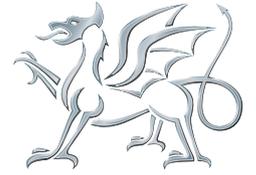


A Key Messages Report



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

A Study of Advocacy Services for Children & Young People in Wales

July 2005

by

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Introduction - study aims and objectives

0.1 This study seeks to meet the key aims and activities required by Welsh Assembly Government contract (170/2003) to examine children's advocacy services in Wales. The results of our exploration of advocacy services for children and young people in Wales across the areas of social care and health will, we hope, inform future developments in the provision of advocacy services. This report provides the 'key messages' from our study and presents these in six sections. These deal with: themes and concepts in advocacy, key characteristics of advocacy services in Wales, children's experiences of advocacy, advocacy and complaints in social services, health services and advocacy, children's experiences of complaints. This Key Messages report does not re-produce all the considerable material contained in our detailed analysis of multiple data sources. This much more extended analysis can be found in Annex 1 (Data Analysis Report) which can be obtained from the Children First Branch, Welsh Assembly Government. We very much hope that this larger report will be read widely as it contains a rich source of insights into advocacy thanks to the contributions made to our enquiry by many children, young people and professionals in voluntary and statutory services to whom we are greatly indebted.

0.2 It is important to note the study focuses upon services whose core function is providing independent children's advocacy, funded mainly by local authorities and health. We do not include education or a multitude of other services that may have, as some aspect of their remit to children, a role akin to advocacy and/or other modes of representation. Our study of advocacy in Wales seeks to meet the following Assembly Government research specifications and aims:

- (i) identify the type and whereabouts of children's advocacy services in social services, the NHS and other (non-education) sectors in relation to access, demand and user characteristics
- (ii) identify the number of children who accessed advocacy in making a complaint in social services and health in the financial year 2003/4
- (iii) collect demographic information on these children: their age, gender, disability, ethnicity, those whose first language is not English, legal status (e.g. child in need, looked after). Information also to include the type and level of services/support received, access arrangements, funding mechanisms, coverage, by local authority and service provider
- (iv) identify the extent to which current advocacy services in health and social services meet national standards

- (v) provide a framework (drawn from the literature) of different models of advocacy, identify those used in Wales and examine whether patterns of provision are different for different groups of children
- (vi) examine the effectiveness of models in Wales in terms of their current purpose. Consider the implications of current funding mechanisms and arrangements for the provision of advocacy services, and implications for development and delivery of advocacy services for all young children and young people, including marginalised and vulnerable children, across social services, health and education in Wales (including benefit/risks and value for money)
- (vii) seek the views of a wide range of children and young people of different ages (including those who have and have not used advocacy services, disabled children, children from black and ethnic minorities, looked after children and those placed outside their home authority and those whose first language is not English) on aspects of advocacy services and experience of complaints procedures in social services and other statutory services.

Our main research methods and products

0.3 The methods used to address the above study aims with regard to children included audio-taped semi-structured interviews, focus groups, closed and open-ended questionnaires. With professionals we used audio-taped structured interviews, closed and open-ended questionnaires, advocacy activity survey, complaints activity survey, and we collected secondary sources (such as monitoring data, quarterly management reports, annual reports) produced by service providers. Analysis was triangulated and developed through a grounded theory approach. Full details of our methods, data gathering instruments and approach to matters of study reliability and validity are set out in the introduction to the Data Analysis Report, Annex 1. Our main research products are:

- Analysis of interviews, focus groups, questionnaires with around 75 children and young people across Wales who have and who have not been users of advocacy services; interviews with 25 children who have been involved in complaints against social services and have or have not used advocacy services.
- Analysis of interviews and a survey of aims, activity and resources derived from all children's advocacy providers, funded by local authorities in Wales.
- Analysis of interviews, questionnaire and survey data on advocacy and complaints derived from key respondents in local

authorities, NHS Trusts, Local Health Boards and Community Health Councils.

- Copies of data collection instruments together with project-analysis formats to assist any future enquiries by WAG.

Research ethics and children

- 0.4 All aspects of the study sought to conform to ethical guidelines stipulated by the British Sociological Association and the Social Care Institute for Excellence. We also responded to any research governance frameworks operated by providers. The study observes the requirements of the Data Protection Act (1998), which came into effect in March 2000. There are no references in any of our data, analysis or report to any named individual; anonymity has been protected throughout.
- 0.5 We acknowledge that discussing emotional issues with children may be potentially upsetting and we ensured that researchers interviewing children in this study were appropriately prepared. The study also conformed to the principle of 'informed consent'. Informed consent is valid where three criteria are met. First, it must be provided by somebody competent to do so (school-aged children required consent from a proxy). Second, information had to be presented to children in a way which they would understand and special attention was paid to those with specific needs in this respect. Third, potential participants had to feel that they could refuse without incurring negative consequences.

Protection and confidentiality

- 0.6 All researchers undertaking interviews and focus groups with children and with staff had enhanced CRB checks, the results of which were confirmed by Cardiff University. Assurances of confidentiality were provided to children and young people by researchers although they were informed that the 'passing on' of information may apply based on the concept of 'significant harm' as informed by procedures set out in *Working Together to Safeguard Children* (2000). Protocols on safeguarding were agreed with relevant agencies when seeking to make contact with children. All protocols and materials used to engage with children and young people are set out in the appendices in Annex 1.

Language

- 0.7 The research team observed the requirements of the Welsh Language Scheme and a specific research team colleague was given responsibility for ensuring that the requirements of the policy were understood by team members. Children represented in the interview

sample whose first language was Welsh were given the opportunity to be interviewed in Welsh. Children represented in the sample, whose first language was other than English or Welsh, were offered the opportunity of being interviewed by a member of the research team using a qualified translator.

The study team

0.8 The study involved two regionally based research groups. In the north, colleagues at NEWI engaged with services in their region and offered capacities in relation to Welsh language. Colleagues at Cardiff University focused on south and mid-Wales.

- Project management was provided by Andrew Pithouse (Cardiff School of Social Sciences) and Odette Parry (Social Inclusion Research Unit at NEWI).
- Specialist expertise in relation to children's identity and children in need was obtained from Emma Renold and Sally Holland (Cardiff School of Social Sciences). Heather Payne (Department of Child Health, College of Medicine) assisted in the design of survey and questionnaires and in drafting the report. Key literature and concepts were provided by Jane Dalrymple.
- Research expertise in interviewing children was provided by Red Kite research consultancy (Anne Crowley, Cath Larkins, Trudy Aspinwall, Lowri Davies). During the study period they had sole contact with children and young people and conducted all individual and focus group interviews.
- Interview transcription and data management was led by Odette Parry and NEWI colleagues who also helped draft and translate the report.
- Interviews with advocacy staff and local authority staff, visits to service providers were undertaken by Cardiff School of Social Science researchers Claire Batchelor, Cathy Anglim and Andrew Pithouse. In the north, this was undertaken by Odette Parry and Iolo Madoc-Jones at NEWI.

