Family Justice Council

6th Annual Debate

Central Hall, Westminster

Monday, 3 December 2012

Chair: Rt. Hon. Lord Justice Thorpe
Deputy Chair of the Family Justice Council

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Motion for the debate:
"Women who have children removed to care, year after year, are being failed by a system unable to respond to them as vulnerable adults needing support in their own right"

WELCOME

Chair: Rt. Hon. Lord Justice Thorpe
Deputy Chair of the Family Justice Council

Thank you, Tessa; I too would like to welcome you all on behalf of the Family Justice Council. This is I think the sixth Annual Debate that we have organised. They have all been very well attended, they have all addressed topical issues for family justice, and this is clearly a worthy successor to those that have gone before. Tessa has said that the speakers are eminent, as indeed they are, but having seen the delegate list of all you who are attending I see what an enormous expertise there is gathered in the room here today.

The format is straightforward; we have one hour for the debate followed by one hour for discussion, and it follows that each speaker has something approaching 15 minutes. Dr Karen Broadhurst is going to propose the Motion; Tina Wilson will then oppose the Motion; Anna Wright will then come in for the Motion; and Natasha Watson has the last word!

I have been provided with biographies for each of the speakers, and I would take 15 of our 60 allotted minutes were I to read these out to you, but suffice it to say that Karen is Senior Lecturer in Social Work at Lancaster University; Tina Wilson is County Manager for Safeguarding Children in Suffolk; Anna Wright is Honorary Research Fellow at University College, London. She has a wealth of experience in local government, in Parliament; and Natasha Watson is co-Chair of the Sussex Family Justice Board, and Managing Principal Lawyer for the local City council. You can see that the debaters know what they are talking about, so with that I will ask Karen whether she would propose the Motion.

Dr Karen Broadhurst
Senior Lecturer in Social Work & Social Science
Lancaster University

Presentation with slides

I have some slides; being an academic I am psychologically dependent on slides, so I will come over here and hope this works, just to show you what I intend to talk about.

As Lord Justice Thorpe says, I am proposing the Motion. My interest is in women who have been subject to repeat compulsory removals of children, and stems from a long-standing engagement practice and research with a number of local authorities, in which myself and my colleague Clare, who is sitting here in the front row in a very becoming fuchsia dress (and who has managed to get out of doing the talk) are involved. We have done a lot of research with local authorities, and obviously the issue of repeat removals keeps coming up. I think it is fair to say that on humanitarian grounds alone it is very difficult not to be bothered by these stories.

Alongside a number of other research projects that we are running with DfE and CAFCASS we decided to do some pilot work, and have managed to profile 30 birth mothers. To set the scene, my view in supporting the Motion is there are two questions that need to be addressed. Anecdotally we all know that these mothers are vulnerable, but we need some empirical evidence, which is what Clare, and I have set out to do, and also FDAC – Judith Harwin, Mike Shaw, Sophie and colleagues - and also colleagues from Suffolk and Reading, have also produced data. We have an aspiration that we will put this data together and produce something convincing for Government.

However, I will just set the scene by asking ‘Are these women vulnerable?’ Part 2 in supporting the Motion is to say ‘Are these women falling through service cracks?’ - so is the system failing?

First I will run through some preliminary findings from this data in relation to broad questions of vulnerability; and secondly, I will just run through a short case study that illustrates the way in which a young care leader falls through the gaps, and has these multiple pregnancies.

I will try to stick to time as well!

So: three local authority sites, work is ongoing. Our criteria were within the period 2008-2012 to identify a sample of women who had had a further pregnancy; previous to that

they had either had single or multiple pregnancies; and they have had compulsory removal of those children – mostly through adoption, some special guardianship.

We have 30 birth mothers with surprisingly 116 infants, and as Tina will tell you later it is a piece of parallel work that we haven't communicated about until this point. You have 30 birth mothers with 116 children, so it does show the volume of children that these mothers can have, how tragic that is.

What we have tried to do is map their life stories in a way, so just to simplify that what you can see here – and I don't think any of this will be new to you – provides the empirical evidence. This is about a pattern that starts very young in motherhood, so we have our youngest mother in the sample, 15 when she starts on this cycle. All the mothers were under 25 at first removal, and having a daughter myself who is 20, that seems incredibly young and vulnerable to be starting out on a pattern of repeat removals.

Staggeringly, within our sample of 30 mothers we also have 35 per cent who are pregnant again before legal proceedings have concluded; and again I think that will be a familiar scenario to you.

What we have begun is to try to map these pregnancies. One of the things that is quite interesting that has come out of this so far is that with these pregnancies some women seem to have a pattern of just having another baby every couple of years, sometimes even within two or three years, whereas other women do seem to have a space between pregnancies – but still failing again, perhaps when they think 'I have met a new partner, I will try again here'. It would suggest that we need to look at planning, that some women are perhaps not planning and their lives are pretty much out of control, whereas other women are taking some control of their reproduction.

Again I don't think anything will surprise you here, but what has really come out of this exploration of these case histories so far is that mental capacity is really running right through this group of women. There are major issues around their capacity to exercise choice, to be in control of the intimate partner relationships they are in, and long-standing mental health issues, some going back into childhood - obviously domestic violence, relationship conflicts, substance misuse, learning disability - 40 per cent which again is quite high.

We have also found sexual assault and sex working, sadly. We don't know how much of this is disclosed, but again you can see if you begin to put this picture together this is a highly vulnerable population. The empirical data does certainly support the Motion that these mothers are vulnerable.

We also looked for positive features and informal networks, but we only found in 13 per cent of the networks that we could identify a relative who could give support, so again we thought that would be an issue we would like to probe further in relation to decision-making and women's sense of control over their lives.

Criminality also features, lots of very, very violent men with these women, and a number of them in and out of prison.

We also wanted to look at mothers' own childhoods, because it is not easy nowadays when you want to look at women's childhoods through case files. Lots of the court reports I have seen have focused on parental compliance; the old psycho-social approach to understanding families seems to be a thing of the past. However, what we managed to probe was that 87 per cent of our sample have children's social care involved in their childhood, and if we were to take just the UK cases – because we have four migrant women here – that would be 100 per cent, so 100 per cent have had very difficult childhoods, and 50 per cent have had a care episode. We have a number of young care-leavers in this sample. Sexual assault in childhood –

I have missed a point there. One of the things that is really interesting is this business of a parent abandoning a child, or death of a parent, which has surprised us but which has come out of the sample; exposure to family violence, obviously again that won't surprise you; and mental health in the parent. So they are incredibly difficult and damaged lives for these vulnerable women.

We have tried to take it a little further, and again recognising limitations of a sample of 30 mothers only, we can say 'Okay, one size doesn't fit all here; actually beneath those global statistics, we have some differentiation in respect of these women'. There are particular patterns of vulnerabilities, and there are particular challenges that they present to services, so we grouped them.

I want to say this is quite limited again, because it is a pilot study of only 30 mothers, but we have a group who think that learning disability is the over-arching feature of these cases. Some of those mothers were very much engaged with children's services, but obviously they are just now above the eligibility criteria for adult services, so when they fall off adoption proceedings maybe they will have access to adoption support, possibly some good practice in some areas, but they are not likely to receive an Adult Services response. It might be that those women can be assisted to access healthcare, etc., during proceedings and certainly after proceedings they are likely to find themselves pretty much alone in the world.

Group 2: substance misuse. This is the FDAC, and again people who seem to have just huge problems with drugs. We see in this group, interestingly in our study, periods where babies are at home but sadly periods of relapse, but again a slightly different pattern of service use and a slightly different pattern of particular vulnerabilities.

We also have a group of young care-leavers, which tugs at all our heart-strings, that these very, very young and vulnerable care-leavers often partnered with other vulnerable care-leavers – quite a worrying population, particularly as we have taken cases that are very recent. This is not historic; this is past all the leaving-care legislation and the New Labour 2006 Leaving Care series, so we would have hoped possibly to be doing something better.

Now, chronic Group 4 Clare and I feel are the biggest challenge for a prevention agenda. We have described these as mothers where the overriding issue is chronic and complex mental health. As all of you know, who are involved every day in the court process, the most likely diagnosis here is personality disorder and a recommendation of 18 months' therapy before you can parent. What are the chances of getting your 18 months' therapy? [*Zero*] Zero – correct; and becoming worse. They are a very challenging group in terms of their histories, which are very poor in terms of mental health backgrounds, but also the prognosis is poor, because I think they fall into a therapeutic hole for which we simply, as a country, don't really provide that service.

On to my last slide – and I hope I am within time – 'Failed by the system'. Just an example of the care-leaver: this is the second part of the Motion, and if we are to support this Motion we need to evidence failures within the system. This is a bit of a busy slide I am afraid, reflecting my teaching background when students want a million numbers of things on the slide, but you can see I have highlighted in red here where this young care-leaver has failed. She is a 16-year-old with a history of care episodes, and at aged 16 returns to live with her parents, who can't cope with her. They make a number of referrals to the local authority, and what does the local authority do? 'No further action, close the case, we are not re-admitting this person to care, we have run out of ideas'.

