Promoting the Health and Wellbeing of Looked After Children - revised statutory guidance

Consultation Response Form

The closing date for this consultation is: 3 August 2009
Your comments must reach us by that date.

department for
children, schools and families

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Please tick if you want us to keep your response confidential. ☐

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If your enquiry is related to the policy content of the consultation you can contact Sarah Lewis on:

e-mail: Consultationlachealth@dcsf.gov.uk

If you have a query relating to the consultation process you can contact the Consultation Unit on:

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Please tick the box that best describes you as a respondent.

☐	Local Authority	☐	Primary Care Trust	☐	Strategic Health Authority
x	Professional Body	☐	Voluntary Organisation	☐	Other

Please Specify: This response has been compiled by members of the Association of Child Psychotherapists, the main professional body for psychoanalytic child and adolescent psychotherapists in the UK. Most of our 800 members work within the NHS as part of multidisciplinary Child and Adolescent Mental Health Service (CAMHS) teams. Others work in social services, including specialist looked after children teams, schools, hospitals, specialist clinics, residential units, the voluntary sector and in private practice.

This response is informed by child and adolescent psychotherapists' extensive experience of work with looked after children, young people, carers and the professional networks around them.

1 When the guidance is published after consultation is complete, would it be helpful for the "Evidence" section to be left in full as in this Consultation draft?

x	Yes		No		Not sure

Comments:

In addition to the useful section on nature and prevalence of health problems in looked after children (6.0 ff) we would suggest an additional subsection is needed (6.1.5) on the prevalence of emotional, developmental and mental health difficulties in looked after children under 5. Children aged 0-4 represent 38 per cent of all children entering care in the UK and 20 per cent of the total population of children in care. It is also the period during which the most rapid and complex developmental changes occur, which affect all aspects of children's development (Fraiberg, S (1980): *Clinical studies in infant mental health: the first year of life* . New York, Basic Books; Gerhardt, S (2004): *Why love matters. How affection shapes a baby's brain.* Hove, Brunner- Routledge; Zero to Three 2009: Special issue on Infants and toddlers in foster care: Zero to Three publications, National Center for Infants Toddlers, and Families) / www.zerotothree.org/policy).

Few studies exist of the prevalence of mental and emotional health problems and developmental delay or difficulties of children in this age range in the UK; those that have been carried out rely on carer report (Sempik, Ward and Darker, (2008) Emotional and Behavioural Difficulties of Children and Young People at Entry into Care *Clinical Child Psychology and Psychiatry*, 13(2): 221-233. However, studies in preparation indicate that carer and social worker reports minimise or under represent mental health, emotional and developmental difficulties in children under 5 (Conway et al, Hillen et al, in press).

A body of evidence is accumulating in the US that substantiates the clinical experience of our members of high levels of unrecognised and unmet need in this population, particularly in infants and young children, whose emotional and mental health needs tend to be overlooked. Numerous international studies indicate the prevalence of emotional, behavioural and developmental difficulties in children aged 0-5 in the general population. For example, in the US, Lavigne et al (1993) found a prevalence of 13% of emotional and behavioural problems in children under 5 in the general population. In a study of 3,876 children, at least 51% of those children assessed by psychologists as having an emotional or behavioural problem had not received treatment or a mental health referral (Behavioural and emotional problems among preschool children in pediatric primary care: prevalence and pediatrician's recognition, *Pediatrics* 1993, 91;

649-655)

Reams (1999) identifies children under the age of three as the fastest growing section of the population of children entering the state's custody in the US. In this study mental health services were recommended for 33% of children aged 0-3 and further developmental assessment was recommended for 76% of children aged 0-3. Reams emphasizes the need for early, specialist mental health assessment of infants and young children in care to ensure that they receive timely interventions during the most developmentally salient period of a child's life ('Children birth to three entering the state's custody' *Infant Mental Health Journal* 20/2 pp 166-174). Urquiza, A et al, (1994) found that 27% of foster children younger than two and a half were two standard deviations or more below age expectations on the Bayley Scales of Infant Development and 39% of children under 4 years scored in the clinical range for internalising difficulties in the Achenbach Child Behaviour Checklist ('Screening and evaluating abused and neglected children entering protective custody' *Child Welfare* 73, pp 155-171). Further prevalence studies for this age range are cited by Reams (op cit). Clyman et al found that infants entering foster care have very high rates of risk for psychopathology , medical illness and developmental delays, citing studies indication that up to three-quarters of children in foster care need further developmental assessment or have developmental delay (Clyman RB, Harden, BJ, Little C (2002): 'Assessment , intervention and research with infants in out-of-home placement' *Infant Mental Health Journal* 23 (5) 435-453). Stahmer et al (2005) investigated the level of behavioural and developmental need in young children entering child welfare and found that 41.8% of toddlers and 68.1% of pre-schoolers had high developmental and behavioural needs. ('Developmental and behavioural needs and service use for young children in child welfare' Pediatrics, 116/4 Oct 2005: 891-900).

