



Response to Health and Sports Committee 'Preventative Agenda – a call for views' – February 2017

CEL CIS (Centre for excellence for looked after children in Scotland), based at the University of Strathclyde in Glasgow, is committed to making positive and lasting improvements in the wellbeing of Scotland's children living in and on the edges of care. We welcome the opportunity to submit our views in relation to the preventative agenda. We would promote any reform that would strengthen early and effective support for children and families.

As of July 2015, there were 15,404 looked after children in Scotland. In addition, a total of 2,751 children were on the child protection register (of whom 798 were 'looked after'). 65% of looked after children live in community-based placements such as foster care and kinship care (friends and relatives). A further 25% are 'looked after at home' by birth parents, and 10% live in residential establishments.¹

While the circumstances, needs and views of looked after children and their families are rich and varied, all have experienced major difficulties in their lives. A significant number will have experienced multiple, serious adversities, including neglect, abuse and pre-birth trauma. The backgrounds of many feature socio-economic disadvantage, drug and alcohol misuse, and domestic violence.² Their outcomes are poor across a range of indicators, and these are children in need of society's conscientious support and understanding.

Which areas of preventative spending/ the preventative agenda would it be most useful for the Health and Sport Committee to investigate?

Unfortunately, due to a complex combination of economic and social issues, many children and families in Scotland experience precarious lives, acutely vulnerable to instability, neglect, abuse and, as a result, the risk of significant state intervention (with children becoming 'looked after' as perhaps the most serious outcome). Failure to respond early, holistically and comprehensively to these children's needs leads to adverse experience compounding adverse experience, with the impact (personal and societal) felt across the individual's life course. For Scotland to have a positive future, from the health and wellbeing of its population, through to its national economic output, little matters more than its success in securing safe, nurturing and educationally rich environments for every child, supported by parents and carers whose own complex needs are being assessed and met proactively. This is why we believe the relevance and efficacy of Scotland's preventative spending agenda should be judged squarely on its success in addressing the needs of vulnerable children, and we would encourage the Health and Sport Committee to concentrate its focus on understanding the barriers (structural, societal and resource) which are inhibiting the implementation of [*Getting it Right for Every Child*](#). That policy framework is an explicitly preventative agenda, with its objectives of delivering the right help, at the right time, in the right way to children and

families. Realisation of what the policy promises would contribute much to improving the lives of children and families in all parts of society. The Committee's focus on this area should help us understand better why it is proving so difficult to achieve, and what is necessary to deliver it.

The 2014 [Brock Report](#) highlights improvements are necessary to address the needs of children who are not looked after, but who are vulnerable and 'on the radar' (p5).³ Providing improved support to these children and families "at the edge of care" will prevent problems escalating.⁴ Based on aggregating the number of children who are looked after at home, on the child protection register, in informal kinship placements, and whose families are receiving voluntary support from social work, CELCIS estimates that over 10,000 children were living on the edges of care on 31 July 2015.⁵

Considering the significant personal, societal and economic costs, over the long-term, associated with children living in on the edges of care, the Committee may wish to concentrate some enquiry on understanding how improved wellbeing outcomes for this population could be achieved. In particular, this requires family support which is structured and resourced to provide comprehensive and sustained interventions, managed through good relationships.⁶

Although a range of services to meet the needs of all age groups of children are required, there is a particular need to bolster services and support for families and children under 3, as noted in the 2010 [Marmot Review](#):

*"The foundations for virtually every aspect of human development –physical, intellectual and emotional –are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking."*⁷

Marmot (2010) suggests that to reduce the steepness of the social gradient, actions must be universal, but with a scale and intensity proportionate to the level of disadvantage.

How can health boards and integrative authorities overcome the (financial and political) pressures that lead to reactive spending/ a focus on fulfilling only statutory duties and targets, to initiate and maintain preventative spend?

Legislative duties enshrined in the Children and Young People (Scotland) Act 2014 provide a framework for joint planning in which a commitment to preventative spending can be shared and prioritised. Health boards and local authorities are jointly and equally responsible for Children's Services Planning under Part 3 of the 2014 Act; and both partners have duties and responsibilities in relation to Children's Rights under Part 1, and Corporate Parenting under Part 9.