So there she is at 16, she is pregnant, she is in a bed-and-breakfast and she is hanging out with offenders. The pregnancy is notified early by the Leaving Care team – great – 16 weeks, so there is a little window of hope there, but what happens is that Children's Social Care hold it in their electronic box and say 'This can come through at 26-28 weeks because we have a queue of these mothers, so she has to join the queue'. It is opened at that point for a child protection conference and pre-birth assessment.

I guess at this point the following events don't surprise you: what the local authority deems during that short window between the pre-birth assessment and birth of the baby is

that here is a young mother who is unable to maintain a tenancy, who is presenting rather too often for food parcels. Again this might be familiar to you. A meeting is called and the young girl comes along; she doesn't have legal representation, but a plan for a Section 20 goes ahead anyway.

Finally the story goes on; the baby is removed at birth, care proceedings, etc., but what really struck me about this is that there is no psychological assessment or therapeutic input around what is noted on the file, 'Query attachment issues'. Of course she has attachment issues; she is ambivalent about the baby, but look at her own childhood. However there is no work done there, so there she is at 19, both infants placed for adoption because she has had another one by now, and she leaves the court with a damning parenting and psychological assessment.

That is my case in support of the Motion.

Ms Tina Wilson

Area Safeguarding Manager, Children & Young Peoples Services
Suffolk County Council

I don't have any slides at all! First of all I would like to say that I am talking against this Motion, and I am talking against it because I don't think there is a system failure. There may be a lack of co-ordination, but not necessarily a system failure.

I work in Suffolk, and for the last three years I have been working with a very small, select, team who have been supporting these women. When I say "a small, select, team" I mean one health visitor, one midwife, and myself. We have done it on the back of a postage stamp, so "team" is probably a little exaggerated.

Why did we start it? We started it because I got fed up with presenting my quarterly reports to my senior managers saying 'We have a problem, look at these statistics; they are not going away and they are increasing'. They said 'Then do something, Tina', so we did; we have tried to do something.

I will come on to what we have done in Suffolk, but first of all I want to address two questions to you: one of them is 'What is the scale of the problem?' Quite rightly so, you have said already there is no national or local data. There are small pockets where people have an interest and have started to gather some statistics together, but nationally and locally they will not be required to report on this. Also, why is it so difficult to meet the needs

of these women? Actually we all know what their needs are. We all know what the outcomes of the psychological assessments say, so why is it so hard to meet that need?

Coming on to the scale of the problem, whilst there are no national or local statistics required, we know from a study in Berkshire where there were 43 babies removed from 30 mothers who previously had had 76 children removed. That is really scary – and that is in one year.

Bringing it back to local issues where I am in Suffolk, we have done some work. We have three hospitals that cover Suffolk, and one hospital has worked with us on this project. We have had 34 babies removed in one financial year (2011-2012), and of the 34 babies removed, 24 had previous siblings in care. Of those 24, four women were on their seventh and eighth child – so it is a problem, and it needs to be addressed.

Why is it difficult to meet the needs of these women? For me, I have learned a lot from engaging with the women for whom we have been able to make a difference, in the fact that one day they are everybody's clients, they belong to everybody, and they have a wealth of activity – and the next day they are nobody's. All the services are directed to them when they are pregnant, and whilst we are trying to look at the assessments with the child, after that there is nothing. Children and young people's services are directed to work with the children; the court system is about the children; there is nothing about these women that make them a relevant caseload for anybody.

For me the key issue you mentioned was the psychological assessment. They are assessed in a period of time where they are scared, they are defensive, they are frightened, they are about to lose their child – and we wonder why the assessment is always quite negative. We have looked at re-assessments which are a lot more positive when they are not in that period of time where they are really fearful that they are about to lose their children.

I do think the current system can work for these women, if we move it forward and we become flexible within the system. That is the basis of the reason why I am speaking against, which has proved difficult – but first and foremost we need to realise that these are a really hard-to-reach group of women, and actually you will not be able to help everybody.

So how do you measure success when you are working with human behaviour? We need to be really clear that there will be a group of women who we will not be able to help. We need to understand the willingness, but also the capacity to change, because they are two entirely different things. We have learned that through the work that we have been doing.

We have one mum – and I will phrase my wording a lot more politely than she worded it to me – who basically told me to 'Whistle in the wind'. She had or was on her ninth baby about to be removed, and she told me 'Don't be ridiculous. I'll join your group when I've had ten. My mum had ten, my grandma had ten'. For me she is in that group which is too difficult to reach. She has a mindset, and we need to be real about the resources we do have.

What have we done in Suffolk with our existing resources? On the back of the fag packet we had this wonderful idea, and we worked with 15 women; we identified 15 women that we could make a difference with – fantastic. By the time we reached between the six-to-12-week period, 10 of them were pregnant, so timing is of the essence! Pivotal to this is the lack of contraception services. These women lead chaotic lifestyles. They don't turn up to an appointment on Wednesday at two o'clock; they DNA and they are then closed, so we have to find a way of outreaching to them to bring them back in.

By the time we realised that contraception was a bit of a problem we had to identify a few more women to work with. We have gone for the real directive approach, where we are hand-holding and proactive. If we don't go and get them for the appointment they will not get there, but the gain in collecting them and building that trusting relationship is ten-fold.

Key benefits to these women: we have spoken to them, and the most telling bit for me is one lady that we worked with, that six hours after delivering her baby she walked out of the hospital to pick a man up in the street to have sex with him. That wasn't about sex that was about a need to be needed. That was a human crying-out. That kind of stuck!

We have also worked really well, from the feedback we have received, in that we have allowed these women to take control back of their own lives, just in small pieces, but by doing that they have a sense of belonging, just a tiny bit that they are not 'done to'. They have a bit of control over their lives, and they come from chaotic backgrounds. You have seen the background history to these women, so I don't need to go back through that.

The impact of this work, whilst modest, means we can report that we have had some early mixed results. Of the seven women that we finally got to engage with they are not pregnant, because we have the contraception services in place. One did drop out and become pregnant; two others also dropped out, but they were transient. They had been through a number of local authorities, so they disappeared off the radar. We have had two that took up long-term acting contraception and have gone on to be sterilised. That is quite shocking, and people don't know whether that is a positive or not, but actually they took control, so I think that is a real positive.

We are engaging with two women at the moment and that is being really successful. They have had their re-assessments, the psychological assessment – believe it or not – and it no longer says 'Eighteen months' psychotherapy, personality disorder', it actually states that 'With three months' therapy this women will be in a position to start to positively parent again', and she is now getting a nursery ready. It doesn't mean it will work, and it doesn't mean if it fails it is wrong, but it means that we are trying.

In Suffolk what have we done? We have worked with these seven women, and we have made savings of about £700,000. That is almost an irrelevance, because it is the human cost, and we have managed to do it on the back of a postage stamp.

That is why I am against this Motion.

We are moving forward, so I will make a plea while I am here – and I might as well, because apparently my colleagues tell me there are some wonderfully eminent people in the room, and I am hoping some of you have some purse strings! We are in the process of setting up three supporter roles to outreach to these women in Suffolk. We already have funding from Suffolk County Council for one post, we have funding for another post from the Ormiston Trust, and we are moving forward. We have co-ordinated our services in Suffolk to recognise these women as a priority status. We have learned from our Looked After Children, which we think we do positively discriminate against now, and we have done the same for these women, so they are fast-tracked into mental health services, drugs and alcohol services, treatments, therapies, etc. We have taken the lax status and moved them forward.

On that note, I will end – but we do have a third role which I don't have the funding for yet, so if any of you do know of anyone that wants to provide any funding, I am more than willing to take your names and numbers!

Thank you.

Anna Wright

Independent Consultant in Education and Children's Services
Norham Fellow at the University of Oxford Education Department

Good evening everybody. Up until March 2012 I was Director of Children's Services in Reading, so what I will talk about relates to my experience working as a DCS in Reading.

Why do I believe the system is failing women? I believe that even though you might be able to deliver within our current system a service that helps some of these vulnerable women, either to parent effectively or to decide not to have babies in the future, the system does need a fundamental re-think if we are to make effective provision for both the women and the children.

Why do I believe that we need this fundamental re-think? In Reading we had a similar story to that which you have heard so far. We found that in a certain period of time we had removed 106 children from 30 families – 106 children from 30 families! We looked at the mothers in detail, and we found an equivalent finding that of these children 30 per cent were born during the care proceedings for a child that was previously in care proceedings, and the average age of the mothers was 26. The biggest reason for initiating care proceedings was substance misuse, with domestic abuse, learning disability, and mental health, bringing up behind them.

Now, why do I believe this was due to a system failure? We looked very carefully with our Adult Services colleagues at what sort of services the women had received. To start off with, what sort of support had they received for those difficulties that I have just described? We found that if you were a substance misusing-mother you did receive a service. It was fairly straightforward: you were substance misusing, you went into a substance misuse service, and if you were referred within five months of the birth, many of those services were very effective at getting the parents off drugs, or to be maintaining drugs safely by taking methadone. So those services were quite effective – provided they had time. If they were referred at two months before pregnancy they didn't have enough time to do that piece of work.