1. Themes and concepts in advocacy

- 1.1 A focused review of UK and international literature was undertaken to examine themes and concepts in relation to children's advocacy, this is set out in some depth in Part One of the Data Analysis Report. It notes the importance of key reports and policy in the development of advocacy for children in Wales (Adrienne Jones Report 1999, Waterhouse 2000, Carlile 2002). Research and investigations by the Children's Commissioner for Wales (2003, 2004), were also seen as pivotal in advancing the case for effective children's advocacy.
- 1.2 The review also noted the Welsh Assembly Government's definition of what it means by advocacy for children and young people as set out in the National Standards for the Provision for Children's Advocacy (WAG 2003). The Standards are issued under Section 7(1) of the Local Authority Social Services Act 1970 requiring local authorities with social services functions to act under the guidance of the Welsh Assembly Government. The National Standards cover advocacy for children and young people (including those leaving care) up to the age of 21. Similar importance is attached to advocacy for children and young people treated and cared for by the NHS in Wales. In June 2003 the Standards were adopted by the NHS for advocacy in respect of complaints from children and young people in the health service under the Independent Complaints Advocacy (ICA) managed by Community Health Councils (CHC).
- 1.3 The Standards are informed by Article 12 of the UN Convention on the Rights of the Child (UNCRC) and the Human Rights Act 1998. The Standards recognise that children are not merely 'adults in training' but people able to form and express opinions, participate in decision making processes and influence solutions (WAG 2003a). The Standards are consistent with the Children First Programme and with the Core Principles of Involving Children and Young People, set out in Children & Young People's Framework Planning Guidance (WAG 2002). They set a basic level that children and young people can expect from professionals providing advocacy services. As well as providing support to children and young people to speak for themselves or speaking on their behalf, advocates also offer information and advice.

Forms and models of advocacy

- 1.4 There is a strong case for independent advocacy services for children and young people generally, but especially so for vulnerable groups such as those 'in need' (including disabled children, looked after children, those in custody and children involved in the child protection process). Whilst advocacy is generally agreed to be a process of ensuring another's voice is heard, enabling another to speak up or speaking for another, there are various and sometimes over-lapping

forms of advocacy in existence. These forms include individual self-advocacy, collective advocacy, citizen advocacy, peer advocacy and professional advocacy.

1.5 All forms of advocacy may be seen to be contributing to the empowerment of service users, although levels of empowerment will vary. For the purposes of delineation we can conceive of models of advocacy to include the following (note that elements of models and forms often combine in practice):

- case and systemic or cause advocacy (where knowledge from individual cases aids collective advocacy for more systemic change)
- passive and active models (speaking *for* someone [citizen advocacy] at one end of a continuum to self-advocacy at the other end)
- service model (where advocacy systems are purchased or set up by providers of services who retain some control over the process as opposed to completely independent services). Such service systems typically provide case-based professional advocacy but may also promote peer and collective advocacy

1.6 The service model is generally seen as potentially problematic when commissioning arrangements do not allow sufficient 'distance' between parties, such that contracts and funding may undercut the independence of the advocacy provider. The experiences of children and young people and their advocates will reflect differences in the forms and models of advocacy outlined above. It will be seen however that the predominant model commissioned by most local authorities in Wales is a service model (service level agreement) that provides mainly case-based support. It is to a much lesser extent that these services promote 'cause advocacy' that might contribute to system change locally or nationally.

Children's views of advocacy

1.7 The literature suggests that for children and young people who have not needed advocacy support, or not had the opportunity to work with an advocate, it is likely that they will be unable to offer any definition of advocacy. This means that when young people initially make contact with an advocate, often as a last resort through the recommendation of others, they are likely to be anxious. However, those young people who have worked with an advocate are clearly able to articulate the advocacy role. The main features they identify are: advocacy should help young people to say what they want to say; help to tell other people what their wishes and concerns are; help

children and young people understand about rights; advocates are committed and keep going - especially when helping to make a complaint. The literature indicates that children and young people have the following key expectations of advocates.

- They should have good communication skills that help the young person feel relaxed; they can establish rapport quickly.
- They are expected to listen and, where necessary, help children and young people to prepare *their words* for a meeting.
- They are expected to be confident and prepared to fight the young person's case.
- They are expected to provide information and help young people make choices, but not make decisions for them.
- Young people appreciate that some professionals may find themselves with conflicts of interest in respect of the child's own wishes and the views of significant others about the child's best interests. Hence, young people recognise the need for advocacy services to be independent of service providers and other adults.

1.8 For many children and young people, working with an advocate enables them to take part in the decision making processes that affect their lives. Young people are able to identify the value of having an opportunity to express their views, and of developing skills and confidence over time as a result of this. They feel that it helps them to say what they want and to be a part of the process, although it has been suggested that the most effective advocacy seems to occur when advocates adopt an active role in meetings.

1.9 The actual decisions involving advocacy can, in the view of children, vary from 'small victories' to being 'lifesaving' and young people generally see advocacy as positive. However, this is invariably on an individual basis (case advocacy) and young people express reservations about the possible impact of advocacy upon 'systems'. Cause advocacy remains very much an area for development.

1.10 Issues of power and participation are key to young people's experiences of advocacy. Meetings such as case conferences or making complaints can feel 'scary' and if they do not have the support of an advocate it is unlikely that some young people would be able to participate. The fact that services, despite best intentions, can make some children and young people unwilling to talk to anyone, including an advocate, should not be underestimated.

1.11 In summary, the literature on children and young people's views of advocacy suggests that many have no notion of what an advocate might be or do. Those that do have some knowledge or expectation are looking for rapport, accurate reporting of the young person's own

words, confidence and persistence in presenting the young person's case and providing information and help without making decisions for the child or young person. Advocacy services in Wales are typically case based and need to be part of a wider participation strategy. Various levels and forms of advocacy can be complementary in meeting different types of need.

2. Advocacy providers – key characteristics

- 2.1 For local authorities across Wales, advocacy is typically commissioned from the voluntary sector under service level agreement. At the time of the study these providers included NCH, NSPCC, NYAS, Spurgeons, Tros Gynnal. The model provided by these agencies is broadly similar in that it is largely a case or issue-based, one to one professional service that supports children and young people in voicing their rights and wishes. Additional activities include: promoting the advocacy service with targeted groups of children and other key parties; promoting children's participation in various policy and practice development forums; providing independent visiting; offering advice and support often via multi-media techniques. These services are provided by three voluntary sector providers that cover between 5 and 7 local authorities each, and two other voluntary providers that work to one authority each. Most projects are small in staff resource and have one to 3 full-time advocacy staff some of whom combine management with the role of advocate. Most projects utilise part-time, sessional and/or volunteer staff.
- 2.2 Differences between these providers exist mainly around the mode of service delivery. One of the major providers combines small numbers of FTE supervisory staff with a sizeable network of trained paid sessional staff, this allows some selectivity and matching of skills and attributes with children's needs. Other major providers employ mainly full and part-time staff with social work or allied qualifications. Such providers spoke of problems attracting social work staff and of the need to broaden their qualification requirements, as well as consider using sessional staff, in order to maximise recruitment opportunities. Two smaller agencies rely on a mix of full and part time staff and volunteers, some of whom are unpaid but reimbursed for expenses.
- 2.3 Variation between agencies in relation to staffing profile, their physical location, their training and qualifications, tend to mark out key characteristics and differences. This does not suggest that type of staff tenure (FT/PT/sessional/volunteer) will of itself determine service quality according to service user views, which were generally very positive and not associated with some schemes rather than others.

Independence

- 2.4 While commissioned advocacy is intended to retain some essential independence, most advocacy providers (and several young people and local authority staff we interviewed) doubt they are independent in any strict sense given their reliance on contracts from local authorities. All would prefer a more distanced and neutral mechanism for funding advocacy and for arbitrating over disputes or concerns that either party to a contract may have about their respective activities. The idea of some regional or national mechanism to help

achieve this was proposed by some respondents, together with some element of ring-fenced funding linked to demography of local need.

- 2.5 It would be important however not to lose sight of the benefits of competition and contracting and the importance placed by local authorities on having close involvement in decisions about what organisations are allowed to approach children for whom they have both a direct and indirect responsibility.
- 2.6 Some advocacy providers claimed they were subject to pressure by local authorities to refrain from or engage in some activity that would thereby reflect more positively on the authority. A few spoke of receiving clear indications about negative consequences for contracts were some action not to be taken by the advocacy provider. Whether such claims are valid, or not, is beyond the scope of this study but such accounts reflect a deep-seated view by most providers that independence is a good idea whose time has yet to come.
- 2.7 Several respondents were concerned that they should remain 'outsiders' and not become 'sucked in' to the care system of local authorities whereby they would be expected to routinely attend care reviews and conferences to help listen, engage with and represent children when arguably much of that work should be part of the social work task. Being there to assist only when a child had a dispute over some significant matter (and when the child explicitly consents to advocacy support) was for many the appropriate means by which a child and rights-led service should be activated in order to voice the wishes of children or young people.

