: In Haringey, I run a team that was commissioned by the London Borough of Haringey to provide a global emotional health screening assessment service, so my perspective is from the ground. I manage a service that works with looked-after children and I am very happy to describe to you how we do that.

Q100 Chair: Obviously Barbara has described a very ambitious approach for Essex in general, and bringing together agencies, which is something that we have been thinking about a lot. In terms of the leadership of that structure, you are obviously at the pinnacle, but what sort of impact has that had within the school system in Essex?

Barbara Herts: It is starting to have a very good impact, because we are clearly involving our schools in this new approach. Our approach is very much founded on the principles of “Future in Mind”, so we were absolutely delighted with its publication. We see schools being very much at the forefront of this approach, because we want all of our children in care clearly to be in schools. We know that across the country there is evidence that a lot of vulnerable children can end up on part-time timetables. That will mean that they are not even in school, let alone getting that essential treatment that they might need. What we particularly have focused on in our new service is that early prevention that Professor Fonagy talked about.

Q101 Chair: Can I just talk about CAMHS now, because we have been talking a lot about them, not least because the Health Select Committee talked about it at the end of the last Parliament, and obviously it has been something that has come up in our own inquiry quite a lot. Are CAMHS effective in supporting looked-after children with a wide range of mental health issues? Barbara.

Barbara Herts: We are clear in Essex that we want to see a very holistic offer for vulnerable children and young people and that is why we reshaped our services. We want to see that early intervention at a very early stage. Part of our system is having a specialist mental health professional that can provide on pathways, the evidence base and bringing that together across social care, health and education. We think it is terribly important to have this integrated approach, not least because in the health system, with the very great deficits in funding around the country, there is a real risk that that money might not be protected for children’s mental health, so we see the benefit very much of having this holistic system.

Q102 Chair: Alison, do you find the same enthusiasm for integration among your members?

Alison O’Sullivan: There is certainly an enthusiasm, but of course it is hard work and joining together the disparate parts of the system that have been described is not a quick journey and you have to make sure that systems are safe while you are changing them. Our perspective on the system generally is that is hugely variable if you look across the country. I think the “Future in Mind” document and the taskforce that informed it managed to flush out quite a clear picture of very variable practice, not just in terms of the levels of investment that there were in the system, but also clinical practice, the extent to which things were joined up and difficulties with access to service—so a huge variation, in some parts of the country very good, in other parts of the country frankly not acceptable. I think that is a problematic inheritance and you do not get to a new, better system overnight. I think the “Future in Mind”

strategy is very helpful and very clear, but the importance will be on making that happen. The investment is welcome, but we have to recognise that is against a backdrop of other financial pressures that have been referred to, and also a history of disinvestment across the system for quite a number of years. This was not a high priority area across the system broadly.

Q103 Chair: A recurring issue is the initial assessment of mental health problems both in terms of timeliness and effectiveness. Wendy, do you think that is an issue that needs to be addressed?

Wendy Lobatto: Yes, definitely. What we are doing in Haringey is we are making assessments of the emotional well-being and mental health needs of all children when they come into care and then on an annual basis. We use the Strengths and Difficulties Questionnaire. We were listening in the last session to the thoughts about how the SDQs are used, and we use the Strengths and Difficulties Questionnaire very actively to triage the emotional needs of children as they come into care and then during their annual review. Would you like me to tell you more how we do that?

Chair: Briefly, because we have seven or eight more questions. Why don't you drop us a line about it?

Wendy Lobatto: Yes, I am very happy to do that. It is in my written evidence so far and I am happy to send that to you again.

Q104 Chair: Okay, we have that then, so that is good. Thank you. Alison, variability is something you have already referred to. Is this something that you are thinking about in terms of assessment as well?