However, we found that for mothers with mental health difficulties and mothers with learning difficulties, they didn't receive services. They were often referred to Adult Services, and they were told they didn't meet the criteria. The parents with mental health difficulties didn't have a disorder that was classifiable under ICD-1 classification; the mothers with the learning difficulties didn't have an IQ that was below 70; however, in both cases their mental health and their learning disability was sufficient to mean that they couldn't continue to parent a child.

When we looked in detail as to why this happened in Adult Services, we found that the basic need as defined in policy is for Adult Services to be offered anybody who is "unable to fulfil a basic family function". That is the definition; but when you are organising your services you don't organise them on that basis, you decide to put together adults who have mental health difficulties in one service, adults with learning difficulties in another service,

and if you don't fit either to those and you have a different sort of difficulty, you tend not to receive a service.

One of the fundamental difficulties is how we organise services, because the way in which we organise services determines the lens through which we look at families and offer them services.

The second interesting thing about the way we organise services is 'What kind of assessments do we do on these mothers?' One of the extraordinary things we found is that we were paying for assessments on all the mothers, at a cost of about £4,000 per assessment – but what question did we ask when we asked for that assessment? We didn't say 'This is a vulnerable adult, we want to know what their needs are', we said 'This is an adult, and we want to know whether they will be able to parent successfully in time for this baby'. We thus received lots of reports saying 'No, this mother won't parent in time successfully for this baby', which didn't tell us what the parents needed, because actually that wasn't what we asked.

Interestingly, overnight we made a difference in our commissioning of assessments. We stopped just saying 'We want to know whether they can parent', we said 'AND we want to know what would help them parent successfully in the future'. What was really interesting was that it didn't cost us any more to ask that question, so there was an immediate change.

We then asked 'Just out of interest, what is all this costing us?', because obviously our Adult Services colleagues were saying 'It is very difficult for us to take on more adults, because we only have this certain amount of resource, and we have these tight criteria to help us manage the amount of resource that we have'. We looked at the cost of provision being made for these mothers across the services, so we costed everything: we costed the referral to Social Care, the assessment in Social Care, both initial and care, we costed the cost of a social worker's time in strategy meetings, we costed the amount of support the social worker provided to the foster carer and to the birth family, we costed the amount of the court fees, the assessments, and also the time of the infant in foster care. That was the biggest cost.

Per infant, the costs were £66,000 for every infant that was in an internal foster placement; and £102,000 for every infant that was in an external foster placement, because independent foster placements are much more expensive. This means the average cost for each mother, and the average number of children they had removed, was three – so each mother had three children removed, and the average cost for each mother ranged from £200,000 if their babies were in internal foster placements, and £300,000 if their babies were

in external foster placements. We had one mother who had eight children removed, and the cost for her babies would have been between £0.5 million and £0.8 million.

So we said 'Mmm – is this very cost-effective for Social Care, to continue to operate in this way, and wouldn't it be more effective if we operated rather differently?' I will now go on to why I think the system is fundamentally flawed.

One of the discussions we had was about what was our objective. Our objective in Children's Services was to keep the children safe. That was the paramount objective that we were focusing on. We didn't really have an objective for the mother. There were two problems with that: one is that at a certain age you stop being a child and you start being a mother, and once you start being a mother you are somehow responsible for what happened to you, and you are not classified with the same vulnerability as if you are a child. That cut-off point seems incredibly arbitrary if you are a vulnerable adult.

The second issue is the fact that we have the wrong goal. We should have had a goal that said 'Yes, we want to keep the baby safe, that is fundamental, but actually we also want more women to be enabled to change their lifestyle so that we remove fewer babies at birth'.

When we re-focused ourselves around that goal and said 'If as Children and Adult Services working together we focussed on the goal of more women being able to change their lifestyle and ability to parent, either to decide they didn't want to parent or to be able to parent successfully, we will then remove fewer babies at birth, and we should have a goal that we don't have to remove fewer babies at birth – not because they would then be safe, but because we know that either they wouldn't be born, or because they would be born and the parent would be able to support them effectively'.

I believe services are fundamentally flawed for two reasons: one is they fail to see children and adults in a holistic way, and understand how they are joined up. They fail to see the connection between the vast amounts of funding that are spent on children's social care and the minimal amount of funding if you are a vulnerable adult and you don't actually meet the core criteria. There is also a fundamental issue with the culture that, at a certain point, we stop seeing adults as children, when actually a lot of these vulnerable adults are really still children in the way that they think, in the way that they process, in the way that they look after their lives.

That is why I am arguing that the system is fundamentally flawed.

Natasha Watson

Managing Principal Lawyer
Brighton & Hove City Council

Presentation with slides

I hate speaking without a lectern; I feel all my special props are ruined! When I was first informed about the Motion, before you can say '26-week timescale' immediately the slots for speaking for the Motion were taken! I thought 'Rats', because I am the Local Authority lawyer, and many of you will think I am the face of the system.

Those of you who know me personally will know that I find the idea of being an establishment figure rather amusing – but nonetheless for those of you in the room I am sure I am the face of the local authority, and so I was quite relieved to receive this advice from the Secretary to the FJC. She said:

> "All of you may agree with the Motion, albeit it perhaps for slightly different reasons. However, speaking against the Motion does not imply uncritical support for the *status quo*."

This came as a relief, because I thought were I to appear to be that uncritical supporter, it would be a bit like Paul Dacre stumbling into the AGM of Hacked Off. I have every sympathy with those of you who are hacked off with what appears to be a very complicated system, that doesn't always know how to assist vulnerable adults, and I should say right at the start that I do agree. I think it is a no-brainer that women who have children year after year who are trying to gain some form of solace from their repeat pregnancies are clearly vulnerable. It seems to me self-evident that those women ought to be entitled to some form of adult services which represent their vulnerability.

The problem I think is do we have a system which will address this? The answer I believe is that we don't have a single system. What we have is a series of systems: we have Adult Services, we have the NHS, we have Children's Services; and for years and years and years one of the things that is curious to me about this agenda is that everybody has recognised that that is a problem that needs to be cracked, but nobody seems able to crack it. Successive Governments have indicated that 'This time they want to solve that problem', but the problem is that everybody seems to do it from an ideological perspective.

We set up Children's Trusts, and the idea there was to have pulled budgets, a plan that Adult, NHS and so forth will worth together again, and the first thing the coalition did when it came into power was to end the Department of Children, Schools & Families, and it became the Department of Education. This was very visibly represented by the dismantling

of the rainbow; did any of you notice that the rainbow became pixellated? [*Yes*] That had previously been the logo for the Department of Children, Schools & Families.

It is really important for the system to be joined-up, so I want to issue now a note of caution about GP commissioning. [*Laughter*] Some of you will notice that changes are coming to the NHS, and it is a very dramatic change. In future instead of having Children's Boards that are supposed to join up some of these services we will have Health & Wellbeing Boards. Actually the commissioning of mental health services – and you have heard a lot of very persuasive information about the need for proper mental health services – will fall to GPs. I would hazard a guess that this is not the most sexy agenda for them, and some GP Commissioners may think hip replacements is an easier issue to solve than what will be necessary to meet the needs of these women.

This is where I come to the 'Graph of Doom', because I can't avoid talking about the vulgar subject of money, so apologies for that. Some of you will have this in your packs, I hope.

You will see in the Graph of Doom that for local authorities, if we continue to spend as we are, by 2018/9, literally in my local authority there will be no money left to do anything other than children and adult social care; so the challenge for the system is that if change is needed it must be done within existing resources, which means those resources need to be targeted. When you hear about very good schemes like Tina's scheme, what Tina can't do is solve every problem, and so it is really, really essential that we recognise that the system isn't to blame for all human failings – and of course, would you actually want a system where all human failings were the business of the system? I suspect that you wouldn't, because the danger is that if we have that kind of culture it becomes very interventionist and rather scary – and as I heard a psychologist say recently, 'Without someone who wants to be treated, there is no patient', and here I find myself in the rather ironic position of defending the right of the mother to tell the social worker – now, I don't want to make the podcast by using the word I would like to, but were they to tell the social worker to 'Go away', it seems to me they have every right to do so.

In an age of finite resources, and given the stakes with the child, it is really vital to work out what is achievable and hone in on it. This isn't an easy thing to achieve, and I am wary of professionals who work in good faith – like those in Tina's team, being branded failures because they can't wave a magic wand. Actually the reality can be very stark.

I sometimes do something I suspect not many eminent people in this room do, which is to attend meetings before action. I remember a meeting before action that I went to last year involving the mother of eight children. I will slightly conflate the facts to protect her

identity. What was tragic about this was not that this mother had been offered no help, she had been offered help from every agency you can imagine; but she was so damaged as a result of her parenting that she could not trust anyone who came from any kind of public agency. As we sat in the meeting offering her this and offering her that, I realised that the fundamental problem was on the table in front of us. This was the clear plastic bottle that she was drinking from, swigging from, that seemed to produce the effect of her slurring her words – and I will say no more than that. Eventually when we were in proceedings and when the liver tests came back, even then she was not prepared to accept any offer of help to deal with what was as plain as day – alcoholism that had been in her family for years and years and years. When we looked at her childhood we didn't have to look very hard to understand why she felt like that.

