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SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

OVER REFERRAL TO SOCIAL SERVICES

HANSARD

Douglas, Thursday, 10th September 2015

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Members Present:

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

Apologies:
Chairman: Mrs B J Cannell MHK

Clerk:
Mr J D C King

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Social Affairs Policy Review Committee

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

[THE SPEAKER in the Chair]

Procedural

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

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

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

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

EVIDENCE OF
Dr D Foreman, MB ChB MSc FRCPsych FRCPCH

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

Dr Foreman: Good afternoon, thank you.

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

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

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

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

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

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

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

Dr Foreman: Yes.

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

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

So it is quite a wide-ranging –

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

Do you mind if I refer to my written evidence?

The Acting Chairman: Please do.

Dr Foreman: Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q145. The Acting Chairman: I see.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Acting Chairman: Yes, thank you very much.

David?

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

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

Dr Foreman: I totally agree.

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

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

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

Q150. The Acting Chairman: Yes.

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

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

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

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

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

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

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

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

How should we measure ourselves?

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

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

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

The Acting Chairman: Okay, thank you.

Jonathan, do you have any points?

Q152. The Clerk: Thanks, Mr Speaker.

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

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

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

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

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

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

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

Q153. The Acting Chairman: Yes.

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

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

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

The Acting Chairman: Yes, thank you.

Any final questions – Mr Cretney? Jonathan?

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

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

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

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

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

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

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

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

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

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

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

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

Q158. The Acting Chairman: Yes, thank you.

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

Thank you very much for your time.

Dr Foreman: Thank you.

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

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

Dr Foreman: Thank you very much.

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

The Committee sat in private at 12.02 p.m.