Alison O'Sullivan: It is. The Strengths and Difficulties Questionnaire is not used as broadly as it should be, as has been highlighted, but it is a screening tool, it is most effectively used, we think, for that kind of triaging. What you also need at early stages is the broader awareness across the workforce for people caring for children in all sorts of settings, including schools, to be able to notice when things are not right and know what kind of help to be able to look for. Also, you need the right access to specialist and professional assessment when that is needed and we know that that is hugely variable. It can be that there are long waits for that kind of assessment, up to many months in some cases, and clearly in the midst of a distress or crisis, that is not acceptable and certainly not helpful.

Chair: Barbara, do you have any final comments?

Barbara Herts: Similarly to Alison, I think it is about the wider workforce being aware, being able to pick up issues that they see, whether in schools, in social care or in health settings. I think the training of the workforce is absolutely vital in that regard.

Chair: Okay, thank you. Lucy, you are going to be talking about the transition out of the care system.

Q105 Lucy Frazer: I wanted to ask about Local Transformation Plans and the variability that I think a number of you have picked up on. Whose responsibility is it to try to achieve a bit more consistency? Because we heard in the previous evidence session from the NSPCC about some Local Transformation Plans excluding any reference to looked-after children at all. I wonder if I could start with you, Alison.

Alison O'Sullivan: Perhaps I can come in on that one. The guidance is very clear that health and well-being boards are the accountable body and that is where the leadership across the local system sits. It is important that those health and well-being boards at a local level truly hold to account the local system to deliver against those plans. Our health and well-being boards have not been established for very long and they are at different stages of development, so I think this will be an important test of their strength and the strength of local partnerships, so that is really important.

Lucy Frazer: Sorry, just to interrupt, there is the difficulty that you have so many different partner agencies involved in the health and well-being board that that sense of ownership is kind of diluted across the board or is it one single person that says, "Hang on a minute, we have to make sure that our Local Transformation Plan is consistent and coherent"?

Alison O'Sullivan: That is always the hazard with collective responsibility, isn't it? I guess this is a good example. What is clear though is that there is a lead agency commissioning for this plan and that lead agency clearly carries the can, so it is important that that is reflected in the way that those boards operate. Within that, I would agree with the NSPCC's concern, it is important that the specific needs of vulnerable children, and in particular looked-after children, are properly looked at and properly reflected. I was pleased to hear from the Department of Health that there is an analysis going to be done of the extent to which the Local Transformation Plans address the needs of looked-after children. I think that is important.

Lucy Frazer: As a separate section for children per se, yes.

Alison O'Sullivan: That is what I read into what was said and I welcome that. It is important we follow that through because the transformation plans are very broad and the challenges are very great in a number of areas, so it is important we do not lose focus on the needs of that particular most vulnerable group of children.

Lucy Frazer: Did you have anything on that?

Barbara Herts: A very similar comment. I think the health and well-being boards are absolutely critical for holding the Local Transformation Plan to account. I think that the role of the boards needs to be strengthened in a wider sense, but it is ultimately those boards that

have to hold the plan to account and I very much welcome as well the Department monitoring looked-after children and vulnerable children in those plans.

Q106 Lucy Frazer: A good point. In terms of statutory guidance in promoting the health and well-being of looked-after children, is there more that we should be pushing for in terms of something that is a bit firmer and more rigid statutorily?

Barbara Herts: I think the guidance is very good and I think it is very strong, but I think we need to push for a real entitlement, that when a child or a young person comes into care that they have that entitlement to an assessment that helps them work out their situation and any needs that they have. I think now particularly in my area we are seeing more older young people coming to our attention, 16 and 17 year-olds with quite entrenched behavioural difficulties, so we need to make sure that we do not have this patchy situation around the country where there is a real entitlement to that mental health assessment.

Wendy Lobatto: Yes, I think the statutory guidance is very good. There is a requirement in the guidance for the emotional well-being and mental health needs of the child to be assessed at the point of initial health assessment, but I think what is less clear is who should be making that assessment. At the moment, it is either a GP or a paediatrician who is likely to be making that initial health assessment and I think they are not the right person to be assessing what the emotional well-being and mental health needs are of that young person. In Haringey, we make our own assessments as an integrated mental health service. I would like to see in the statutory guidance that all children should be entitled to have their mental health and emotional well-being needs assessed by a trained and experienced child mental health professional at the point at which they come into care and have their initial health assessment.