I would just like to mention something about the timescales of the child, because what is essential here is that the system targets its resources to avoid children repeating generational cycles of abuse. That is essential, because what we know is that where adults are very, very damaged, for some of them it is too late for the child and they will not be successfully offered help.

Some of you will know the Loughborough research from 2010 that really looked at the need for changes to be made within the first six months of the child's life, and unless that happened it really was too late. What this tells me is that the system is not good at addressing pre-proceedings the needs of the adult, and I strongly believe that this is something that has to absolutely fundamentally change. Once we reach the beginning of that 26-week timescale it is very unlikely we will be able to turn really fundamental problems around unless it is at the cost of the child.

The system really needs to be able to distinguish between those parents who can and want to be helped, and those who are unresponsive and dangerous – and that is quite a task isn't it? Let's take an example: let's think about a young woman, her early twenties, she is the mother of four by different fathers. She has experienced an absent father who was a sex offender, a neglectful and abusive mother, and another relative who was lured into a paedophile ring in one of the biggest children's home scandals of the late twentieth century; and when the State intervened to protect her, it was too late and it was ineffective.

Now, what should the system do when confronted with someone with that history? They should be sympathetic; they should recognise that she will need assistance; they should recognise that this parent will need help in their own right; and no doubt the system should recognise that that help might not be effective on fast timescales - so what should we do? Should we offer her a package of support, should we offer her some respite care,

maybe a childminding service, maybe some therapy for her? What shall we call that mother? Shall we call her Tracey?

Tracey's experience with Social Services is that a girl made her terrified of social workers, and it also made her attuned to the sorts of buzz-words and language that the system likes to hear, and feel reassured when it does. In fact, Tracey might be so co-operative that we could ask her to participate in solution-focused practice, and we might even film it in an hour-long interview as part of a course in new social work methods, aimed at encouraging parents to co-operate with the authorities.

Who couldn't sympathise with Tracey when she says 'I don't like having people interfere. I know that the social worker is there for a job, and I know they are there for a purpose – and at the end of all this, I hope that they will back off and leave me alone, because I am a caring mother'. We will have lots of monitoring and lots of different professional agencies being involved with the family, including such lauded organisations as Great Ormond Street Hospital.

What happened with Tracey's fourth baby? Well, her baby – Baby Peter – died after months of abuse under the noses of Adult, Housing, Health and Children's Services. It was a seminal moment in child protection in the 21st century, and it is one that we shouldn't forget.

So I want to issue a note of caution: because while I am very sympathetic to the sentiments behind the Motion, and I would support much of it, I think it would be a disaster if the voice of the child were to be lost because of sympathy with the evident pain of the parents.

Creating a vicious generational cycle of neglect and abuse will never be a way to solve this problem. The challenge for our society is that prevention is <u>always</u> better than cure, and the one thing this audience can agree upon is that where the system works best, treatment and cure become one and the same. Treatment of an adult represents prevention for the child, but in the few cases where treatment cannot succeed, the system must save the child. This way there is hope borne from tragedy – and that, ladies and gentlemen, should never be regarded as failure.

Question & Answer Session

Rt. Hon. Lord Justice Thorpe: Thank you, speakers, for your wonderful presentation. [*Housekeeping details*] Would the first contributor like to put up a hand and gain the microphone? Perhaps you would kindly say what sort of work you do.

Question: I have two hats, one is as a Legal Advisor for the Families Proceedings Court in Berkshire, and the other is as a Judge in the Social Entitlement Chamber, so I see lots of very damaged individuals – people with mental health problems, learning difficulties, and who have been involved in care proceedings.

The thing which struck me which all of the speakers have talked about, and which is something that I see day-in-day-out in both jobs, is that is that it seems that once care proceedings have come to an end the treatment and the focus on the mother also comes to an end. I have noticed it even when you have a parent who is in care proceedings for one child and who is pregnant with another child, the court almost inevitably makes a care order, and despite the fact that there have been recommendations in various reports for mother to have the psychological treatment, and that within 18 months by that time she should be capable of parenting, that comes to an end. All of those recommendations have ceased. Even when we know she is pregnant we are still not doing anything because, until that child is born, proceedings won't be issued.

It seems that we are really failing in that respect, because we already have an example of a child that will be born, a parent who needs so much time, and that time even now – and goodness knows what it will be like when we hit 26 weeks – shows that there is not sufficient time to treat that mother, so again another child will be lost into the system.

A thing I see when I am sitting as a Judge is that I have dealt with hundreds of cases just in this last year, and I would say 75 per cent of them were mental health difficulties, learning difficulties, perhaps receiving counselling or other kind of medical treatment, but as far as Social Services support is concerned, I can count on my hand the number of people who have received that support who aren't parents. If they have children then there is a high level of support; if they don't have children then they seem to be lost to the system.

Rt. Hon. Lord Justice Thorpe: Is there a particular Panel member to whom you would like to address your comment?

Anna Wright: I would just respond to that; because interestingly when I was in Reading it was the Berkshire courts that were dealing with it. We did find that effectively

the mothers were abandoned after the child was removed, except for some support from the post-adoption services, which really focused on the bereavement issues around the loss of the baby, rather than the problems they had in their lives. So exactly that experience – that actually we were focusing on this person as a parent who had lost a child but not as an individual who needed to get a better life – if you know what I mean.

We felt a lot that a number of mothers needed something like a 'life coach', who would actually befriend them, be very assertive in their outreach. In fact what we ended up doing in Reading as an immediate response was to employ a very assertive contraceptive outreach nurse who worked with the mothers immediately after birth, and was willing to be persistent in persuading them to take long-acting contraceptives so they could have time to focus on how they might turn their lives around.

Question: I am a psychiatrist, so I thought it might be useful to say something as to how I see borderline personality disorder. I agree completely that there is a falling between services when you come to dual diagnosis people, or people with learning disabilities who have problems, and I am sure there is work that can be done to improve combined care.

However with borderline personality disorder I have found that there is a lot of prejudice. I know we are all prejudiced, but there seems to be a lot of prejudice from Social Services, and once that diagnosis is there it tends to stick.

What we know about the problem is that younger people are often diagnosed with this problem, and then maybe their diagnosis changes. I remember particularly one girl who had a diagnosis of borderline personal disorder, who had three children by different fathers, and after each pregnancy she was particularly ill and she went off the rails and the child was taken away.

In one case it meant that the court order meant she served her sentence in hospital, so she was obviously separated from her child, and we suddenly realised that what we were seeing was her hypermanic episode, and what she actually had was bipolar disorder. When we treated that effectively we changed this lady's behaviour on a long-term basis, and she was perfectly able to look after the child, and in fact was a very good mother.

We had an enormous difficulty in persuading Social Services to look again at this problem; in fact it only happened that she had her three children back when the father, who had had all three, against a lot of evidence that he wasn't performing well, actually

discovered through other information that he was an appalling father, and they came back to her.

What I think we need to understand about borderline personality disorder is that there is an overlap with bipolar illness. Quite a few – 15 per cent of people – have dual diagnosis of the two. There is a group that moves from one to another, and anyway if their diagnosis is borderline the chances are that they become better as they mature – so it is not a hopeless situation, they do gain maturity, and they can do things later on that they couldn't do before.

If that attitude were prevalent we probably would provide more comfort and support to these women to help them look forward to coping better.

Rt. Hon. Lord Justice Thorpe: Would anybody like to comment on that?

Anna Wright: I have spent the past two years looking at pre-proceedings practice in local authorities, and one of the things that has struck me is the lack of mental health assessment early when children are first subjected to Child Protection Plans. It seems to me an unintended consequence of the public law outline that specialist assessment work is done very late when care proceedings are sort of in view, or certainly within the local authorities that I have been working with.

There is often a feeling that local authorities are not taking proactive action at a timely point to say 'We can see there is something wrong here, we don't know what it is, let's see if we can have an assessment'. However if you leave everything until the absolutely last minute, when you are in care proceedings, it is almost as though the assessment is done not to inform a treatment plan or a family support/child protection plan, but to ratify a decision that has already been made, and to prove a case.

Then as you say it does tend to stick, and one of the things that Clare and I have been quite concerned about in our work with local authorities is that there is a bit of a *fait accompli*. That might be also about being economic with time, 'Oh, here's one that will be relatively easy to progress through proceedings'.

It must be very easy anyway as a social worker to be completely overwhelmed by loads and loads of cases of neglect, and to look at which ones can be fairly swiftly progressed through care proceedings again.

I don't know if I am answering your question! But I thought your comment was really interesting anyway, so I will stop there.

Question: I would like to question this notion about hard-to-reach families. I have been in social work for 35 years, and for nine of those years I managed a completely non-referred cradle-to-the-Zimmer-frame family centre. We were packed out with these families that social workers said couldn't be worked with. I met one of those people and she sat me down one day, and it was continuing education about social work. She said a very interesting thing that I think of every morning when I put my key in the door: she said, 'The thing is about you lot, social workers, is it is too little help for too long followed by too much help too late'. [*General agreement*]

Question: I am an adult psychiatrist working with families as I have all through my career. I was interested in the last few comments, because it made me start to think about what would be the sort of control group for the work that you are doing. That is the mothers who get their second child back, and what is different about them.