Holding shared rationales in relation to the reasons for taking a preventative approach will support organisations in overcoming pressure to do otherwise. An understanding of [Heckman's curve](#)¹ provides strong economic rationales, and the report of the [Christie](#)

¹ The highest rate of economic returns come from the earliest investments in children. Society invests too much money on later development when it is often too late to provide value. The curve shows the economic

[Commission](#) clearly articulates the need for preventative action to tackle the root causes of inequality and remove demand from the system.⁸ A key recommendation from the report of the Christie Commission is that work should be carried out with individuals and communities to understand their needs, mobilise their assets, and support self-reliance and community resilience. The views and rights of service users must be respected and taken into account for local service planning. For Community Planning Partnerships (CPPs), this means having an in-depth understanding of how the current system is working to support children and families by mapping the statutory, third sector and community supports within the area, and assessing evidence of which approaches are meeting the needs of children and families. This is why Scottish Government funded programmes such as Realigning Children's Services are critical to the achievement of the preventative spend agenda. Without specialist advice and practical assistance, many CPPs will not be able to collate and analyse the data they need to make the strategic decisions they need to shift resources, and without those shifts in resources, 'prevention' will remain an aspiration, rather than reality.

Care Inspectorate reports often highlight that children's services plans are developed without a clear understanding of need across all agencies. For example, the feedback in one area, which is similar to the Care Inspectorate's findings in other areas of Scotland, was that:

*"[p]artners... need to further strengthen their work towards prevention and early intervention, ensuring that priorities are informed by a robust and transparent needs assessment across the whole partnership area."*⁹

Failing to understand the range of children and families' needs means that the infrastructure of support in an area may not be a good fit with local need. This may result in support which is ineffective, or which is provided at a stage when problems have escalated, are most complex, and are therefore most difficult to address. This creates and maintains a self-perpetuating demand and supply cycle for expensive, complex crisis-intervention work, and the attendant allocation of resources to meet this 'failure demand'. Redressing this balance means having a more sensitive understanding of needs, before problems escalate to crisis point. The SHANNARI wellbeing indicators potentially provide the sensitivity to address problems early, but this may require a cultural shift in how workers view, and carry out, the process of assessing families, particularly at universal service level. Traditionally, training for staff in health and education has focused primarily on child protection. To support this shift – as a precursor to earlier intervention and prevention work – some of the professionals specialising in assessment could be redeployed 'downstream' to support universal services, as staff in these services may not have the core competencies for this task.

To complement this approach to assessment, there will also need to be access to a range of support options for families with less acute needs. The start-up costs of new services, or the process of reconfiguring current ones, can be a barrier to moving from reactive interventions. However, CPPs could be supported to more effectively pool their resources. By understanding their current total resources in terms of statutory, third sector and community provision, as well as their staffing, finance and other assets (including capital), CPPs would be in a better position to maximise the benefits of economies of scale in introducing new approaches.

benefits of investing early to provide greater success to more children, greater productivity and reduce social spending for society.

In a seminal paper from 1996, Kotter suggests that 70% of change efforts in organisations fail.¹⁰ When considering the multi-agency context of GIRFEC and the need for organisations to come together to work effectively with families, the change effort becomes increasingly complex. There is a growing literature on how to support organisations to implement and sustain meaningful change. Active implementation (AI) provides a framework for introducing, developing, and sustaining change.¹¹ AI involves a number of inter-linked stages within the exploration, installation and implementation phases of a change programme, with the full process taking a minimum of 2 to 4 years.¹² Using AI, CPPs could be supported to achieve the shift from acute, crisis-intervention services to preventative and early intervention work. Over time, this would reduce the level of 'failure demand' and reduce the number of children who are accommodated in expensive, out of authority placements, and the emotional, social and societal impact of family breakdown.

How could spend that is deemed to be preventative be identified and tracked more effectively? What is required in terms of data, evidence and evaluation to test interventions for producing 'best value for money'?

Whilst 'best value for money' is an important driver for prevention work, measuring 'value' is entirely contingent on understanding the outcomes achieved for children and families, through the contribution of particular services. In order to achieve 'best value,' the report of the Christie Commission notes that users must "have a pivotal role in designing and evaluating" services. To generate robust information on which to judge 'best value', CPPs must therefore have systems in place to consult widely with children and families, closely monitor spend (on specific services) and develop or deploy indicators which provide a reliable proxies for changes in outcome.