We believe that this guidance offers an important opportunity to rectify a wide-ranging omission and to help to alert health care professionals to the need for careful observation of infants and young children, training in these issues, and referral to or consultation with mental health and child development services as early as possible following a child's entry into care.

We would also suggest the inclusion of Gilbert, R. (2008, Burden and consequences of child maltreatment in high-income countries, Lancet Volume 373, Issue 9657, pages 68-81) to highlight the scale and impact of maltreatment on children entering care.

2 Do you think that the idea of an "email box" is the right way forward for improving notification?

x	Yes		No		Not Sure

Comments:

3 Do you agree that the question of which PCT carries out health assessments for children placed out of authority should be left for local determination?

	Yes	x	No		

Comments: As noted in Evidence section of the guidance (p7-14), a significant proportion of looked after children are placed outside their local authority boundary (5.1 p7), which has implications for how health services are commissioned and provided for these children. In our experience the question of which PCT carries out health assessments for children placed out of authority is often left for local determination on the basis of local priorities., leading to disparity, inequity and uncertainty about access to services. We understand that this situation is likely to change in light of NICE guidance on the physical and emotional health and wellbeing of looked after children and young people, which is due to be published in September 2010. In our view, a system of national guidelines would help to highlight and streamline the care of this group of children with high levels of clinical need would be beneficial.

4 We have received differing views on whether the Government should publish paperwork for documenting the Health Assessment. Do you think the Government should publish paperwork and make it mandatory for all local authorities and PCTs to use the same forms?

x	Yes		No		Not sure

Comments: As noted at 5.1 (p7), many children and young people move between local authority areas, and this has significant implications for how health services are commissioned and provided for them. In our experience it is often the case that knowledge of a child or young person's history is fragmented, making it difficult for the professionals and others working with the child to build a clear picture of their situation. One of the biggest obstacles to promoting the health and wellbeing of looked after children is that difficulties are often not recognised early enough because much of their history has been lost in this way. Understanding the detail of each child's history also helps those around them to make meaning of their behaviour, which is often disturbed as a result of adverse early experiences. Any system which helps to provide a more coherent framework around them, close some of the gaps that are frequently found in their records (see 7.2 p11) and enable those working with the child to see the whole child in the context of their whole life experiences would be helpful. A uniform way of documenting the Health Assessment could be more economic and, importantly, less burdensome on children and young people, who can begin to suffer from 'assessment fatigue' as a result of repeated assessments by different professionals.

5 Do you think that provision of dedicated CAMHS services for looked after children will improve the health and wellbeing of looked after children?

x	Yes	☐	No	☐	Not sure

Comments: We welcome the guidance's recognition that dedicated CAMHS should be available for looked after children and young people as set out in the Care Matters white paper (p55). The experience of our members indicates that the complex mental health needs of looked after children are best met by specialist multi-disciplinary teams of highly qualified, experienced professionals working alongside social services and dedicated Child and Adolescent Mental Health Services (CAMHS). Such arrangements can help provide the high levels of liaison and consultation that are needed to support looked after children and young people, their carers and the professional networks around them.

Currently, many and perhaps the majority of looked after children do not receive the treatment they need. For those children who do not have access to appropriate services, their emotional and mental health difficulties can have lasting and damaging consequences. It has been estimated that 90 per cent of children who have experienced sexual abuse receive no substantial support (Baginsky, M. (ed) 2000, NSPCC). Untreated children who have suffered from abuse – up to 60 per cent of those who enter care – can be at increased risk of

depression, post-traumatic stress disorder, relationship difficulties and attachment disorders, risky behaviour and negative self image and attitudes towards other people (Kendall-Tackett, 2002, in Child Abuse and Neglect, 26).