First I started to think 'Well, in the trickle of cases that I have had, part of what is different is that they have a very supportive social work team going for them', but then I started to realise that it is something more intrinsic about the mother that gets the social work team on her side.

Going back to the comment about borderline personality disorder, the mothers who come to me, just off the top of my head, who do have their children back, or who have back the next child, are the ones who were not free of mental health problems but usually the diagnosis was more about disturbed personality traits and not an organised personality disorder. There was often a longer gap between the first and the second child, in keeping with your study.

However, I think you have given us a check-list now of the points that we might start to think about, that might help us to distinguish. For, say, Tina's team, is this someone who is likely to make that jump, as opposed to somebody for whom actually it is not the best choice to put your resources into.

Rt. Hon. Lord Justice Thorpe: Any response to that?

Natasha Watson: The voice of the local authority feels obliged to do a bit of defending here, so I apologise in advance.

I don't disagree with anything that anybody has said, but I notice you keep using the phrase 'local authority'. Local authorities do not provide mental health services; that is not what we do. It is not our function. Local authorities would love to have an enormous budget

in order that we could make quick and easy referrals for precisely the cases that you are describing.

One of the reasons that debates like this are so important is that it is vital that we keep that mental health service agenda alive, because if you are talking about mothers who need 18 months' worth of treatment, many mental health services now will only provide six months'. I will give you a Top Tip now: in my own Authority you will often see things in the final care plan where a recommendation has been made for a particular type of treatment. The phrase that you might see is that 'Children's services will actively support this referral' – but you will notice the word 'referral'. That is because Children's services can't provide the material to do the work.

What we can do is try and persuade those that can to prioritise the referral, and so my Top Tip is before the ink is dry on the final order, and the parent walks away feeling wounded and having to work with the bereavement that they will inevitably suffer if their child is permanently removed from them, do what you can to get that parent to make that referral so that they can take advantage of the sway that Children's services may have, with linked public agencies, to provide that service.

The problem is I have every sympathy when people say 'When the proceedings are over things come to rather an abrupt halt', and it will not surprise you that mothers who have just had their children removed from them are not terribly sympathetic to children's social workers saying 'Now, what else can I do for you, Gladys? Can I help you with that referral?' It is really important that advocates for the parents try and persuade their clients to take advantage of that, at a time when it is still before the court, because of course were other agencies then to refuse that referral or to refuse to give it the priority needed, there are of course – one hesitates to mention the term – other means with which to challenge unreasonable decisions about the provision of services for the most vulnerable members of society.

Dr Broadhurst: Just a short comment on that! That means that we can't, or shouldn't be, completing matters in 26 weeks. [*Laughter*]

Anna Wright: I am saying nothing!

Question: I don't have half as much experience as most of the people in this room. I have worked in Social Services for six years, and I have just gone back to law school, but I am studying the use of forced sterilisation in Asia. I am researching as part of a working group, and I was curious to find that the UK – the International Development Agency

– had sidelined £166 million to support a programme to support forced sterilisation in India. I was curious to see what a speaker from either side of the Motion might say to the proposal of having optional sterilisation as part of a care plan.

Anna Wright: We had a big debate about this in Reading, because for a while we had an organisation on our patch that was paying mothers £200 to undergo a sterilisation. I don't know whether people remember this? [*Yes*] We decided very strongly that we didn't agree with that. However, we did agree that long-acting reversible contraception was a definite option, and that this could be very beneficial to mothers, particularly as we had found that 90 per cent of the pregnancies were unplanned – obviously consciously unplanned, maybe not unconsciously unplanned – but that most of the women who were not using contraception in any kind of organised way (and even if some of them said they were on the Pill they weren't taking it regularly, which is why they became pregnant in an unplanned way).

So what we decided to do was to offer what we called assertive outreach, and we employed somebody who would be persistent and meet the mother anywhere, in the local Costa Coffee, not insisting they came to a clinic; they made a relationship with them while they were in hospital, and then subsequently met them several times and tried to persuade them to access local services. This was before Reading had put together a more specific offer for the women.

We felt it was completely unethical to suggest or propose sterilisation for the women, because who knows what they might not be able to do with their lives in the future?

Tina Wilson: I have to come in on this one as well, sorry. In Suffolk what we have learned is actually we start talking about the contraception when they book in for that first maternity appointment for the baby that they are about potentially to lose, so by the time we have delivered we have now worked with our key maternity hospitals so they will not be discharged without a contraception package, if that is what they wish to do. It is not fast; it is about taking them on that journey right from that booking-in appointment.

Speaker in the audience: I just wanted to make a point, that I have worked with Karen on this study, and what I would say to your point is that within our study there was one mother who had had six children removed, but did go on to successfully parent two others with a change of partner, maturity, services – what would have happened to her?

Question (male): I am a child psychiatrist. I was interested in the comment my Adult colleague made, that people with borderline personality disorder tend to become

more competent as they become older and more mature, less prone to the effects of emotional arousal, which I have heard presented plausibly before. I wonder whether any mothers who have had a recommendation for therapy, which does speed up the process and allows them to reach that maturity earlier, have sued under the Human Rights Act their local Health Commissioner for not providing them with the right to produce a family?

Rt. Hon. Lord Justice Thorpe: That is a legal question!

Natasha Watson: I may not be the most senior legal authority on this Panel – [*Laughter*]

Dr Broadhurst: It is down to you then!

Rt. Hon. Lord Justice Thorpe: Come on, I am not a human rights lawyer. Any human rights lawyers here like to take that on? [*No response*]

Question: [*No microphone – inaudible*] I am another child psychiatrist, funnily enough, but as I understood it there is no right to produce families; there is a right to a family life, and all of that is superseded by the right of the child, the welfare of the child being paramount.

Related to the point about sterilisation and contraception, I was actually wondering about the journey starting even earlier than that – about sex education in our schools, which I think is very patchy and inadequate. Many of these girls who were in care who then go on to become this vulnerable group of young mothers don't access education properly, and I would welcome your thoughts on that.

Anna Wright: I would agree; in fact we did a major study looking at what was the difference between young women in Reading who had a rather active promiscuous sex life during their teens and the women who didn't, or who were more careful about organised contraception. Part of the difference was about their access to information about contraception, but a bigger difference was about their whole attitude to life. What was uncovered was that the young women who tended to have a more active sex life without contraception had a much more external locus of control. They felt events just happened to them, it was fate, it was *c'est la vie*, they imbibed a lot more alcohol and didn't watch what alcohol they drank; whereas the young women who had a more organised and less frantic sex life were careful about what they drink, they were very careful about taking contraception regularly. They had a future story about their lives which was not about becoming a mother or becoming an attractive young woman, it was about becoming something in society.

Part of the challenge we have found, particularly now schools are increasingly independent, was that we lost our resources for our PHSE advisor who had done a fantastic piece of work with the schools. The schools felt their curriculum was increasingly crammed and the focus was much more on standards, so a lot of schools moved over to an approach of having three days of sex education over the course of Year 9, and that was then it. That was your lot.

Really while the Government leaves schools to get on with it and then measures them only by the results they achieve, schools will not prioritise this part of the curriculum, particularly as teachers don't feel incredibly confident about how to teach it. If schools were measured more on the number of teenage pregnancies that they come up with, or the number of terminations that occur on their patch, I think we would see a completely different result – but we get what we measure, really.

Question: I am a play therapist and I work with lots of looked-after children and do assessments of children for courts, but also assessments of attachment between children and their parents. I wanted to make two points: one was that it seems to me there is insufficient assessment of the adult's attachment styles as part of the early assessments, because if you know that you have an adult who is very avoidant you need then to make great efforts to engage that adult; or if you have an adult who is very attention-seeking and ambivalent you will contain that adult. That is one piece of information that is very much missing from a lot of the assessments, because that then really identifies need and about how you can put services in.

The second point is in relation to contact. I go and observe a lot of contact, and I am completely frustrated that contact supervisors sit in the corner of the room and just make notes and observe, and don't actively intervene. It seems to me that this is an opportunity that we are really missing, where we could actively work with parents in contact. With a colleague of mine, that is present here tonight, we are thinking of piloting a project of actively intervening in contact by doing an assessment and training contact supervisors to work with parents within the contact sessions. I just think they are just missed; you have three or four contact sessions a week and nothing is being done, and we could have an enormous amount of information for the courts within a relatively quick timescale.

I would welcome your comments about that.

Anna Wright: I am really delighted to hear you say that, because we are about to start exactly what you have suggested in Brighton and Hove during contact sessions. We think some parents will find this extremely intrusive in a very precious time that

they have with their children, but we agree with you. We think for a lot of parents it is really dead time, and it would be useful to use it as some kind of parenting programme, so I welcome your comments.