Q107 Lucy Frazer: Presumably resource-wise that is a very rare commodity, to have somebody with that expertise?

Wendy Lobatto: I think it is quite rare across the country, although I think we do it in a very lean way in Haringey, where we do assess the emotional well-being needs of all children when they come into care with a very brief service model that I think is nevertheless very effective and helpful in terms of informing care planning decisions.

Alison O'Sullivan: I think many of the elements of what is needed are there in existing guidance, but you have to put time and energy into searching them out and then joining them together. I think probably what would be helpful is if we do a trawl of what is in the various bits of guidance, including the NICE guidance on practice and all of the rest of it, and that we have that drawn together in a way that makes it accessible to Commissioners and those responsible for these services so that they can see what it is that they are trying to achieve and what the outcome should look like. It may be that when we do that there are

some gaps, and in that case we should fill them. I think what I would suggest is that we look at whether a strategy is needed that draws together the existing best practice and maybe adds to it if there are any gaps or deficiencies.

Lucy Frazer: That is very interesting, thank you.

Chair: Thank you very much. Lucy, you are going to be talking about transitioning out of the care system, sorry about that mistake.

Q108 Lucy Frazer: How do you think looked-after children with mental health problems can be better supported after they leave care?

Barbara Herts: I think there is a need for much greater support because young people leaving care are dealing with a lot of very complex situations and I would like to see across the country particularly services that are more flexible. If a care leaver wants to stay with the CAMHS service rather than having to transition into an adult mental health service, I think that should be provided. I welcome some of the initiatives that are taking place to design 0 to 25 services, because adult mental health services can be very frightening places, there are very different systems of working and of course there are the budgetary and financial constraints as well, where a care leaver may or may not get the type of support that they need. I am very pleased that the Committee are looking at this area, but I think it needs a lot more work, and I am very pleased that “Future in Mind” is coming up with practical suggestions.

Q109 Lucy Frazer: Would you agree with the Professor’s comment in the earlier session that it should be permissive but not mandatory?

Barbara Herts: Yes.

Lucy Frazer: Alison?

Alison O’Sullivan: Yes, I would agree with that. I think when we are thinking about children leaving care there is the obvious focus on children growing out of care through age, if you like, and there is a welcome focus at the moment on care leavers and the support to care leavers. I know that that is an area that Government are looking at the strategy again and thinking of renewing that. That is very welcome; this needs to be part of that. But we also need to think about children leaving care because they become adopted or subject to special guardianship orders—so they may often be younger children and they have needs too. So I think when we have in mind what the needs are for children in care, we need to be thinking children in care, children who are adopted, children subject to special guardianship and care leavers who are growing out of care, and the sort of entitlement that has been described needs to spread to encompass all of those groups of children.

Wendy Lobatto: Could I just add that I welcome the fact that children are now more likely to be able to stay in their foster placements for longer periods of time, and for us not to forget that children who are likely to have suffered attachment problems and disruption in their relationships as either very young or middle school-aged children need continuity of relationships as they go through life. Our children have continuity of relationships with parents and I think the expectation that children leave care at 18 and then that it is it, they never see anybody again, is very unhelpful and unhealthy for them. I would like to see services that do put increasing emphasis on the importance of continuity of relationships for young people.

Q110 Lucy Frazer: For those who do not want to stay in the previous CAMHS system, should there be a dedicated CAMHS service for post-25?