It is to be welcomed, that following the recommendations of Lord Laming (Laming, 2003, The Victoria Climbie Inquiry), many local authorities have set up designated multi-disciplinary mental health teams for looked after children. These services provide fast response multi-disciplinary assessment; placement support; treatment for children in transition; consultation to carers, social workers and professional networks; training, audit and research (Wakelyn, J., 2008, in Journal of Social Work Practice 22/1). There is substantial variation across regions in the provision of these services and emerging good practice in this area needs to be built on (DoH, 2004, What's New: Learning from the CAMHS innovation projects).

Laming's recommendations were echoed in the report of the House of Commons Children, Schools and Families Committee on looked after children (March 2009), which recommended that children and young people in care should have guaranteed access to CAMHS and that urgent action should be taken to address the shortage of therapeutic services for this vulnerable group. A needs assessment, perhaps linked to existing CAMHS mapping, would help the government to establish how specialist mental health teams for children in care can be put in place and sustained in all areas. It could also investigate the development of specialist CAMHS provision for looked-after infants and young children under 5 and for 'children in need' or children 'on the edge of care', who struggle to access mainstream CAMHS.

6 Will a new statutory role of lead health professional improve the health care for looked after children?

x	Yes	☐	No	☐	Not sure

Comments: Please see our comments on Q 14 pt 3 – we believe that this new role has the potential to improve the health care for looked after children, but that organisational changes by themselves will be limited in their efficacy unless psychological impediments to multi-agency collaboration and communication are recognised and addressed, through multi-agency training and dialogue and consultation with mental health staff.

7 Can you tell us what current staff (profession, pay-band and WTE) you deploy to the role of lead health professional?

Comments: N/A

The Impact assessment is based on several different assumptions.

8 Of the three assumptions outlined in the Economic Impact Assessment that was published alongside this guidance, which assumption most accurately reflects the current situation in your PCT A, B, C or other (please give details).

☐	Assumption A	☐	Assumption B	☐	Assumption C
☐	Other	☐	Not Sure		

Comments: N/A

9

Which staff group would you see undertaking the proposed role of the lead health professional?

Comments:
We would see this changing according to the child's needs and use of services; clear criteria will be needed to indicate how the lead health professional is identified and the procedures for handover of the role to another professional if required.

10

Are the responsibilities outlined for lead health professionals the right ones?

☐	Yes	☐	No	☐	Not Sure

Comments: N/A
We would see one of the crucial roles of the lead health professional as ensuring that each child's developmental history is as complete as possible and is effectively kept in mind in all assessment and planning for the child.

11 Is the guidance helpful in informing the ***inspection*** of health services for looked after children?

☐	Very helpful	☐	Helpful	☐	Not very helpful
☐	Not at all helpful				

Comments:
N/A

12 Is the guidance helpful in informing the ***commissioning*** of health services for looked after children?

☐	Very helpful	☐	Helpful	☐	Not very helpful
☐	Not at all helpful				

Comments:
N/A

13 Is the guidance helpful in informing the ***delivery*** of health services for looked after children?

☐	Very helpful	x	Helpful	☐	Not very helpful
☐	Not at all helpful				

Comments:

14 Is there anything missing from the draft statutory guidance?

x	Yes	☐	No

Comments:

1. **The scale of the impact of trauma, abuse and neglect**: We welcome the guidance's recognition of the impact of instability (10.5 p27), child abuse and neglect and a lack of secure attachments in early childhood (p42) on children and young people and the link between unresolved childhood mental health problems and difficulties in adulthood (p54). However, we feel that the profound impact of trauma, abuse and maltreatment on looked after children needs to be a core theme throughout the guidance document. All looked after children have experienced family breakdown and two-thirds have suffered neglect and/or abuse. These experiences have a serious and significant long-term impact on children's development, mental health, emotional wellbeing and attachment. Mental health problems amongst children in care, for example, are four times higher than in the general population (DCSF, 2007, Care Matters: Time for change p6). Many children survive adverse early experiences by forming psychological defences (Kenrick, J. et al, 2006, pub. Karnac), becoming withdrawn and retreating behind a protective shell or becoming hyperactive, too busy to think or feel. This can make it difficult for children in care to make use of the opportunities available to them. Health care professionals working with this population need training in children's developmental needs and the impact of trauma and disruption, and opportunities for joint training, consultation and supervision from specialist mental health staff