Question: I am an academic from Essex University, in Sociology and Criminology. I would just like to make a quick comment and then add a question. The quick comment is that I think we do need a robust and mature discussion about long-acting reversible contraception in Britain. It is not something that has crossed many people's radar, and I don't think many teenagers know about it. We have a very low uptake of that particular method compared to other countries.

My question is do people on the Panel think the Capacity Act could help in this way in any shape or form, in terms of helping people to build capacity and putting structures in place to assist with the building of capacity?

Tina Wilson: I will have a go, with the limited knowledge that I have of the Mental Capacity Act. I think there is something more fundamental, really. I was interested before when the lady towards the back of the hall asked the question about sterilisation, because there is just a question about how these women are empowered to access healthcare. That is the fundamental starting point. We probably need to start there, really, and to do some analysis of that. I am sure that our colleagues at FDAC could probably illuminate, certainly in Suffolk and Reading, but there is a fundamental point about access to healthcare and then access to choices then about, as you call it Pam, reproductive autonomy and decision-making.

There was a test case in the High Court with Mr. Justice Bodey presiding, where the local authority did try to bring a case under capacity. From the very limited reading I have done around this it seems that the courts are unwilling to set any precedent in that respect. Am I right, or have I got that completely wrong!

I think that perhaps that is going down the wrong avenue, although we could consider it on a case-by-case basis, but there is a fundamental thing about supporting women to have access to healthcare, looking at the relationships there within and what power they have within those to access contraception, and general stuff around sexual health. What we know about these women are that they are highly marginalised and outside of services, unless a proactive approach is taken – like your Outreach Nurse. There is a real need here for outreach work to proactively engage people, and ensure that they have access to the things that other people have.

Question: I would like to ask a question. I am a solicitor in private practice, and I was very struck by the way the Motion is worded. It says "Women who have children removed to care". None of them are immaculate conceptions are they – or at least we don't think so! [*Laughter*] There are fathers here as well, and I am very struck by the focus only on the mothers, whereas you do have fathers, and sometimes you can engage with the fathers. I would be very interested to hear from the Panel as to what is happening as far as fathers are concerned, because they have to step up to the plate and they need to be as encouraged as mothers in this particular environment.

Tina Wilson: In Suffolk we had a wonderful project of just that – young parents, both for young fathers and young mothers. Unfortunately the funding was withdrawn, and we were able to evidence that we made a difference, and it is key. It is vital – and it is missing in this. We have purposefully concentrated on the women because we have started with the project, but recognising that it is a gap that we are missing.

Question (male): I am a childcare solicitor only representing parents in care proceedings. One of the things that I wanted to hear about is whether you think there is the hunger to have a more holistic approach to things? I can't think off the top of my head of any client, any young mother who I have represented, who did well in school, who went on to do A-levels, who went on to have those prospects. They were as far as I am aware, and thinking off the top of my head, all my young mother clients who are either on their first child but, unfortunately and inevitably, going on to have more children in the care system, they dropped out of school at 14 or 15, and sometimes I speak to an 18-year-old who left school at 12, and you think 'How is that even possible?', but they did. Where is the impetus for the Education Department linking up with Child Services, linking up with Housing, linking up with Mental Heath?

I appreciate that earlier on you said that 'local authority' is not the term that one can apply to all resources available to everyone in that region or area, but is there this hunger for a joined-up thinking approach? Because to me it seems that is the logical way forward. We have to change this system because we are just having children going through, having children themselves who are there for care. What will break this cycle, and is there a hunger to do it?

Anna Wright: I couldn't agree more, and it is a very, very helpful point to have raised. As Director of Children's Services we knew that the biggest single way to reduce the number of teenage pregnancies was to improve the quality of your secondary

education in particular, and that actually teenage pregnancies go down as academic achievement goes up. Very, very frustratingly, exactly as you said, the Rainbow has pixcellated. The leadership now is that schools focus on standards, and somehow children's services are slightly peripheral and slightly awkward occasionally, and we don't get much leadership nationally around children's services in particular.

We particularly don't get leadership around preventive services for young people in need, and I think one of the biggest tragedies we have experienced is that we were making such a difference to young people who were identified as 'not in education, employment or training', or otherwise, NEETs. The curve has really turned downhill on that one, partly because of the loss of the education maintenance allowance, which was an absolutely fantastic way of keeping young people who didn't have very much money in college, but partly because of the complete devastation of the Careers Advice Services. They were the substitute for a good middle-class professional parent who supports their young person to think about their career, and those services have absolutely been decimated.

I totally agree with you, and we need a lot more leadership from the Government, which supports those local authorities that still want to deliver an integrated children's system despite the pressure, which is actually splitting it up at the moment, I feel.

Natasha Watson: I would just like to add to that; I think I am right in saying that the Children Act 2004, which gives public agencies a duty to promote good outcomes for children, does not apply to academies. It beggars belief really, doesn't it?

Question: There was such a compelling presentation that we went immediately into questions and debate and discussion, but I just want to comment on the high quality of each of the four presentations. I thought they were really excellent, and the whole level of discussion.

This is a really incredibly difficult area, but I sensed from everybody on both sides and from the audience that there is a real desire to do better here. Our experience in the Family, Drug and Alcohol court is that it is all about timeliness and about creating the right sort of connections, so one of the fundamental connections is finding <u>the</u> person, the mother, the father, at a moment where they really want things to be different in some way. That won't be everybody who is in difficulty, and sometimes with these repetitive cycles it will be further down the line, or wherever. It is very odd, we don't always know what it is that changes things, but there is something about finding that moment where people are really desperate for things to be different from how they have been; they are tired of what has happened

already, at that moment, to be able to introduce the sort of level of support and help that would be appropriate.

I don't think that is easy to do on a case-by-case basis. We are lucky working with drug and alcohol problems; it is harder to get that kind of link with our adult mental health colleagues and to get things lined up. We want things not in a few weeks' time or a few months' time, but we really want it tomorrow – and we really want something quite comprehensive and thoughtful going forward, we don't just want an assessment.

That can only be achieved by some kind of quite careful and thoughtful commissioning; I don't think it can be achieved just with all the goodwill and hard work of the advocates and the sense of the courts standing by.

The third element is that it has to count for something. It has to be the choices that people make. You are giving people an opportunity to make a choice, as Tina was saying, to take control, but it has to count. That is where I think the court can come in. It might not be the court in these proceedings, it might be the court in the next proceedings, and it might be that the time taken for the journey by the parent is so different from the time needed for the child that this child and this parent need to part company. The child can only wait for six, or at the most nine, months and has to move on quickly. The parent might need two years, might need more, but it is still a worthwhile journey.

Again we have to commission this; we have to design something that will address this need, because I don't think on a kind of referral-by-referral basis we will get something. It is bringing together that moment, that desire for a change with the opportunity for change with some kind of sense of compulsion – not compulsory sterilisation or compulsory anything, but some sense that whatever decision these people make will have consequences. It is not a nothing thing.

Anna Wright: Could I just comment on that, because it really struck a chord with me? One of the most impressive things I have seen is the way that the Kids' Company Project in London works with young adolescents, quite a lot of whom have very, very severe attachment difficulties. One of the ways in which they work, which is very important, is about how you create the moment that Mike is talking about – the moment when the young person is willing to commit to some kind of change, and the way it is created in that organisation is by an outreach worker who has some understanding.

Often they are workers who previously were in gangs themselves so they are very close to the young person as role models, but they may persist for six to nine months just making contact with the young person. In fact I met one of the mentors and one of the young people who previously was a male prostitute, who had been brought up by substance

misusing parents and nobody knew they were substance misusing. He said 'For the first six months this young black man just told him to F-off', but he kept on contacting him saying 'I am still here', and after six months the young man said 'Well, you're F-ing persistent' and then began to engage with him.

He was willing to persist for six months in the face of being refused, and what happens with many of these young people and these young vulnerable mothers is the same. They can't trust people, because nobody has ever been trustworthy before, and it takes them a long time to believe that here might be somebody that is worth investing in, and that they might not actually be hurt as a result of the connection.

That is why we have to think of services very differently, because most services say 'There has to be some motivation for the adult to engage before we will help', but actually we may need to put something in place before that.

Rt. Hon. Lord Justice Thorpe: Anybody else want to add anything?

Anna Wright: I would just like to comment on that, again in a parallel study that Karen and I were involved in, where we were following social workers and doing some home visiting alongside social workers. We were fed up with seeing in case files this 'Won't engage', and echoing the point made at the back about these hard-to-reach people. We would position it as lack of skills to engage amongst the workforce. What we saw in these home visits was the difference between the worker – and one in particular stood out – that would have a conversation through a letter-box, and then go back and have another conversation through the letter-box, compared to the worker that knocked on the door, there was no answer, so they walked away and recorded on the file that 'There is nobody in, they are not engaging'. That is a real challenge for us, particularly in Social Care services.

Question: I am a trainee psychiatrist from Essex. We are talking about mental health problems and all this, and attachment issues in particular. I am really curious to know how the system works for the children particularly those who have been removed, because that is very important. As Karen said about the history and background of these ladies, they had a chaotic lifestyle, and most of them were taken away from their parents when they were young. What we don't want is 116 children taken in four years' time, because they will start to multiply if nothing is being done for those children in particular who have been taken.