Competition contracts and change

- 2.8 The marketisation of advocacy was seen to generate a number of difficulties whereby some providers were thought to 'cut corners' to obtain a competitive edge in tendering. Furthermore, some advocacy providers were seen (by competitors) as much more 'biddable' by authorities than others due to their desire to retain contracts and win new ones. Such claims by respondents suggest a distinct air of distrust between advocacy providers, some of whom said they were wary about sharing good ideas about practice in case this might lend some commercial advantage to others.
- 2.9 Respondents thought three-year contracts that underwrote many service level agreements were too short a period and promoted uncertainty, insecurity for staff, fractured relations with children if contracts were not renewed, and inhibited strategic planning. Indeed, our interviews with children revealed the frustration for some who had been involved in participation groups developed by an advocacy provider and who then perceived their efforts and investment (often over many months), to be discarded when that provider's contract was not renewed.

2.10 None of our respondents described the transition from one provider to another when contracts went elsewhere as 'straightforward'. On the contrary, most spoke of the lengthy development time to get a new contract up to full speed. Advocacy is not some 'plug in and play' service. It takes time to recruit and induct FTE supervisory staff, to vet and train sessional and volunteer workers, to engage with a number of local stakeholders to gain their interest and trust, and to develop systems of service promotion and participation.

Impact, activity and funding

2.11 Measures of advocacy service impact resist simple definition. For example, were we to take number of children supported by an advocate as an indicator then much depends upon the willingness of social workers and other key staff to refer children for a service. Yet, it seems evident that in some areas there is some reluctance by social work teams to meet with advocates and make referrals and that this stems from a culture of mistrust and a belief that advocacy 'creates complaints'. By contrast, some social work staff were said to refer indiscriminately, viewing advocacy as an additional source of general support to children in need rather than a selective and problem-focused service around particular child-led issues.

2.12 Were we to take advocacy involvement in complaints as a measure we can note that, as a proportion of their cases, advocates are typically much less involved in this task than in advising and helping the child to voice their rights and wishes with service providers around particular case-based issues. Activity around complaints can of course be time-consuming, complicated and require technical/legal input, thus the number of such cases involving advocacy tells us little about actual staff time-costs.

2.13 In brief, there are no agreed units of activity and associated measurements and costs that allow comparison across projects. Thus, at this point we have no way of knowing the time and expenditure involved in, for example; one to one advocacy encounters; achieving regular contact with target groups of children; providing phone-lines, website, leaflets, newsletters and promotion events; supporting participation by children and young people in various policy and practice development forums. These sorts of activities are attempted to varying degrees by most providers. And in the view of most providers, seeking to accomplish these activities through what, for the most part, are small and modestly funded schemes is unrealistic, certainly in the sense of delivering all these sorts of activities in the early stages of a new contract. Thus, there can be a significant time-lag of several months (longer in some cases, see Part Two in Annex 1) before all the requirements in service level agreements are fully implemented.

2.14 When funding offers little margin to respond to expanding or changing demand for advocacy then providers will stick closely to the letter of the service level agreement. The idea of going 'the extra mile' that is expected in many commercial relationships is unlikely to obtain according to some respondents because neither their grant income nor their scale of resource allows such flexibility. As social services patterns of activity shift (e.g., more children being looked after for shorter periods, more reliance on foster care, more out of area) so the challenges and costs for advocacy can inflate. In such circumstances advocacy providers may re-target their slender resource around children looked after, as a consequence other priorities around disability and children in need may get displaced.

Number of children seen and funding

2.15 Data returned by advocacy providers indicated a total of some 695 children seen by an advocate across 20 authorities in the year 2003/4 (one of these 20 projects had only been running for 6 months; 2 authorities had no contracted service at the time of the study). The total funding that supported advocacy activities was approximately £966,000 according to figures given by providers. (We might also note that this total, while met mainly by local authorities, includes some £300,000 contributed by some of the larger advocacy providers according to data they supplied) Across all 20 projects, funding ranged from around £25,000 to around £150,000.

2.16 The numbers of children seen by an advocate per authority during 2003/4 varied between 5 in 1 authority and over 80 in another. There was no necessary connection between numbers seen and project funding. It is notable that some authorities with some of the lowest numbers of children seen in the year (e.g., authorities with 5, 13 and 15 children seen), were authorities where there had been a change in advocacy provider, or where the authority had introduced a service level agreement for the first time at the beginning of 2003/4. We might also note that those authorities that tended to fund advocacy at a higher level were in the south of Wales (although these authorities did not necessarily have more children seen by an advocate). The low numbers seen by some projects does raise value for money and capacity questions. Advocacy 'rejection' by professionals may also lead to reduced referrals and less immediate access to children and young people.

2.17 It is important not to overlook the work of ChildLine and Voices from Care (Cymru). The former has good name-recognition and is a national service costing some £700,000 and a small element of this is funded by the Assembly. It has offices in north and south Wales with 20 full-time staff plus counselling volunteers and other voluntary workers – over 300 people in all. They provide 24 hour phone contact available to children and young people to whom they

offer advice, support and a gateway to other help. More active and ongoing phone-based advocacy is offered to particularly vulnerable callers who may fall between services (homeless street-children, asylum seekers, children in and out of care, those with mental health needs). Childline's UK-wide calls and letters concerning children in the year 03/04 numbered 138,442, (the largest category of which, around 22%, was in regard to bullying). It is estimated that some 10% of this UK total stems from Wales.

- 2.18 Voices from Care have a more campaigning/policy development role on behalf of looked after children and children in need. With a small group of 5 or 6 core staff they do not seek a case based advocacy role (but they do respond to children and young people who make direct contact). Rather, they engage with children and young people over their individual and shared experiences of care and/or need, and in so doing promote their interests by lobbying key publics. While the potential overlap and links between Voices, Childline and other advocacy providers seems evident these did not seem much exploited by the various parties. Indeed, there seems to be some insulation across the whole field of providers with little means of generating a shared or joint strategic approach to service development.

Issues of scale and opportunity to develop

- 2.19 Several local authorities have an advocacy service in their area with a local base. Several authorities have an advocacy service but no local base. Some respondents believe that a base allows more contact with other professionals and children. However, bricks and mortar offer no advantage without staff to give a service and most advocacy providers would be unable to deliver adequate office space with flexible opening times (children may want to see advocates during evening and week-ends) across the authorities they serve through current funding. Problems of proximity in both rural and large urban areas also challenge the idea of some single physical base. Advocacy occurs in multiple settings and contexts and has to be seen as a virtual or network organisation. This calls for flexibility of resource and durable well trained supervisory staff and practitioners who can respond to the variable nature and timing of children's needs for advocacy and support.
- 2.20 Linked to the above, the small scale of many projects, with a full-time manager/advocate supervising any number of part-time staff, sessional workers and volunteers, makes these schemes relatively vulnerable to staff losses. While there were many examples of commitment and durability of staff across all projects there were also examples of services struggling to meet contract specifications due to the fragile nature of their key resource – staff. Also, the dispersed nature of staff and the relative distance of some offices from their HQ

(or from their other advocacy offices elsewhere in Wales and England) does not allow for any swift and flexible switching of practitioner or supervisory resource to manage unanticipated problems.