2. **The needs of under-fives**: There is growing evidence that infants and very young children have high levels of unmet mental health need. Children aged 0-4 represent 38 per cent of all children entering care in the UK and 20 per cent of the total population of children in care. It is also the period during which the most rapid and complex developmental changes occur, which affect all aspects of children's development. Studies from the US have established that the mental health and emotional needs of under-fives are significantly under-reported. UK prevalence studies such as the one quoted at 6.1.4 (p9), which found that one in five children looked after under the age of five showed signs of emotional or behavioural problems are helpful, but the indications are that many significantly underestimate levels of actual clinical need. Please see our more detailed response to Q1.We believe that this guidance offers an important opportunity to rectify a wide-ranging omission and to help to alert health care professionals to the need for careful observation of infants and young children, training in these issues, and referral to or consultation with mental health and child development services as early as possible following a child's entry into care.

3. **Psychological barriers in health professionals**: Understanding the psychological processes at work is critical to addressing children's mental health issues. Unless the complex dynamics that have brought children into the care system are recognised and addressed, the disturbance and distress of family breakdown can continue to impede effective working between

professionals. So while we endorse and support the systems and structures which are being put in place to support coherent multi-agency working around looked after children, we believe that psychological barriers that can impede effective multi-agency collaboration need also be taken into account. Such barriers in health professionals may include the fear of hostility from parents or carers; the repetition or re-enactment of family conflict in breakdowns of trust or communication between professionals; a lack of support structures in which to raise concerns; and 'action-oriented' workplace cultures that discourage reflective practice. Unless such impediments are addressed, failures of communication are likely to occur however robust and sophisticated the systems. Access to consultation from mental health professionals, supervision and reflective practice can help address these complex psychological barriers.

15 Would the Practice Guidance benefit from further information about access and engagement?

x	Yes	☐	No	☐	Not Sure

Comments: We believe that the voice of the child needs to be heard and that it needs to be recognised that children of all ages often communicate through their behaviour and emotional and/or physical states rather than or as well as in words. We would support a framework that assists healthcare workers in recognising and responding to *all* communications from infants, children and young people, whether through voiced in words or communicated in other ways, such as play, drawings, acting out, or somatic states, so that the whole story of the child can be understood and kept in mind. Findings from attachment research on the ways in which children and young people with insecure or disorganised attachments are often unable to elicit nurture and care in straightforward ways and struggle to make and sustain trusting relationships (see Dozier et al 2002 'Intervening with foster infants' caregivers: targeting three critical needs' in *Infant Mental Health Journal* 23(5) 541-544) should be included in trainings for health care professionals.

16 What further information, if any, should be included in the Health Promotion section of the Practice Guidance?

Comments: In our view, the Health Promotion section of the Practice Guidance would benefit from the following further information:

1. **Child development**: All looked after children have experienced family breakdown and two-thirds have suffered neglect and/or abuse which often results in developmental delay. Carers and those who work with looked after children should be trained in children's developmental needs and the impact of trauma, maltreatment and the disruption of care. They may need to be encouraged to "think younger", even where the child or young person presents him- or herself as precociously mature. Carers and healthcare workers would also benefit from understanding the importance of play at different stages of a child's development. Research shows that those children who have missed out on earlier stages of play because of their disrupted early lives can benefit from going back to those types of play at a later stage.

2. **Individual attention**: Most children at most ages will benefit from regular one to one time with their carer, which can help consolidate the kind of "caring, consistent, stable and secure relationship" with a carer that the guidance recognises as crucial (p41). This may consist of free play time (p43) or story time before bed. It should be recognised that the psychological defences routinely adopted by looked after children as a result of their adverse early experiences (Kenrick, J, 2006, as before; Dozier et al 2002) can mean that they do not naturally elicit nurturing care from those around them. They may retreat behind a protective shell, becoming withdrawn and cut off from emotional life and development or they may become hyperactive, too busy to think or feel. This can mean that attention from a carer is rebuffed. Carers need to draw on their own emotional resources together with specialist training and support to recognise and respond to the signals that children give out, and to persist in reaching out to the children in their care in the face of apparent hostility or indifference.

3. **Relationship difficulties**: Related to the previous point, the high levels of mental health difficulties amongst children in care will impact on their progress in all areas of life. The nature of their difficulties can mean that making strong, consistent relationships becomes a struggle for them, their carers, social workers, health professionals and others who are involved in their lives. The psychological defences sometimes adopted as a result of their traumatic early experiences, as outlined above, can make ordinary relationships highly problematic. Health professionals should be supported by access to mental health professionals and opportunities for reflective supervision in order to help navigate these difficulties.