Natasha Watson: When I was preparing for this debate I did look at that Loughborough Study, and it is quite interesting in the questions that you asked. They looked

at about 47 children, and what they discovered was that by their third birthdays over half the children who didn't have a recognised medical condition were displaying developmental problems, or showing signs of significant behavioural difficulties, and particularly aggression and speech problems were prominent. These were children that effectively the study was saying had not been removed from a neglectful environment early enough.

This is one of the difficulties with this debate that we must not lose sight of the timescale for the child, because one of the things we need to remember is all the scientific evidence that is emerging now about brain functioning. We do know that if children are exposed to very neglectful or abusive experiences in the first six or nine months of their life, it can actually affect the way their brain develops. It is as fundamental as that, and this is one of the very, very difficult balancing exercises that we need to perform, which is why I was saying in my response to the Motion that it is so important to assist these adults prior to there being a child.

It is absolutely key, and it is one of the reasons that the system needs to be more joined-up than it is, because if you look at that Graph of Doom, as it is known in local authority circles that I produced, it is very difficult to persuade mental and adult services that they need to lower their thresholds for a new client group to access long-term services.

My own view is the spend-to-save argument is a pretty unanswerable argument, and it needs to be made forcibly. I do hope that when we see Health & Wellbeing Boards come live in April 2013, that we will see those arguments pursued rigorously.

Tina Wilson: One of the things we should avoid is an either/or – we are either child-centred or we are looking after parents, because they are not mutually exclusive. As Mike said before, you may feel this child needs to be removed and placed for adoption, but that doesn't mean we throw the parent on the scrap-heap – it is a not an either/or. We get into that if we are not careful, with the child-centred discourse, that actually we save children and in doing that it means we reject parents, we abandon parents and replicate what has happened in their own childhoods.

We should be careful of that, and just remember that if we are removing a child, if we are saying 'We are not leaving this child in this neglectful household beyond 12 months', or whatever period is deemed appropriate, fine. An argument in favour of the Motion supporting birth parents is not an argument against removing children, but it is an argument about meeting their own needs in their own right.

Question: I am a knackered District Judge, who has probably been doing this work for too long. I am very concerned for these very vulnerable women, but I am more concerned for their unborn and often un-conceived children. At the end of a really tough

week I sometimes veer towards compulsory sterilisation, but I don't really mean that. I really like the sound of the assertive contraceptive outreach nurse – but I would prefer an aggressive contraceptive outreach nurse!

The problem is the clash of the timescales. I just wish parents would not see the birth of a child as a motivation to start dealing with their problems. I wish they would deal with their problems first and then think about getting pregnant. I would really go for this whole contraceptive argument, and we have patches and we have reversible injections, and I would almost go – in fact I think I would go – for compulsory contraception.

Mike has talked about FDAC and what I like about FDAC is the use of the authority of the court in a collaborative attempt to accomplish change, because I think that is important; and what I like about FDAC is that some of our parents who fail understand why they have failed, and don't fight, and don't have that five-day case which produces bitterness and resentment. That leaves them in a better place next time they get pregnant, and we do have a few second-time mums now in FDAC who have come back to us and said 'I understand why I failed last time, I am in a better position this time, can I try it again?'.

I just want to tell you one rather sad story which ties in to what Tina has just said: I have a friend who is a Senior Partner in a GP practice in a country district, who about eight years ago was very concerned about the level of teenage pregnancy in her area, and she wanted to set up a clinic to advise these kids in school; but she couldn't do it at her practice because they would be seen coming in and so they wouldn't come.

She had a discreet unmarked mobile clinic which went to the secondary schools, and after five years teenage pregnancy in that area was reduced to zero, and for three years it was zero – so the Government have withdrawn the funding because there is no evidence of need! [*Laughter*]

Question: I have a couple of points and then a question. The first point about the hard-to-reach is that we have a 50 per cent increase in the number of calls to our Advice Line at the Family Rights Group from birth families, and it is more than we can deal with, and funding is being reduced – it is continuing but being reduced. It was just part of that hard-to-reach group, but in fact we are having a lot of birth parents trying to contact us, trying to obtain independent advice and support, and they are the very people who are being termed 'hard-to-reach' on the other side.

The second point is in relation to pre-births. We often find that it is very late in the day that there is any form of pre-birth conference, and actually it is not enough time for the

parent to be able to demonstrate that they can address the concerns that have been outlined. I do think there is scope, and I would really like to see some form of conference or some form of activity in terms of looking at what works effectively at that pre-birth stage, because I feel there are some pockets of good practice, and obviously there is the question about the woman's rights in relation to the foetus and how much the State does intervene. Nevertheless it is a big window of opportunity that we are, I think, continually failing.

The third is about domestic violence. I know that Karen and Clare did further research in relation to not just young mothers who were losing children into the care system, but also you were finding sequences of teenagers being also removed, and there were very heavy levels of domestic violence in those households. There has just been a phenomenal increase, in terms of analysis of calls to our Advice Line, in domestic violence being present in so many of the cases that we are dealing with, and so I do think that we need to think about mothers as well as fathers. However, we also have to look at the question about how women are able to turn around their lives and address some of those problems, when at the same time they are dealing with phenomenal amounts of abuse within their life at that point.

Lastly, just a question: we have real concerns about the impact of the 26-week reduced scrutiny of care plans, etc., and I just wondered whether the Panel would like to say anything about that. Our experience - which is counter in some senses to the discussion we have had here, which has been incredibly helpful – is that increasingly adults are being referred to in terms of their relationship to their child, and that is their function, rather than being seen as being worthy of support in their own right in relation to themselves, and also future children.

Dr Broadhurst: Somebody last year, sitting not a million miles away from me, said something like 'It is essential that 26 weeks doesn't become a straitjacket'. I would really like to endorse that. However, the reality is that there are cases when 26 weeks is about 16 weeks too long, and there are cases like that and there is no point in us denying that. We do know from study after study that where it is an absolute disaster is if a child has waited – and I think the average for care proceedings at the moment is over a year – for an outcome that was pretty much inevitable from Week 1. Not every inevitable outcome represents a failing of the system, and it is really, really, important to recognise that.

There are some – and I will use the phrase – 'hard to reach' families, but there are also some very obstinate families who refuse help, don't see the need to change, and won't change. One can be very sympathetic as to why they are in that position, but the system has chosen to elevate the rights of the child and therefore the system can't wait forever for those families.

On the flip side of that there are families where it is really important that we don't have a 26 week straitjacket, and I can think of some very imaginative cases I have done in my own career, where the social worker worked incredibly hard to bring the parent alongside, and it really didn't feel safe or right to withdraw the judicial eye on that procedure until the parent was really able to parent the child safely. Those were cases where it would have been a disaster had it been over in 26 weeks, but as I understand the proposals for the new legislation, those are precisely the sorts of cases where we would crave some judicial indulgence to move away from the target.

Anna Wright: I just wanted to make a point about the domestic violence, and the point made earlier, that we were focusing on mothers. We could have had a separate debate tonight about the way we deal with domestic violence in the system, and certainly in my Authority one of the key issues we felt there was that there was a failure to have the right objective around domestic violence – i.e. the objective would be that not only was the child safe and the mother (usually the mother) free of abuse, but that the perpetrator also would not be violent in the future.

What we found was a massive big hole in services for men that they felt were acceptable to access. In fact we have experimented with a wide range of things, but some of the best services are not run in the UK they are run in the States, where services are run by men for men to help them look at how to manage their emotions, to speak about their emotions, to manage the emotions of others, and they are very, very effective in improving the quality of relationships between men and women.

One of our challenges is to see perpetrators of domestic violence as people needing services, and in children's services unfortunately we try and wean the woman – usually the woman – away from the man, and if we successfully do that, the man goes off, receives no more service, but probably finds another partner fairly soon and repeats the cycle.

Tina Wilson: Just on another no-brainer, Cathy, to pick up on your point, pre-birth assessment! Why do we wait until 26 or 28 weeks, when all the research says that pregnancy is a window of opportunity? Clare and I found local authorities quite resistant to that. Interestingly, working closely with colleagues in Coventry where they have started pre-birth work much earlier, they have some very good diversion rates, they are able to marshal kin and draw on the support networks beforehand, and also if they then go into care they have had longer to get evidence.

It seems to me that this is actually win/win all round, but local authorities are hugely resistant, because obviously they have to ration resources; but waiting until the foetus is viable is a classic child-centred perspective that is not holistic, and that is missing a real time

in which you might be able to effect change. It could be one of Mike's turning points – a window of opportunity.

Question: I am a District Judge and also a member of the Family Justice Council, and we are looking at these 'revolving door' cases, certainly from the mothers' point of view, where they are repeatedly coming back to court. We are talking about the interventions being too late, and we are very familiar with reports in drug and alcohol, also in borderline personality disorder, and in domestic violence, that say the timescale is 18 months or two years, and the child's timescale is too short. It seems to me that what we are missing is what might be called a post-proceedings protocol [*General agreement*], a way of gathering the assessments and the information that crystallise during the proceedings, and then finding a way of formally handing over the case to Adult Services.