Wendy Lobatto: I welcome the idea that services should go up until 25 if that is appropriate, but I guess the point I want to make about that is that CAMHS should be all of our business and that emotional and mental health needs for looked-after children cannot, I think, be sequestered off into this agency called CAMHS, which then has to manage all of the difficulties, but that they should be the concern of all of us, so foster carers, residential care staff, education staff, social care staff. All of us who are working with and looking after children as they grow into adulthood need to have an awareness of emotional well-being, because mental health services might not be welcomed or appropriate for that young person, but that is not to say that they do not have needs that can be met by other people in their professional networks.

Lucy Frazer: Barbara and Alison, do you have anything to add to that?

Barbara Herts: No, not really. I think it is important, as Wendy has said, that CAMHS is everybody's business and that CAMHS very often comes at the end of the line, and I think we need to get in that early identification and we need to get in that early help offer. I think that is where the other agencies come in with providing that help at an earlier stage.

Alison O'Sullivan: I would just emphasise something that came up through a discussion with the previous panel about the importance of building personal resilience and equipping young people to deal with the ups and downs of life more broadly.

Chair: Thank you, Lucy. Marion, you are going to be talking about monitoring of care leavers and workforce development.

Q111 Marion Fellows: Yes, I am, thank you. Good morning. Barbara, in your written evidence, you recommended that the Government invest in outcomes monitoring of

looked-after children. How could better monitoring of care leavers support their mental health and well-being?

Barbara Herts: As we have heard in the previous session, in this area of work outcomes and data are very patchy and very lacking, so I would recommend some very strong outcomes to do with resilience, to do with early help, to do with workforce development so that there is some effective monitoring of how effective services are. I think this is a very complicated area, particularly working with different organisations such as Health that might measure things differently from local authorities. But I think there is an opportunity from “Future in Mind” to develop a lot of stronger outcomes so that we can get to a better evidence base of what works in therapeutic care and treatment.

Alison O’Sullivan: I would add to that, because I think that—and this is one of the things that “Future in Mind” recognises—we do not have baseline data about either levels of need or what is being spent, let alone outcomes, and we need that across the whole system and we certainly need that locally. We do need that baseline information, and as Barbara says, we need to be clear about what the outcomes are that we want to see. We have some sort of prevalence information about populations in general, so we know 75% of children in care have some kind of emotional or behavioural difficulty, but that does not tell us enough, or nuance the needs of those people within that. We need to get to a point where we are clear at not just a population level, but also at a local level as to what the needs are, how effectively they are being met and what difference it is making.

Marion Fellows: Wendy, you are happy with that?

Wendy Lobatto: Obviously I think we need more data. One of things that we need more data about is what services are available around the country for looked-after children, because even that data isn’t available at the moment, as far as I am aware. I would like to get to a positive thought about what would a successful career in care leave you looking like, and I think it is something like when you get to your mid-20s, if you have something to do, someone to love and someone who loves you and somewhere to live, that is a reasonably good outcome and you have not had all sorts of unfortunate things occur to you in your life. It would be interesting to see how many of the children who go through our care system are able to claim those things when they get to be young adults and I certainly hope that we would see that many would be, but I think if we could measure that, then we could start looking at how services can be made more effective.

Q112 Marion Fellows: Yes, so we could look at the good practice and make that better. Could I ask, how could the current statutory guidance be improved to focus more heavily on transition out of care?

Alison O’Sullivan: I think what we need to see is a joining up of the work and thinking around support for care leavers and this area and collaboration across Government. I know that that is taking place, but I think we need to bring greater focus to joining that up.

Marion Fellows: Wendy?

Wendy Lobatto: I think if there is more provision for young people generally when they get to the age of 18 that young people who are leaving care can access, then that would be helpful for them. I think that those services should be more than just mental health services, that they should be wider well-being services, so a place where young people can go, where they can do education, training, sexual health, relationship talk, all the kind of things that young people need to be healthy and have well-being in their lives. I think if those services were available for young people more generally, then looked-after children could be part of the user groups.

Q113 Marion Fellows: And not be stigmatised almost?

Wendy Lobatto: Yes.

Marion Fellows: Barbara.