- 2.21 The marginal and sometimes unpredictable flow of staffing, particularly when reliant on sessional and volunteer workers, does not always provide continuity of service for children or local authority. Delivering on advocacy contracts (funded by a modest grant in many cases) provides no foundation to expand into other areas, such as education or health. Nor do the tasks and resources associated with these sorts of service level agreements allow (much less invite) cause advocacy that might change systems at local or national level.
- 2.22 We might also ask does such a diversified field lead to duplication of activities around, for example, recruitment, training, advertising, leaflets, phone-lines and so forth. Also, should these multiple providers seek to mesh with the case and cause based advocacy of ChildLine and Voices from Care Cymru? The answer is that there appears to be little if any strategic oversight of this field and little 'coming together' of these agencies in order to advance some shared position on policy or practice.
- 2.23 As currently configured, it is hard to see how children's advocacy can evolve to meet the challenge of a more thoroughgoing and inclusive approach to engaging with children across social care, education and health. The notion of a 'one stop shop' as a network of advocacy and sign-posting that connects children and young people to appropriate support at local and regional level offers food for thought depending upon the pace of advocacy developments in health and education. The possibility of such a network system has yet to be explored but it is unlikely that simply 'bolting together' various small schemes and stretching them across sectors would be the way forward.
- 2.24 In summary, there is a need for some fresh thinking about a regional or national-based children's advocacy commissioning body that can connect and integrate provision across key service areas and generate a step-change towards a more independent, consistent and inclusive advocacy for children and young people.

3. Children - key views about advocacy

- 3.1 We interviewed some 25 children across Wales who had received an advocacy service in the last year or so. In addition, we conducted focus groups with over 60 children across Wales with different backgrounds and needs. These young people may or may not have had experience of an advocacy service. We asked them all about their understanding and knowledge of the service. Young people were generally not aware of advocacy services and in many cases relied on adults around them to inform them of the service and to help them access it. The most common way for young people to hear about the service was by meeting the advocate, few had seen (or could recall seeing) information about the services prior to contact.
- 3.2 Of those who had used advocacy, a majority requested help with more than one issue – often needing advocacy support across a range of agencies.

Advocacy and complaints - awareness and visibility

- 3.3 Advocacy was not well advertised or accessible in the view of most respondents but once contact had been made young people found it easy to use and often became repeat-users. Respondents favoured opportunities to meet with advocates and to get to know them.
- 3.4 Generally, young people were not aware of complaints procedures or how to use them, nor were they aware of the availability of advocacy in this regard. Most thought it was hard to raise concerns/make a complaint. Easy to understand information, a simple process, confidentiality and support were all things that young people felt would make it easier to complain. Overwhelmingly, young people felt the best way to support young people to make complaints was to ensure that the key adults in their lives (the people they would turn to if they had a problem) were aware of how to complain, how the process worked and what support would be available.
- 3.5 A range of agencies and adults need to be aware of the existence of advocacy services in order to support/refer young people to access them. Visible, known, one-stop-shop type of arrangements that offer non-stigmatised services were highly valued. Some young people did make use of advocacy support in all areas of their lives both at home and across agencies.

Professional and flexible

- 3.6 Most young people stated a preference for a 'professional' advocate in more formal situations (important meetings and decisions) and carers/family for more every-day issues. Key reasons given include the professional advocate's training and knowledge of systems, as well as

their focus on the young person's wishes and feelings (no conflict of interest) and the provision of a confidential and independent service. The nature of the advocacy relationship means that many (but not all) young people seek and receive key emotional support from their advocates. Young people of all ages valued this. Young people want advocacy support that is flexible and responsive and which can offer advice, mediation and representation in a range of settings and at different times.

Confidential, independent, accessible

- 3.7** Confidentiality and independence were seen as very important. Young people thought these features were what really made the advocacy service distinctive. Not all young people were clear about the meaning of independence in this context. Not all young people felt that confidentiality had been clearly explained to them, although the vast majority thought it had been well respected. Some young people wanted more time to get to know their advocate – having time available for young people seemed to increase young people's feelings of being listened to.
- 3.8** Respondents indicated their limited involvement in service development and even less in any 'cause' or collective advocacy. Young people had positive and negative experiences of involvement in project-linked forums and consultation groups. There were positive experiences around involvement in the interviewing of advocacy staff.
- 3.9** Generally, young people were not aware of how advocacy services were organised or managed. A widely shared response existed in the way young people would like advocacy to be more accessible, more of it, at more flexible times, more advertising.
- 3.10** Respondents believed that adults and agencies should support young people's access to advocacy sooner rather than later. They thought it should be more available in schools and at places where children and young people go at the local level.

4. Complaints and advocacy – the local authority

- 4.1 All local authority social services in Wales were requested to complete a survey instrument (see appendix 3, Annex 1) in relation to activity during the financial year 2003/4 at complaints stages 1, 2, and 3. They were also asked to complete a questionnaire (see appendix 3, Annex 1) seeking details about the role of advocacy in relation to the complaints process. The completion of these two instruments was undertaken by a range of social services staff drawn from operational, policy, and quality assurance divisions across authorities. Nearly all authorities (n=20) were able to respond to both the survey and the questionnaire. Two authorities did not complete the questionnaire.
- 4.2 Some authorities were unable to provide much more than the total number of complaints in process over the financial year. From this alone it is notable that some authorities had very few complaints. This seems unlikely to be a simple function of demography or rurality but as much about the way stage 1 complaints come to notice and get recorded and the way in which divisions, departments and/or authorities and key individuals within them perceive complaints as a threat, or an opportunity to consider if services warrant some change.

Stage 1 Complaints

- 4.3 Survey returns indicated 611 stage 1 complaints involving children and young people. Of these, 20 complaints were included in returns but without any details of whether these were adult or child led. A majority of stage 1 complaints involving children are led by adults (n=390 or 64%), almost double those led by children and young people (n=201 or 33%).
- 4.4 Of some 611 stage 1 complaints we can note that 264 (43%) involved children looked after.
- 4.5 Of the looked after children, the atypically high number of complaints in respect of those in residential care at one authority (n=59, see tables section in Annex 1), tends to skew the pattern of complaints activity across the LAC group. Without this unusually high figure (compared to all other authorities), complaints activity is more likely to collect around foster care. Nonetheless, given the much larger population in foster care than in residential settings in Wales it seems that proportionately, there are far more complaints involving children from residential settings.
- 4.6 Comparatively, there are few complaints from those from Wales in residential care out of area, or in secure settings, or living independently.
- 4.7 Most stage 1 complaints concern older age groups, just under 3 to 1 for those aged 10+ compared with those aged 0 to 9.

- 4.8 With stage 1 complaints we can also note that a sizeable number of the 611 complaints involve children (n=144, 24%) living at home with kin, mainly parents, other carers or friends in the area. Very few complaints involve children living with kin or friends out of area.
- 4.9 One Welsh speaker was identified across all the survey returns, this may have more to do with information collection and retrieval by authorities.
- 4.10 Less than 5% of complaints were known to involve children registered as disabled according to returns. This too may be understated, as one respondent indicated that their authority's register was not up to date and hence was reluctant to offer a response. Others failed to enter against this sub-category whilst acknowledging elsewhere in their return the presence of cases involving disability.
- 4.11 Less than 3% of complaints were identified as linked to Black and minority ethnic communities.

Advocacy in Stage 1

- 4.12 When looking at involvement with some type of local authority-funded professional advocacy in relation to these 611 complaints, the returns suggest just over 10% (n=63) of complaints were involved with such a service. More likely to be participating were other adults, mainly kin (n=150) but some other professionals too (n=13) in complaints involving children. Thus in all, some 27% of complaints involved other adults who were unlikely to be professional advocates.
- 4.13 Some 113 (18%) complaints involved children looked after who were leading their own complaint. There was another group of children leading their own complaint but with professional advocacy support funded by the local authority (n=40; 6.5%), and a smaller group of 9 children and young people who led their complaint but were supported by other professionals acting as advocates.
- 4.14 There seemed to be no peers involved in supporting children and young people in leading a complaint but a sizeable number of complaints involving children (n=138; 23%) who were their own and sole advocates. Again, the unusually high figures at one authority tend to skew the distribution of child-led activity (see 4.9.).

