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Response of the Association of Child Psychotherapists to the Children, Schools and Families Committee inquiry into Looked-After Children

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Summary

1. The Association of Child Psychotherapists (ACP) is the independent professional body for the training and regulation of child and adolescent psychotherapists in the UK. It is recognised by the Department of Health (see Appendix for more about the ACP).

2. The ACP welcomes the inquiry of the Children, Schools and Families Committee into the government's proposals to improve the care of looked-after children and the opportunity to submit evidence. We recognise that more resources are being made available to ensure that this vulnerable group of children and young people have access to educational opportunities. However, it is also crucial that there is understanding and treatment of the mental health and emotional difficulties that can prevent children from taking up the opportunities they are offered.

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

4. Three key themes underpin the ACP's thinking about social care provision for children and young people in care.

5. **A Emotional understanding is central to care -** All looked-after children have experienced family breakdown and many have suffered neglect or abuse. The ACP believes that

understanding the impact of experience on children's mental health and emotional well-being is central to their care. Untreated mental health difficulties and psychosocial problems can lead to learning difficulties which prevent children from accessing educational opportunity.

6. **B Children and their carers need stability** - The ACP believes that stability and predictability in relationships are fundamental to ensuring positive outcomes for children in care. We need to ensure that children have stability so that they are able to form supportive emotional attachments with their carers and make use of educational provision and opportunities. The quality and continuity of children's relationships with carers and social workers is central to their recovery and future development.

7. **C Complex needs require specialist services -** The complex mental health needs of children in care are best met by specialist multi-disciplinary teams of highly qualified, experienced professionals working alongside social services and mainstream CAMHS.

Why do children in care have such poor outcomes?

8. The effects of abuse and neglect that two-thirds of looked-after children and young people enter care with lead to a high incidence of mental health difficulties and placement breakdowns, which have profound impacts on their development.[1] [2] Mental health problems in children who are in care are four times higher than in the general population.[3]

9. The symptoms presented by this group of children are serious. They include chronic depression and anxiety, attachment disorders, low self esteem, obsessive-compulsive disorders, soiling or smearing of faeces, sexualized preoccupations and sexual activity, volatile mood changes, aggression and defiance. Many looked-after children reject help, leaving their carers feeling helpless and useless.

10. Children who have been in care form up to a third of rough sleepers and a quarter of adults in prison.[4] Childhood conduct disorders cost the economy in excess of £3,000[5] per year per child and this escalates to £70,000 as the young person reaches adulthood.[6]

11. Many children survive adverse early experiences by forming psychological defences.[7] 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. Some children become identified with the person who hurts or deprives them. This can lead in turn to future abusive behaviour. These maladaptive defences, if untreated, can make it impossible to trust, accept help, or learn.

12. Understanding the detail of each child's history helps to make meaning of their disturbed behaviour. For many children, the process of finding meaning is like a lifeline that allows them to connect with others and to reconnect with their own minds. Research in neuroscience and attachment shows how making meaning is central to emotional and cognitive development.[8] [9] [10]

What do child psychotherapists do to improve outcomes for looked-after children and young people?

Support for carers and teachers

13. Child psychotherapists support foster carers and teachers to understand and manage the range of difficulties that children in care bring to family and school life. This facilitates more stable placements and reduces school exclusions. We know from research that the more stable foster placements are, the better the outcomes in all areas of life.[11]

Facilititating understanding of difficult behaviour

14. Distorted ways of responding to carers are often repetitions of patterns developed in earlier neglectful and abusive situations.

15. Child psychotherapists use their training in observation, child development, and psychodynamic theory and practice to help carers understand the emotional meaning behind a defiant or dismissive front and to reach the vulnerable child behind the defence.[12]

Work in schools

16. Child psychotherapists also carry out observations and consultations in schools, and work with teachers to find ways of supporting children so that they can manage the classroom setting. This reduces school exclusion and facilitates take-up of educational opportunity.

Assessment and treatment

17. Child psychotherapists assess children's individual needs for treatment and provide psychotherapy which can last between six months for children in transition up to two years or more. This slow, careful work allows children gradually to find new ways of coping that allows them to learn, trust, and form new relationships.[13]

CAMHS and specialist CAMHS

18. Child and adolescent psychotherapists are core members of multidisciplinary CAMHS teams providing specialist assessment and treatment for children and young people in care. About a third of the children referred to child psychotherapists have already received other interventions that have failed to lessen their distress or change their

behaviour.[14] Specialist CAMHS work closely with related professionals such as looked-after children's nurses to coordinate care for conditions where physical and mental health needs are interconnected, such as eating disorders, wetting and soiling, risky acting-out, alcohol consumption and substance misuse.

Training and supervision

19. Along with colleagues in adult psychiatry and psychotherapy, psychology and social work, child psychotherapists provide training and reflective supervision for staff in social work, schools, residential care and Connexions. Child psychotherapists help to reduce illness and turnover among staff who deal with disturbed and disturbing children on a day-to-day basis, by offering psychological support and reflective consultation.[15] Retention of quality staff who are emotionally invested in their work and are able to tolerate and respond effectively to young people's needs helps to provide the continuity that children in care need.