Aggregated data are required from all agencies in each CPP to calculate the spend for supporting families with various types of need. This would involve recording the stage at which support is being offered to families (preventative, early intervention, crisis), as well as the agencies involved, the aims of each session, and the outcomes achieved, as measured against baseline data (need) recorded before the intervention begins. Mapping the outcomes achieved against total resources will give an indication of cost per head of supporting families. This may necessitate a review of data systems, particularly within statutory services, though developments associated with the provision of self-directed support may assist in this effort. And in some local areas, as noted above, it may also require significant learning and development programs for staff.

How can the shift of spending from reactive/acute services to primary/preventative services be sped up and/or incentivised?

Research suggests that effective implementation takes at least between 2 and 4 years to achieve, therefore it is important to be realistic about the pace of change, and supportive of medium to long-term strategies to achieve change. But on the shift to prevention, this has been an explicit policy objective for at least a decade, spanning different governments and ideologies. We can therefore hazard a conclusion that the shift to preventative spend represents a fundamental change in the way services are organised, professionals prepared, and civil society organised. A change so fundamental that just increasing resources or the introduction of new duties is unlikely to be sufficient. However, in the near-term, some changes could make a big difference. Legal requirements for joint planning and increased priority given to vulnerable children (e.g. corporate parenting duties) will help, as would recalibrating public and third sector

budgets so that funding reflects the reality of the problems they are trying to resolve, many of which require long term attention. For example, in evidence to the Audit Committee concerning Health Inequalities, a health visitor commented on targeted funding provided in 2008 in South East Glasgow for an infant feeding team: 'just as we were getting up and running and what we were doing was beginning to work, the money was removed and our team went' (2013, para 42).¹³ CPP areas should be encouraged to build longer term financial planning into their Children's Service Plans, over 3- 5 years. This will require Scottish Government to also look at how it allocates resources through the budget.

Financial modelling may be an effective tool to demonstrate the longer term benefits of investing in change, for example, in highlighting money spent per head on out of authority placements for looked after children, versus the cost of delivering family support focused on early intervention and prevention work. Aberlour has estimated that around £170 million was spent on funding out of authority placements in Scotland in 2013/ 2014.¹⁴ Earlier intervention work with these families may have resulted in a significant financial saving to local authorities, and reduced the social, emotional and societal costs associated with family breakdown.

Thank you for providing us with this opportunity to respond. We hope the feedback is helpful; we would be happy to discuss any aspect in further detail.

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¹ Scottish Government (2016). [Children's Social Work Statistics Scotland 2014/15](#). Edinburgh: Scottish Government.

² SWIA (2006). *Extraordinary Lives: Creating a positive future for looked after children in Scotland*. Edinburgh: Social Work Inspection Agency.

³ Brock, J (2014). [The Brock Report: Safeguarding Scotland's vulnerable children from child abuse](#). Edinburgh: Children in Scotland.

⁴ Scottish Government (2015). [Getting it Right for Looked After Children and Young People: Early Engagement, Early Permanence and Improving the Quality of Care](#). Edinburgh: The Scottish Government.

⁵ CELCIS (2017). *Children on the 'Edges of Care': Transforming Pathways, Improving Lives*. Glasgow: CELCIS.

⁶ Daniel, B., Burgess, C. & Scott, J. (2012). [Review of child neglect in Scotland](#). Edinburgh: Scottish Government.

⁷ Marmot, M et al (2010). *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010 (The Marmot Review)*. London: UCL.

⁸ Christie, C (2011). [Commission on the Future Delivery of Public Services](#). Edinburgh: Scottish Government.

⁹ Care Inspectorate (2015). *Services for Children and Young People in South Lanarkshire: Report of a Joint Inspection*. Dundee: Care Inspectorate.

¹⁰ Kotter (1996). *Leading Change*. Cambridge, MA: Harvard Business School Press.

¹¹ For further information, please refer to the Active Implementation's Hub's summary at <http://implementation.fpg.unc.edu/module-1>

¹² Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature* (FMHI Publication No. 231). Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

¹³ Public Audit Committee (2013). [Public Audit Committee 1st Report 2013 \(Session 4\) Report on Health Inequalities](#). Web only: Scottish Parliament.

¹⁴ Aberlour (2016). Aberlour proposal: Highland Edge of Care Service. Stirling: Aberlour.