Stage 2 Complaints

- 4.15 Information from all but one authority indicates there were some 57 complaints at stage 2. Much the same pattern emerges as at stage 1. Those looked after are often in foster care, only one in residential (out of area). Most complaints were led by adults, over 4 to 1 of complaints; most children involved were in older age groups.

- 4.16 There were more children living 'in area' with kin or friends than in foster or residential care (17 to 10). There were proportionately slightly more children registered as disabled at stage 2 (9%) than in stage 1 (5%), but the number overall is small and comparison may be unwise. One Welsh speaker was identified.
- 4.17 No association with minority ethnic communities at this stage was noted.

Advocacy in Stage 2

- 4.18 Proportionately more cases (25% or 14 cases at stage 2 compared with 10% or 63 cases at stage 1) involved local authority funded advocacy services.
- 4.19 There were, proportionately, more children who led in complaints and got support from local authority funded advocacy providers at this stage (19% compared with 7% at stage 1) and very few children advocated for themselves alone or with peer support at this stage (3 in all).
- 4.20 To repeat, there were some 57 stage 2 complaints in the financial year 2003/4; on average less than 3 cases per authority.
- 4.21 Most cases involved children living in area with parents/carers /friends or in foster care. Most children involved in these complaints (70%) had support from a parent/carer or other adult.

Stage 3 Complaints and advocacy

- 4.22 Survey data for stage 3 revealed 10 complaints. Most authorities reported nil cases. None reported more than one case.
- 4.23 In 4 complaints children lived with kin (parents/carers/friends). The circumstances of the other five appear not readily known to those returning the forms.
- 4.24 Of the 10 cases, 2 were linked to a local authority funded advocacy service.
- 4.25 All complaints were led by adults. The small numbers and missing information allow no useful comparison apart from noting the comparatively low incidence of complaints at this stage.

Questionnaire returns

- 4.26 All local authorities were sent a questionnaire that sought additional information from social services about advocacy and complaints. Two authorities did not return a completed questionnaire. We also requested sight of annual reports on complaints and any other relevant monitoring information for the year in question. Most reports

contained relatively scant detail on the characteristics of complainants and the presence (or not) of advocacy or other kinds of support to children. Questionnaire returns provided the following data:

- 4.27 Recording complaints and withdrawals.** Most authorities recorded that there were no withdrawals for the survey period; 5 authorities each claimed one complaint withdrawn at stage 1. One authority claimed one withdrawal at stage 2.
- 4.28 Complaints about other agencies by children known to them.** Nine authorities indicated that they did not record such matters. Ten authorities stated they did so; of these 5 had no such events in 2003/4 and the remainder had records of one or 2 cases, one authority recorded 3 cases.
- 4.29 Complaints about the ACPC.** On this subject there was no response entered from 4 authorities, another 4 claimed that records of complaints were maintained but were unable to provide any further information. Seven stated records were kept but that there were no complaints for the period in question. Four authorities indicated receiving 5, 3, 2 and 1 complaints made about the ACPC.
- 4.30 Time-lines for completing key stages.** Four authorities claimed not to monitor this area of activity. Approximate averages claimed by several authorities was around 65% completions within time requirements including agreed extensions. Those that responded by referring to the separate stages ranged from 27% to 94% for stage 1 completions. For stage 2 there were claims ranging from nil completions by the required time to 100% completed within the expected period. There were no claims by any authority that all stages were completed within expected time limits.
- 4.31 Software.** Twelve referred to either excel/spreadsheets or paper-based systems. Three stated they used 'Respond'; 4 stated they had developed their own electronic database.
- 4.32 Welsh and other languages.** Returns indicated that 2 authorities might have difficulties in always providing staff with Welsh language capacities to engage with complaints involving children or young people. In respect of other users who did not speak Welsh or English, most respondents stated they would rely on external interpreting provision to meet the language needs of those making a complaint.
- 4.33 Children with a disability.** Some 5 respondents indicated limited ability by their authority to provide advocacy in this area. Eight authorities referred to their advocacy providers as playing a key role. Six authorities relied mainly on child disability teams, leaflets, Mencap packs and other specialist materials. Much of the commentary on this subject was more at the level of aspiration and several spoke of 'design groups' and plans in progress. This topic seemed to reveal an area of some underdevelopment.

- 4.34 Additional support for looked after children.** Most responses (12) referred to advocacy providers joining with complaints officers or children's rights officers in 'reaching-out' to children looked after, via a mix of visits, participation forums, newsletters, flyers, care reviews. Time and costs were noted by many as preventing meaningful and regular contact outside of mail-shot and occasional forums.
- 4.35 Lay advocates (kin, other professionals) in the network of children.** All responses indicated a clear willingness to enable such persons to assist children in complaints and representations. Thirteen of the 18 authorities replying to this question indicated no involvement by lay advocates in the year in question. Five authorities did have a record of such involvement (n=9 cases, these were mainly kin but also a school teacher, a school headmaster, a drug and alcohol voluntary agency worker).
- 4.36 Ensuring access to advocacy.** Most referred to trigger points (child protection conference, becoming looked after, LAC review) that generate contact with the child from a complaints officer and/or advocacy worker and/or leaflets being sent or other communication and materials made available to the child or young person.
- 4.37 Evaluation.** Some 14 returns indicated that their authority did not evaluate the advocacy services they commissioned. Three claimed that their quarterly monitoring meetings with providers met this purpose. One return claimed to evaluate but gave no detail and another return claimed to evaluate by getting children to complete questionnaires about their satisfaction with the way their complaint was managed, including the role of advocacy.
- 4.38 Benefits and challenges re-advocacy arrangements.** Replies to this topic included 5 authorities who cited clear benefits to the child and young person. Five returns claimed no particular benefits associated with the service. Other returns spoke mainly of challenges such as: extending the service to other categories of children in need; lack of choice over advocate due to single-person service; getting managers and staff to understand and value advocacy. Few mentioned any direct benefits to the local authority or the service they provided.
- 4.39 Key changes in next 12 months.** For most authorities, advocacy contracts were a matter of ongoing discussion about possible changes to function and scope. For some there were either new providers in situ or changes soon possible through tendering as existing contracts had come to an end. The general message from returns was one of frequent adjustment and change with fresh impetus stemming from the introduction of new advocacy standards by WAG and anticipated changes in WAG guidance on dealing with complaints.
- 4.40 Other advocacy available to children in authorities.** We were keen to establish whether there were other children's advocacy providers known to local authorities as operating in their area. Most returns

suggested little was known by those responding about any other local schemes. Where there were references these were to local participation forums; very few referred to any advocacy schemes run by education, health or voluntary agencies. Several returns mentioned Mencap, SNAP, Voices from Care, ChildLine and the Children's Commissioner for Wales. It is possible that responses understated the range of additional advocacy services because these are simply not known about.

4.41 New developments – education, health and other services. A minority of 5 responses indicated existing or intended discussions between social services and other statutory (education, health, housing) and voluntary/private providers to explore a shared approach to developing advocacy for larger populations of local children.

Outline causes of complaints

4.42 Each authority was asked to set out in the survey returns and in the questionnaires their view of primary reasons for complaints at each stage and to locate complaints under broad categories. Most authorities attempted to respond.

4.43 Impressionistically, we can note some outline distributions whereby some complaints appear, proportionately, to be more associated with children than adult-led complaints, bearing in mind that there are far more adult-led complaints overall.