The Children's Services come out at that point, and that to me seems the opportunity that is missed. We have the information, we almost have a definition of what this vulnerable group might look like and how you find who is in this vulnerable group, and to have the special category of formal hand-over, release of those reports that are appropriate, or at least the opportunity to release them during the proceedings, and then a proper handover to Adult Services at that time. It would be more difficult for them to reject the case if they had the information that is available to the court at that time.

Tina Wilson: I would definitely like to come in on that, because that is just what we have been trying to set up on a very small scale within Suffolk, and that is how we have effected the change; because we have in effect put in a team around the parent approach, a kind of an exit plan to that pregnancy about what needs to change, what needs to happen next, and who can do that. We are now in the process of firming that up, both with CAFCASS, Children & Young People's services, and the integrated teams, just to do exactly what you have said – and it makes a key difference.

Question: As a family magistrate, I am also heavily involved in domestic violence, and it is that I want to go back to. There is a shortfall in services for men. If you come through the criminal courts then you can get on to IDAP. If it is private law then CAFCASS can recommend a contact activity going on to an equivalent IDAP programme; certainly in Hertfordshire it is a question of doing it through the criminal IDAP programme.

In Hertfordshire as well we are using something called Caring Dads, which came from London and originally from America, but that is privately funded. It is funded but not through local services, and we are hoping locally it might be taken up by CAFCASS as an alternative to IDAP. That is something that would be really helpful for CAFCASS to take on board.

I am not sure whether this is something as well that can be done through public law. It is there through the private law route, but I don't know if it is there through the public law route.

Anna Wright: I really want to echo that. When my own Authority looked at commissioning services around domestic violence recently, and that is an on-going process, I had a light-bulb moment when I realised that actually we did have a number of treatment programmes for men who were abusive, but you had to wait until you had a child to be put on them, or be an offender. It did strike me that this was a bit of a problem if you were aiming at prevention! [*General agreement*]

Question: I am almost definitely the least-educated person here, but I am a graduate of contact centres, and 15 official inquiries, four Ombudsman investigations, two Parliamentary, which found in my favour against local services who facilitate and promote false allegations of domestic violence based purely on grounds of gender. The lady solicitor earlier asked about men as part of the solution, and the response from the Panel was 'We are focusing purely on the mothers' – so be it.

While there is the deep desire institutionally within so many services to only see fathers, even if they are primary carers for a decade and the mother is bipolar, only to focus on the allegations against the father, denying all services to a father who has concerns, then the situation will only be perpetuated. This applies to the middle class; it doesn't just apply to the people who come out of care. It is behind nice, pleasant, suburban doors and it is a problem that needs to be addressed. It is the elephant in the room all too often in family courts and private law proceedings, and I hope that this question is suitably examined by some agencies and authorities. Thank you.

Tina Wilson: I am certainly not sure we said it is only women! I would probably come back on that. It is recognised, exactly as you were saying, and I can't argue or come back at you on that one, but we haven't said 'This is just purely women'. However, at the moment with the project that I am running we are only able to look at that part of it.

Mike: I will take a risk in suddenly sharing some thinking out loud. I wonder if one approach is that we really need to profile this group of people that we are interested in, as well as we possibly can? We then need to imagine where they were five years ago and ask whether that would help us identify a recognisable group of people.

One question a few minutes ago was 'They might be the very young women that we took into care 10 years ago', and five years ago they were still in local authority care, and the local authority was being a parent and had an opportunity to intervene.

I am involved in another project to do with sexual exploitation of children, and I am very impressed by some of the police forces around the country and the kind of proactive approach that they are taking. They are saying 'We don't wait for someone to be sexually exploited, we identify a group of people who are highly at risk and we intervene in that group'. There is a certain amount of pragmatism and self-interest there; in that once they have been sexually exploited they fall off a kind of cliff. It is a bit like the Graph of Doom, they fall off a cliff in terms of how damaged they are, the limitations in terms of being able to engage, the extent of resources that are necessary.

We could all learn quite a lot from the police here (which is a bit surprising), but they are a lot more strategically driven in some areas. There is a real drive at the moment about domestic violence, and it is again the same thing: the view that domestic violence is fuelling a lot of other difficulties within families. It leads to the lack of supervision of young people because families are at war with themselves and so on and so forth, and that by intervening effectively with domestic violence you can save an awful lot.

I think there are some models like that, so find these families five years ago, intervene then. You obviously have to intervene with more people, they will be at risk rather than actually in that category, but there might be a lot more options.

Question: Apart from being slightly less knackered than Nick Crichton I also work as a District Judge in the Family Proceedings Court; but I also spend an awful lot of time in the Youth Court. Just picking up on that last point, you say that you are looking for the families. You really don't need to look very hard, because the families whose young children are appearing in the Youth Court today, those young children are the problem parents in not as much as five years' time. I can never, ever, understand why Children and Families and Youth Offending teams don't seem to share information more and get to work with those young people before they are parents and wreak the havoc that they heap on young children.

It seems to me that it will not be expensive for Children and Families to pick up and feed into those problem families. The police know who all the problem families are, all the anti-social behaviour that is out on the streets, and it is getting back to the points that were made earlier about joined-up thinking. The information is all sitting in a number of different filing cabinets, and none of those filing cabinets seem to talk to one another. I would have

thought that in an age of computer technology where Local Authorities all have the ability to have shared locations for their files, it shouldn't be very difficult to try and pick up on some of these people, and save them.

Tina Wilson: I would echo some of that, but I think it goes right back to early years as well.

Anna Wright: I recognise that too, but I have to say in the defence of Local Authorities I heard a presentation from two people from Finland a couple of weeks ago about the Finnish approach to helping vulnerable young people. They have set themselves a target of every young person to be able to be entered into education by the age of 25, so they track down the young people who will potentially fall out of the system and they provide them with very intensive services. Their ambition is that there will be no workless young people at 25, because they will have done everything to ensure that they have the right education and qualifications that they need.

They have worked out that the cost of a young person who doesn't find work to their society is €1.5 million over their lifetime, if you take into account all the things that they might need, in terms of unemployment benefit and their children might need support, etc., so in a sense we need as a society to grasp the nettle and say 'This is our ambition too. It isn't acceptable to have young people not going through our education system. We will have this goal, and we will resource it, because if we resource it in the short term it will deliver for us as a society in the longer term'.

Local authorities are working with the context where each year 7 per cent of their budget is being taken away, and they are also being told to take more and more children into care, so that means the Graph of Doom is heading towards us. There are some potential long-term invest-to-save commitments we could make as a society that would make the difference.

Question: I have also enormously enjoyed the debate. I am doing the evaluation of the Family, Drug & Alcohol court, at Brunel University. I would like to make some general points. I think the debate has been very eloquent, but it does seem to me trying to think through my own position that it is a no-brainer that something has to be done on this, and that the first thing that needs to be done is that we need to know the size and the scale of the problem. We are talking about small pockets, and already it is very clear that there are huge financial implications as well as human costs, so it seems to me that is the first thing we need to do: get a much better-informed picture of exactly how extensive this problem is, and the impacts of it. That is Number One.

Number Two is that in terms of the joined-up thinking we need to know the joined-up costs as well in the short and the longer term. We have touched on offending but we haven't put it all together, and there does need to be a holistic view of precisely how this is affecting society at large.

Thirdly, we have been a bit economical with the truth regarding the effectiveness of the care system. It seems to me that we can't be complacent about its outcomes at any point, and I don't think I need to underline that point any further.

From the resource point of view we know full well that there aren't enough foster carers, there aren't enough adopters. The kinds of debates that are going on at the moment have been repeated so many times over from different political Parties, and we are still stuck. We know that particularly in relation to substance misusing families there is reluctance amongst some of the prospective adopters to take these children, because they are concerned about the possibility of long-term problems that aren't there at birth or can't be detected.

For all these reasons, to me it really is a no-brainer. We have to do something. We have to find a way of best practice, of engaging with these families, and everything that everybody has said about the need for a continuum of services from Children's Centres through to all the other services that have been mentioned is absolutely right.

I am concerned about some of these arguments that suggest that there is only a very short window of opportunity to turn families around. I know that is a very powerful argument at the moment, and Harriet Ward's research is first-rate in tracking families; but there is other more hopeful research from FDAC itself which certainly found that these families, where repeat removals were very, very common, were able to start a new lifestyle.

We are only doing our second-stage evaluation at the moment, and the first stage was very encouraging, but I think we are in a pendulum shift at the moment. I can't say that with any kind of grounds, but the rhetoric seems to be 'Removal, removal, removal' without sufficient thinking of the consequences.

I am concerned about the 26 weeks, partly because it will also be cost-driven - we have to be very honest about these things – and also these families are very vulnerable at a time of economic huge uncertainties.

It is a huge agenda; I think it is a very important one. I have been fascinated by the debates, particularly around sterilisation, but I know where my own mind is made up!

Rt. Hon. Lord Justice Thorpe: And no less, I thank the audience who have brought such varied and valuable contributions, so thank you all very much.

[*Conference concluded*]