4. **Support for teenage parents**: As noted in the Evidence section and at p45, young men and women leaving care are more likely than their peers to become teenage parents. Our experience is that services for teenage parents are very patchy and differ widely from borough to borough. Care leavers who become

teenage parents need more coherent provision, including intensive treatment, to help them form nurturing relationships with their infants and to prevent damaging cycles of intergenerational abuse or neglect.

17 Would a revised version of the health care flowchart which is Appendix 5 in the current guidance (Promoting the Health of Looked After Children, 2002) be a helpful Annex for this guidance?

x	Yes	☐	No

Comments: The health care flowchart would be a helpful Annex for this guidance, with the addition of the following information: Under 5s: under the final bullet point, “monitoring developmental milestones”, we would add **developmentally appropriate play**. We would also add **mental and emotional health including depression and post-traumatic developmental difficulties**. Ages 5-10: we would also add **developmentally appropriate play** to the list for this age group. Adolescence and leaving care - 11-18: after the bullet point “communication and interpersonal skills”, we would add **including friendships and peer relationships**. Studies have shown the crucial importance of peer relationships in adolescence as an important part of preventing future mental health difficulties. Hodges, J. for example (‘The natural history of attachment’, in *Children, Research and Policy* eds Bernstein and Brannen, 1996), found that the importance of peer relationships in adolescence increases and that good peer relationships are a significant protective factor against the psychological effects of stress. Because of their difficult early experiences, looked after young people often need sustained support to start and maintain these relationships.

18 Are the boxes in the Practice Guidance on the suggested content of Health Assessments the best way for the guidance to advise on content?

x	Yes	☐	No	☐	Not Sure

Comments:

19 Please use this box to tell us about any further thoughts you have on the Guidance, not covered by the previous consultation questions.

Comments:

We would emphasise the following points:

1. Unmet need in under-fives: The mental health and emotional needs of infants and very young children tend to be overlooked despite research which suggests high levels of unmet need as a result of maltreatment, trauma and disrupted care. Numerous studies indicate the existence of infant mental health difficulties including depression and post-traumatic developmental difficulties from a very early age. Health care professionals have a crucial role in observing infants and young children and seeking advice from mental health specialists at as early a stage as possible when they have concerns.

2. Need for specialist support and training: There is a need for carers and all those who work with looked after children, including health visitors and early years workers, to receive specific training in children's development and emotional and mental health needs and to have opportunities for reflective supervision to help them negotiate the difficulties that such children present. The powerful psychological impediments to effective multi-agency working should also be recognised to prevent failures of communication and co-working in the team around the child from undermining support for the child's health and wellbeing.

3. Recognition of the impact of trauma: All looked after children have experienced family breakdown and two-thirds have suffered neglect and/or abuse which impacts on their development and all aspects of their lives and relationships with others. As recognised by Gilbert, R. (2008, Burden and consequences of child maltreatment in high-income countries, Lancet Volume

373, Issue 9657, pages 68-81), child maltreatment has long-lasting effects on mental health, drug and alcohol misuse, risky sexual behaviour, obesity and criminal behaviour, which persists into adulthood. The study concluded: “The high burden and serious and long-term consequences of child maltreatment warrant increased investment in preventive and therapeutic strategies from early childhood”.

Thank you for taking the time to let us have your views. We do not intend to acknowledge individual responses unless you place an 'X' in the box below.

Please acknowledge this reply x

Here at the Department for Children, Schools and Families we carry out our research on many different topics and consultations. As your views are valuable to us, would it be alright if we were to contact you again from time to time either for research or to send through consultation documents?

X Yes	☐ No

All DCSF public consultations are required to conform to the following criteria within the Government Code of Practice on Consultation:

Criterion 1: Formal consultation should take place at a stage when there is scope to influence the policy outcome.

Criterion 2: Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

Criterion 3: Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

Criterion 4: Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

Criterion 5: Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

Criterion 6: Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Criterion 7: Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

If you have any comments on how DCSF consultations are conducted, please contact Phil Turner, DCSF Consultation Co-ordinator, tel: 01928 794304 / email: phil.turner@dcsf.gsi.gov.uk.

Thank you for taking time to respond to this consultation.

Completed questionnaires and other responses should be sent to the address shown below by 3 August 2009

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