- Matters in relation to foster care, leaving care and placements seem more often led by children.
- Matters in relation to contact also seem to find strong involvement of child-led complaints but adults also figure here as a major area of their complaints.
- The few instances provided in survey returns about looked after children being subjected to bullying by other children, or about the behaviour of other service users, were led by children
- Matters in relation to communication between local authority and service users seemed to be as often raised by children as adults

4.44 Adults seemed more likely to raise matters about service quality, delivery or non-delivery, lack of information. They seemed more likely to complain about the attitude and conduct of staff and to challenge allegations of abuse or neglect. The few cases identified in survey returns in relation to child protection matters and to the ACPC were also led by adults. Disability-related matters were also likely to be led by adults.

4.45 Children seemed more likely to complain in relation to matters of personal care, contact with others and communication with staff – more to do with the emotional and relationship side of care and wellbeing. Adults too complained about contact and communication but as much or more so around the substance of provision, decision-making, quality of service, the perceived attitude/conduct of staff and the content of records/minutes of meetings.

Interviews with social services officers dealing with children's complaints

4.46 Interviews were conducted in all authorities with staff designated to deal with children's complaints. They were based in a wide range of non-operational and operational settings and some were line-managed by staff with operational responsibilities. Consequently, conflicts of interest were not unlikely in several authorities. Several complaints officers carried responsibilities for adult services as well. It is possible that this impedes a more dedicated focus on children, young people and their needs.

4.47 Complaints officers dealing with children were typically located at practitioner or administrative grades. Several spoke of status-related difficulties in lacking the seniority to challenge operational staff and/or promote system change.

4.48 Complaints officers spoke of the 'culture' within their organisation in respect of the way complaints are understood and dealt with. It seemed evident that some authorities are notably open and supportive in respect of children's complaints. Others are not so receptive and much depends upon key figures in management who set the 'tone' over whether complaints are seen as a threat or an opportunity.

4.49 Most complaints officers considered that the advocacy service commissioned by their authority was either good or adequate, a minority (5) indicated that the service was not meeting the expectations set by the authority. Most thought advocacy to be of direct benefit to children rather than of benefit to the authority or children's services.

4.50 Philosophical differences between advocacy service and local authority over engaging with children and/or handling children's complaints were not thought to be a problem in a majority of cases. There were examples where there seemed to be significant differences of view between parties about the role of advocate and advocacy but these were the subject of ongoing negotiation.

4.51 The issue of financial dependence was raised by a minority of respondents who considered there to be dilemmas for advocacy providers in the way their orientation to the local authority and to the child might be compromised by the power of those commissioning the service.

- 4.52 Most respondents referred to attempts by themselves and advocacy providers to jointly seek out 'hard to reach' groups about their needs for support and advocacy. The gaps in this aspect of the services, notably in relation to children with a disability, children out of area, those in short-term respite care, foster care, were noted by many respondents.
- 4.53 The financial, logistical and time-costs in engaging individually with a large and/or dispersed population of children in need were noted by several respondents as a major challenge. The aspirational nature of much of the aims and plans in this area suggests some significant underdevelopment of advocacy provision at the moment in regard to children that are hard to reach.

5. Complaints, advocacy and health services

- 5.1 One of the study aims was to discover and map the use of advocacy services for children and young people within the NHS in Wales and to identify numbers of complaints made in 2003-4. The aim was also to identify best practice and innovative projects to promote advocacy in health services for children and young people.
- 5.2 The study was conducted using a specially developed questionnaire and survey sent to all NHS Trusts (n=15) Local Health Boards (n=22) and Community Health Councils (n=19). Responses were received from 12 out of 15 Trusts (80% response rate), 18 out of 22 LHBs (81%) and 14 out of 19 CHCs (76%). These were collated and results themed and analysed (see Annex 1 Part Five).
- 5.3 Advocacy services designed to help children and young people access and use health services are seen as a priority by the majority of Trusts and LHBs in Wales. However, at present, only 4 Trusts and 3 LHBs are offering advocacy services to children and young people in a general context, over and above offering assistance at the point of making a complaint.
- 5.4 The total number of complaints made to Trusts and LHBs in 2003-4 regarding health services for children and young people was 226 (203 Trusts, 23 LHBs). Of these, only 2 were made by young people themselves.
- 5.5 The quality of data collected on children and young people making complaints was very limited. In particular, there was little reporting on the age, sex, ethnicity of the child, or whether they were disabled. None of the complaints recorded in 2003-4 is identified as being made regarding a disabled child or a black or ethnic minority child, refugee or asylum seeker. One complaint out of the total of 226 in Wales in 2003-4 was related to a looked after child.
- 5.6 More widespread use of appropriate software fields could assist Health bodies to collect comparable figures for benchmarking quality. It would be helpful if annual complaints reports all contained a section relating to children.
- 5.7 Virtually all respondents were confident in being able to provide a Welsh speaking response to complaints. However, access to complaints procedures for children and young people with physical or learning disability suggested significant shortcomings. Only 33% of Trusts and 6% of LHBs reported mechanisms for children and young people with specific difficulties to access complaints services, such as minicom or texting for the hearing impaired, availability of BSL or Makaton signers, or productions of Braille documents.

Nature of complaints made

- 5.8 The responses indicated that there were three main types of complaint made:

- the quality of clinical care received (eg mistakes in medications, wrong immunisations, incorrect diagnosis, delayed diagnosis)
 - the availability of care (eg waiting time for Child & Adult Mental Health Services, waiting time for speech and language therapy, autism support and therapy, transitional services for disabled adolescent, distance travelled for out of hours service)
 - Communication, for example, professional attitude and pleasantness.
- 5.9 A few Trusts and LHBs are actively involved in direct provision of broad based health advocacy services. Many other responses indicated that development of advocacy services is an area of active change. Current pilot projects offering advocacy to children and young people are multi-agency arrangements, commissioning 'arms length' advocacy services (Swansea, Wrexham and Powys). These projects aim to promote independence from service delivery and to be transparent for service users. The commissioning process should incorporate evaluation of client satisfaction, and contract monitoring using Welsh Assembly Government standards.
- 5.10 Responses indicate that innovative pilot projects have shown that representations from young people can be readily resolved through a mediation process, with no formal complaints ensuing. This suggests that a complaints process alone is not sufficient to ensure that children and young people gain effective involvement and a voice in children's health services.
- 5.11 Service changes were anticipated during the coming year by 50% of Trusts and 83% of LHBs in development of advocacy services and other mechanisms whereby the organisations seek to hear the voice and views on services of children and young people. These include plans for consultation and advice groups, a children's panel; youth forum; youth champion representative on the Board; children and young people participation subgroup; annual conference for children and young people; local forums working with hard to reach groups.
- 5.12 All organisations reported that they had made responses to the Carlile report, but few referred to actions relating to development of advocacy services. A more formal audit of activity on the Carlile recommendations is advisable for those trusts and LHBs that are not making progress in this area.

Community Health Councils (CHCs)

- 5.13 CHCs in Wales comprise nine federations in which there are 19 local councils. They are linked to a statutory Wales CHC Board. There are performance evaluation frameworks for each CHC who report to the Board who monitor activity and have financial oversight. In turn, the Board reports to Assembly Government. Complaints advocates, funded by the Assembly, are located within federations and operate across community health councils within federal groupings. The arrival

of these funded posts has been accompanied by the design of a bespoke computer package geared to record categories of CHC complaints. This new ITC system went live in 2004 and is gradually being implemented across the CHC system in Wales.