Barbara Herts: Yes, very much along the same lines. I do think that particularly for care leavers and for all vulnerable children, this needs to be within the rest of Children's Services as well, so moving away from that stigma, the principles and that whole vision of "Future in Mind".

Q114 Marion Fellows: Thank you. I am going to move on to workforce development, which is an important part, I think we could agree, of all of this. Do you think that—all three of you—is there enough training available for foster and residential carers, particularly on how to support children who have experienced a significant trauma, and how would you rate the quality of any training?

Alison O'Sullivan: Perhaps I should begin. I think this is an important area, and "Future in Mind" is quite ambitious in the scope of the training and awareness-raising that it envisages, from broad-based training for anybody who comes into contact with children through to more specialist focused training. Our experience in my local authority in Kirklees is that it is very helpful to equip people with a role caring for children, those with a professional role caring for children—residential carers and foster carers—with some tools that they can use, not just to understand mental distress and mental ill health in the young people that they may be caring for, but also then to know what to do about that. There are a number of programmes around.

We have adopted the Pillars of Parenting approach, which supports those workers. We have started with the residential care workers and we are moving on to train and equip foster carers as well, but it gives them a framework to understand children and young people's mental well-being, but also it gives them techniques to engage in terms of tackling difficult behaviour. They have told me that that is very empowering. There are other programmes of a

similar kind, but I think we need to recognise that those people with a role caring for children who are inherently vulnerable need to be equipped and supported to know what to do and have the confidence to deal with that well.

Barbara Herts: I think there is a role as well for parents that are adopting to have that training. That is very much something that we are doing in Essex. We have a programme of therapeutic work for parents who are adopting, but also, I think, training the workforce so that these placements do not break down, because it is very, very difficult and time-consuming. We want the placements to last, so I think it is vitally important that the current programmes of training for foster carers and adoptive parents are sustained.

Wendy Lobatto: I would like to echo what both Barbara and Alison have said, but I want to add something, which is that while training is extremely important and relevant to assisting professionals to look after children, training tends to be kind of a one-off event and you have done it and then you are trained. The question is how you then operationalise it in your day-to-day working lives? That is what I think we need to be thinking about: individual children's needs and bringing together parenting teams around individual children, where everybody in that team has had the training and understands the principles and practices of effective childcare with children who are vulnerable, but the teams of people come together to work together in parenting teams.

Something that Professor Fonagy mentioned earlier was how fragmentation in systems can sometimes reflect the fragmentation of children's inner worlds, and bringing people together who are charged with parenting that child in a group so that they are supporting each other with parenting, using the training that they have, but operationalising it for each individual child I think is inescapably important.

Alison O'Sullivan: I absolutely agree with that. It is important to embed that training and it is about developing new ways of working, not just one-off training, I absolutely agree.

Q115 Marion Fellows: So you think that this sort of thing would improve the current quality of the training that is available if this particular aspect was gone into?

Wendy Lobatto: I think it is an addition. There needs to be all the training that we can get for people, because it is very important, but on top of that there needs to be a practice of people working together, thinking about the needs of individual children and how to meet them.

Q116 Marion Fellows: Do you think the Government should commission core training in mental health for all professionals working with looked-after children? Should this be mandatory?

Alison O'Sullivan: It is always difficult, isn't it, to say whether something should be mandatory or not. I think it would be very helpful if it happens, but I think that is important, that it is tailored to the particular circumstances. I think very often, by influencing existing training channels and existing training mechanisms and making sure that that is built in, that can be a more sustainable way. There is a danger with mandatory training, if it is not designed and embedded well, that it becomes a bit of a tick-box thing. I would favour embedding it in, but you need to have a systematic approach and you need to know that that is ongoing, that it isn't just a one-off.

Barbara Herts: Very much along the same lines: I do think there is a gap here, but I think it needs to be perhaps thought about in local areas, perhaps as we are implementing in local authorities "Future in Mind" it would be very helpful to share plans, to share training and to think particularly about workforce gaps. But I am not sure about a sort of blanket tick-box mandatory approach at this stage.