- 5.14 It is estimated by CHC Wales that they deal with a quarter to a third of complaints that come to the NHS. Few of these complaints involve children and very few would involve children referring themselves. Most children's cases entail an adult taking the lead. The CHC service across much of Wales recognises it has limited capacity to offer a child-centred service at present and is as likely to refer or signpost to specialist children's advocacy if needed.
- 5.15 Survey and questionnaire data were received from 14 of 19 CHCs. Findings suggested that not all CHCs maintained records or could access details of involvement of children in complaints. In 10 of the 14 returns it was reported that separate and accessible records on complaints activity involving children were maintained. From these, we can note that some 67 children were involved in complaints led by adults and there were three known cases where children made contact on their own behalf without the support of adults. Where records were available, most complaints were subject to local resolution and three went to independent review.
- 5.16 Annual reports on activity reveal limited detail on complainant characteristics, for example, most reports did not separate out children and young people by age, gender, legal status, adult or child-led complaint. This is not a criticism given (a) the current implementation of a new ITC monitoring system and (b) the fact that supporting children has been a marginal aspect of most CHC activity.
- 5.17 There are notable examples in regard to specialist advocacy work with children, particularly around mental health needs, provided by two mid-Wales CHCs. Their returns indicated activities that, relative to others, were informed by much more child-relevant knowledge, skills, values and processes. These two CHCs were thus highly distinctive and stand as useful (internal) benchmarks.
- 5.18 Apart from the mental health advocacy (noted above), most respondents reported that there were no additional arrangements for providing a complaints advocacy service for children during the financial year in question, other than the mainstream provision (then) operating. None of the CHCs claimed to target any particular sub-groups of children as their primary focus, instead they would operate more on a case by case basis. A few CHCs referred to contact with junior CHCs and youth forums and the use of specialist leaflets in order to engage with children. Most relied upon their usual approach of advertising to a wider public to bring to notice their service to all age groups.
- 5.19 Three of the 14 responding CHCs indicated they would be guided by National Standards in Children's Advocacy when providing a service for young people and children. Most however referred to pre-existing

CHC standards as the main guide. (National Standards were available at the time of the study and CHCs were in the process of embedding these into the service).

- 5.20 Most respondents identified CHC and health timescales as informing their service planning and standards. Of some challenge was provision of advocacy in the medium of Welsh where almost a half of respondents considered this as either unavailable or not always available. A majority of respondents also believed the capacity of their CHC to engage with other languages was limited.
- 5.21 Capacity in respect of communication and child disability was also an area where councils had a scarce resource. While most respondents believed they could offer good physical access and home visits where necessary to facilitate interviews, none referred to any specialist competences to engage with cognitive, aural or emotional needs of children and most would refer such cases to other child advocacy services.
- 5.22 Most complaints or concerns claimed by adults for the child seemed to collect around:
- waiting times for assessment or some procedure
 - resource not available – psychologist, physio, OT, mental health support
 - inappropriate aids/appliances
 - quality of care/treatment in hospital
 - response by out of hours service
 - not being listened to
 - attitude of response from social services
- 5.23 CHCs evaluate their service via user-satisfaction surveys and feedback forms. A few CHCs had child-specific mechanisms to collect the views of young people and children. This was mainly in relation to the two mental health advocacy services identified earlier (5.17).
- 5.24 The main disadvantages described by respondents were seen as lack of specialist capacity to engage with children; lack of training in advocacy for children; no guidelines and standards embedded for children in several CHCs; no knowledge in some CHCs about where to get specialist advocacy support for children; not sufficiently pro-active in regard to children; physical distance and thin resource in rural areas, few cases involving children from which to build experience.
- 5.25 Respondents saw the main advantages of the CHC as tailored to case by case needs. It was seen as an open and responsive service, well focused around the outcomes of patient support in respect of specific complaints procedures.

6. Complaints to social services – children’s views

- 6.1 Structured and audio taped interviews were conducted with a purposive sample of 25 young people from across Wales who had made a complaint to social services in order to explore their experience and insights. Our analysis of this material (see Annex 1 Part Six) indicates that young people have a range of agencies involved in their lives and may need support to access complaints procedures. In respect of social services, young people did not recall being given relevant information about the different stages of the complaints process.
- 6.2 Their views suggest that ‘informal complaints’ (stage 1) are not always processed and confirmed as such at the outset, this sometimes leads to lengthy periods in dealing with matters. The views of respondents suggest a lack of clarity about roles and the rights of young people to progress the full complaints process.
- 6.3 The local authority response to complaints alleging abuse, unsafe care or inappropriate behaviour from carers was an area of confusion for some respondents who were not sure which local authority procedures actually were (or should be) initiated (complaints and/or child protection).
- 6.4 Lack of an effective complaints process persuaded two young people to take action through the ombudsman and through the court.
- 6.5 The most common reason young people gave for deciding to complain to social services was ‘not being listened to’ or ‘not taken seriously’. All the young people interviewed stated they had tried repeatedly to get their concerns dealt with by social services and felt that staff had not given due weight to the issues they raised.
- 6.6 Young people claimed they often struggled to get answers from social services to apparently simple questions about what help or support they were entitled to.

Access to the Complaints Procedure

- 6.7 Many of the young people interviewed said that while they had become aware at some point that they had a right to complain, they still lacked information (and more importantly, explanations) about how to complain and what they could expect to happen as a result. A third of the respondents found out about their right to complain from adults around them (mainly social services staff). In some cases this was combined with knowledge gained from a leaflet, poster or card. A third of the respondents found out about their rights to complain, how to do it and what the complaints process was, through an advocacy service. Some young people thought that the adults responsible for young people’s care should do more to promote their knowledge of, and rights to, making a complaint.

- 6.8 Regular mailings and information from complaints officers directed to those looked after or receiving services does reach young people but many of them do not have contact with an advocacy service. Hence, many of the young people we interviewed struggled to make sense of this information and felt it did not tell them enough about the procedure and what to expect. Information should respond to young people's concerns about using the procedure, for example the lack of faith in social services by some and/or their fear of repercussions.
- 6.9 Based on the experience of our respondents, some social workers and residential staff appear to be referring young people with a complaint to an advocacy service rather than, in the first instance, giving out information or advising and supporting young people themselves.
- 6.10 Few young people understood what would happen when they made a complaint. Information about how young people will be kept informed and can participate in the process was considered to be unclear.
- 6.11 Many young people remained unclear about the process they and their complaint had gone through even after they had completed the process.

Support and advocacy

- 6.12 Guidance on where to find support was not always offered to young people when they first decided on making a complaint. Children's complaints officers, social workers and other care professionals were pro-active in helping a third of respondents gain support from advocacy. Independent advocacy where used by respondents was said to be easy to access when its existence was made known, many would have liked to have had such support earlier.
- 6.13 Independence and distance from the local authority was important for many young people but where complaints officers were committed to making the process children-friendly, then independent support was not always so crucial.
- 6.14 Young people valued independent services for giving them time, resources, information, listening to them, and for support and staying with them throughout the process. Those that used independent support indicated that they found the practical and emotional help they received in negotiating the complaints procedure, invaluable. The sense of close involvement by an advocate in helping progress the complaint was a key determinant in young people's overall satisfaction with the process of making a complaint.
- 6.15 One young person described a negative response to his/her request to an advocacy service for support in raising concerns with the local authority because the advocacy service judged the nature of the complaint to be inappropriate. Young people's right to support in raising concerns and complaining should not be conditional.

The complaints procedure

- 6.16 Writing a letter, often with the support of an advocate, was the most common way of young people registering their complaint. For most of our respondents this was done after making verbal complaints to local authority staff on a number of occasions and not gaining a response, or the response anticipated. This raises concerns about whether social workers and/or carers are acknowledging stage 1 complaints.
- 6.17 Complaints officers can make a real difference to young people's experiences of using the complaints procedure particularly if young people get to know them. A strong impression gained was of young people and their advocates driving the complaints procedure rather than the process being facilitated by social services. Young people frequently perceived advocates to be pushing the local authority to take the young person's complaint seriously. Of those respondents who did not use advocacy support (n=5), four of them stated they struggled to get their complaint acknowledged and they expressed considerable confusion about the purpose and working of the complaints process.
- 6.18 There are problems (from the young person's perspective) of some complaints not being dealt with promptly and with the seriousness they deserve. Half of the young people received a response from social services within 21 days of first registering their complaint. Three young people had a response within 28 days. Over a third of respondents (n=9) had waited six weeks or more for social services to get back to them. Three young people waited between 2 and 6 months and one young person was still waiting to hear 'many' months after making a complaint.
- 6.19 The mode of response from local authorities was difficult to recall in all cases but nearly half of the young people remembered the complaints officer getting back to them by phone or by letter. In most of these cases young people were given information about what would happen next.

Role of the complaints officer and involvement of social worker

- 6.20 The role taken by complaints officers appears to vary widely across local authorities, with some much more pro-active than others. Young people felt more informed and involved in the whole process when the complaints officer had more contact with them. The young people we interviewed who did not have much contact with the complaints officer generally felt disenfranchised and seemed to have little understanding of the process.
- 6.21 Complaints were more likely to be treated as such, kept to time and purpose and young people's rights respected when a pro-active, interested, complaints officer was in post. Generally young people felt they got a better service from dedicated children's complaints officers or from other complaints officer who were perceived as being sensitive to young people's needs and circumstances.

- 6.22 Whilst a few young people spoke positively about the role their social worker had played in encouraging them to make a complaint, in general young people were critical of their social worker (or the lack of a social worker) in their lives. For over a fifth of respondents it was their social worker and the service they received that was the basis of their complaint.
- 6.23 Most respondents recalled that they had tried to get their concerns resolved through other less formal channels. The role of the social worker as an advocate for their client was largely absent from the young people's perspective.

The complaints procedure – satisfaction and perceived outcomes

- 6.24 Twelve young people, approximately half of those interviewed were very satisfied (4) or satisfied (8) with the complaints process. A fifth said they were neither satisfied nor dissatisfied. Approximately a third were dissatisfied (5) or very dissatisfied (3).
- 6.25 Half of the young people interviewed (13) received decisions on their complaints within the time framework recommended by legislation. For three of these young people the decision reached comprised an explanation for events and a promise to make improvements or some other kind of resolution to the complaint.
- 6.26 Of the 17 young people whose complaints had concluded, 10 were satisfied with the outcome; three were not and two neither dissatisfied nor satisfied; two young people said they felt satisfied immediately after the complaint but now some weeks later with improvements short lived, they were dissatisfied.
- 6.27 Nearly three quarters (18) of the young people interviewed thought it had been worthwhile making a complaint to the local authority; 4 young people had mixed feelings and three said using the complaints procedure had not been a worthwhile experience for them.
- 6.28 Over half of the young people (13) thought making a complaint had improved their situation. A third of young people (8) just felt things were about the same for them after they had made their complaints and four young people thought that using the complaints procedure had made their situation worse.
- 6.29 The majority of interviewees thought it hard for young people to raise concerns and make a complaint. Some thought it was particularly hard to start the process (to actually register the complaint with the local authority) particularly as most young people do not know what kind of response to expect. Others suggested that not being listened to, moving around and the length of time the complaints process takes puts young people off complaining. A quarter of young people suggested that fear of repercussions could make it hard for young people to raise concerns.

Summary of key messages

- Many children have no notion of what an advocate might be or do. Those children that do have some knowledge or expectation of advocacy are looking for rapport, accurate reporting of the young person's own words, confidence and persistence in presenting the young person's case and providing information and help without making decisions for the child or young person.
- Having their rights supported and swift access to support if their rights are threatened should be something children and young people grow up expecting. We still need a sizeable shift in attitudes towards the rights of children and young people and their role in helping shape our public services.
- While children and young people who have experience of advocacy speak positively about the service they also think it needs to be more accessible and visible. Leaflets and written information are often not read and/or retained by young people. More innovative multi-setting and multi-media approaches are needed.
- A generic service, available for all children and young people is required to support young people making representation and/or complaints to schools, social care and health. There needs to be more active promotion with 'hard to reach' groups, for example black and minority ethnic young people, young people placed in specialist residential provision, and children with a disability.
- Young people were appreciative of advocacy in relation to complaints. Most complaints to social services and health that involve children are led by adults (mainly kin). Relatively few complaints involve support from professional advocacy services. Most complaints get resolved at the early, more informal, stage of investigation.
- Relatively few complaints progress to more formal stages and when they do these are rarely led by children without some adult support. Interviews with children who had led a complaint indicate that most found the experience to be worthwhile.
- The majority of young people had suggestions for how their experience of making a complaint could have been improved upon. This included key adults (social care staff) working with young people taking a more pro-active support role; raising awareness through reader-relevant information; better access to independent support and speeding up the length of time to get a decision.
- Young people suggested that a commitment to education, information, support, and an effective and positive approach to listening to and resolving complaints needs to be put in place if children and young people are to be encouraged rather than put off by the complaints process.

- The role of the designated complaints officer needs better recognition as a key player in the way (a) complaint procedures and processes are understood by children and young people as meaningful and responsive and (b) the way advocacy is introduced and mediated to the complainant and to those professionals in the service complained about. Often, complaints officers have insufficient status or authority to influence solutions at case and at service level.
- On the health front, most NHS Trusts, LHBs and CHCs in Wales do not provide a dedicated advocacy service for children outside their mainstream systems of patient guidance in relation to complaints and representation. However, there is widespread support by health providers for the Carlile Report recommendations on better safeguarding of children and young people. A small number of children's advocacy pilot projects have been commissioned by NHS Trusts and LHBs in partnership with local authorities.
- There is much aspiration in relation to children's advocacy by health providers and a further audit of implementation is needed to test progress. Very few complaints to health services are led by children or young people, most are led by adults (parents). CHCs provide advocacy for users of health services but few are able to offer specialist skills and capacity in regard to children.
- Children's advocacy services in Wales are typically case based and need to be part of a wider participation strategy. Various levels and forms of advocacy can be complementary in meeting different types of need. Innovative services, highly committed staff and strong approval from users typify much of local authority commissioned children's advocacy services.
- At the same time there are problems around independence, capacity, consistency, competition, value for money, and lack of strategic overview across advocacy provision in Wales. Staffing structures can be fragile and impair continuity of service and relationships. Several local authorities saw little added value through advocacy in relation to its impact upon service delivery or quality and saw it as of relevance to the child or young person only. Other local authorities believed advocacy to offer a range of benefits to both child and the authority. A few authorities reported a history of quite strained relations with advocacy providers leading to a change of contract and supplier.
- The relatively low level of 'cause' advocacy within the projects we examined compared to the higher level of 'cause' advocacy claimed as important by young people we interviewed, raises important questions about the independence and capacity of small advocacy projects in Wales.
- Advocacy unavoidably gives and receives mixed messages – is it an institutional partner, an 'insider', should it be 'outside' looking in on behalf of the child? Should advocacy be a residual highly targeted

activity for a small number of children or should it become a more pervasive part of service structures? Should advocacy become part of a larger 'one-stop system' and as a result possibly lose some of its voluntary sector 'brand names' and the sense of identity, purpose and value-clarity that comes with small project-based organisations?

- The above dilemmas might be more imagined than real, the acid test will be whether advocacy in future can offer a rights, advocacy and participation matrix that can help local and national government be consistent in its treatment of children, as well as help advance its policy to improve children's well-being in Wales. It is unlikely to achieve this as currently configured.
- The need for some fresh thinking about a regional or a national-based children's commissioning body, that can connect and integrate advocacy provision across key service areas and generate more independence for advocacy merits full consideration. A pressing need for change seems hard to refute.

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- (see Annex 1 for full list)