Wendy Lobatto: I think I share those views, because obviously different areas already have different approaches to how they support their foster carers and it would be good to build on the best of those approaches. I think it would be helpful obviously if there was kind of vigilant oversight from Government to ensure that all areas are putting sufficient resource and attention into the needs of looked-after children and the needs of the workforce that support them.

Q117 Chair: Thank you, Marion. It remains for me to ask if there are any changes—perhaps one each would be a good idea—to improve provision of mental health care in the sector for children. Who would like to go first?

Barbara Herts: I would like to follow on from what Professor Peter Fonagy said, because I do think there is a need, with the transformation plans. I would like to see every area have that specialist that could be that sort of systems leader for mental health and well-being to identify appropriate pathways, to be thinking about evidence-base and research and how things can be done differently. I think for each area to have that systems leadership, and perhaps it would be a person or a partnership, and I think it would make a great deal of difference to the lives and futures of children and young people.

Q118 Chair: Would that be sort of in line with your approach to integration, which you have obviously developed so successfully in Essex?

Barbara Herts: Yes, it would be, and clearly we have a lot of GPs around the county that are fulfilling that role. I have to say it was a very enabling feature of our development, that we have had those systems leaders, but I know that around the country that is not the case, so I would like to see some consistency in having that approach.

Q119 Chair: So you are saying systems leaders with a special focus with an integrated system?

Barbara Herts: That is right, yes.

Chair: Okay, thank you. Wendy?

Wendy Lobatto: That is an interesting suggestion and I think that fits quite well with what my recommendation is, which is that I think we should have assessment services like First Step, which I manage in Haringey, in every local authority in the country assessing the emotional well-being and mental health needs of children when they come into care, giving advice on care planning and therapeutic input and then following up those children's emotional welfare needs every year subsequently. I think without having dedicated services, however small they may be—we are not a big service, but we do have a remit for being mindful of the child or young person's emotional health needs and making recommendations about what they need in terms of placement planning, contact with birth family, educational needs, therapeutic needs and other needs that that child may require, including debriefing on what has happened to them. I think if we had a service like that in every local authority in the country, maybe which could be headed or have a relationship with this CAMHS LAC lead or the kind of person that Professor Fonagy and Barbara have talked about, then I think we would be on the way towards improving outcomes for looked-after children quite quickly.

Chair: Thank you, Wendy. Alison?

Alison O'Sullivan: I would like us to find a way of making sure that we shine a spotlight on the needs of looked-after children, and when I say children in care, I mean adopted children, special guardianship and care leavers too, that we shine a spotlight on their needs within the breadth of the ambitions of “Future in Mind”. It is an ambitious and broad programme and we need to make sure that we do keep a focus on looked-after children in particular. That might be through drawing together from what is already there and enhancing to create a strategy. I would like to see an entitlement for children in care articulated as part of that, an entitlement. I would like to see us articulate what an entitlement would look like for children in care. I know that there are reservations about singling out particular groups for access to universal services like the NHS, but my challenge back would be which other groups are in fact the children of the state? I think we have a responsibility to those children over and above other children in the population.

Q120 Chair: Just to clarify, because obviously your role as President of the Association of Directors, when you say “we” and “shining a spotlight”, who?

Barbara Herts: I think the purpose of the Committee is obviously to make recommendations—*[Interruption.]* Can you hear me still?

Chair: I am still going to be here, because I am half-deaf, but carry on.

Barbara Herts: I will start again. I think Government should know how well we are addressing the needs of children in care and that is the purpose of the overview strategy that I was referring to earlier. But I think it would be very helpful for us all to articulate what an entitlement might look like for children in care to be a benchmark against which we should all be measured.

Chair: Thank you very much indeed for your answers to our questions and the three suggestions, all of which we have noted. Thank you very much indeed.