Research

20. Child psychotherapists also carry out research in order to continuously develop and extend the wide range of clinical applications of child psychotherapy.[16]

A - Emotional understanding is central to care

21. Mental health problems in children who are in care are four times higher than the general population.[17] 28% of children in care have a statement of special educational needs compared with three per cent of all children.[18]

22. Critical to addressing children's mental health issues is a thorough understanding of the psychological processes at work. For children and young people who have experienced family breakdown, the professionals working with them in different areas of their lives have to join together like parents to carry out their responsibilities. Unless these complex dynamics are recognised and addressed, the disturbance and distress of family breakdown can impede effective working between professionals and agencies around the child.

23. From this perspective we recommend that Independent Reviewing Officers have substantial experience and training from mental health professionals, including child psychotherapists, in understanding the complex dynamics around broken families and mental health difficulty.

24. The ACP regrets the omission from the Bill of an emphasis on the mental health and emotional needs of looked-after children and young people. We agree that their educational and life outcomes must be improved. We think this will best be done by integrating mental health with educational, health and social work provision.

25. Child death enquiries have regularly found that breakdowns in communication have prevented action from being taken even when children are visibly at risk. However, services have increasingly fragmented as the NHS and Social Services have come to operate in competitive market conditions.[19] The findings of child death enquiries need to be linked to policy so that there can be learning from experience. Like research, policy in this area needs to be 'experience-near', so that deficits in understanding are not repeated at the cost of the most vulnerable children and families in our society. This means building better relationships between practitioners and policy-makers. The ACP welcomes the opportunity afforded by this Bill to enter into closer dialogue with government.

B - Children and their carers need stability

26. The ACP believes that stability and predictability in relationships are fundamental to ensuring positive outcomes for children in care. We need to ensure that children have stability so that they are able to form supportive emotional attachments with their carers and make use of educational provision and opportunities. The quality and continuity of relationships with carers and social workers is central to recovery and future development.

27. Therefore, services for children in care need to be stable and sustained so that children have enough continuity in their relationships to form a secure base from which to develop and thrive. At a stage when continuity is what is most needed, many children in care have to manage repeated and damaging endings.

28. Stable relationships can only be provided by organisations with stable staffing. The Bill's envisaged framework of 'delegated provision' risks adding to the complexity and potential for fragmentation between agencies working to support children. There is a danger that children's fundamental need for continuity in their primary relationships

– with foster carers and social workers – will be lost sight of in a plethora of new organisations and procedures. Rigorous monitoring of the Bill's provisions for delegated services will be needed to evaluate its effects on continuity of professionals and placements for looked-after children and young people.

29. The Bill envisages an enhanced role for the Independent Reviewing Officer (IRO). We agree that a more clearly designated co-ordination role is needed to facilitate effective joint working between professionals working with children and young people in care - who can number over 45 for a single child.[20] The IROs will need to work closely alongside CAMHS and specialist CAMHS. They will need to be well-qualified practitioners with relevant recent experience.

30. The *individual* emotional and developmental needs of children and young people should be central to placement planning. While for many children, in-borough placements may offer continuity, there is a proportion of children for whom a move away from warring or enmeshed birth-family relationships may offer their only realistic chance of developing their own identity and potential. Other children may need specialist residential care not available in most boroughs.

31. The Bill revisits arrangements for children placed with family and friends. Research has shown that these carers are often older, poorer, in poorer health and have worse housing than non-related foster carers. It is important therefore that there is careful assessment of these placements to ensure that they best meet each child's emotional and developmental needs. Financial, therapeutic and social work support for kinship carers should be on a par with that for non-related carers, to enable them to care for children who would otherwise be the responsibility of the local authority.[21]

32. While ethnic and cultural matching is desirable for all children, individual needs and circumstances should be assessed on a case-by-case basis. Children at risk of later mental health and emotional difficulties have a primary need for emotional continuity. Important as ethnic and cultural factors are, they should not be the prime basis for placement decisions for children vulnerable to attachment disorders.[22]

33. Stable and continuous services are needed to provide a context for audit, follow-up and research to add to the evidence base for therapeutic work with looked-after children

and young people, thus ensuring continuous service development and improvement. Investment is needed in high-quality, experience-near research, audit and follow-up studies to further develop a robust and relevant evidence base.

34. C - Complex needs require specialist services

35. The complex mental health needs of children in care are best met by specialist multi-disciplinary teams of highly qualified, experienced professionals working alongside social services and mainstream CAMHS.

36. 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.[23] Untreated children who suffer from abuse – up to 60% 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.[24]

37. However, access to services across England is patchy. For instance in the North of England 35 out of 50 primary care trusts do not commission child and adolescent psychotherapy.[25] This means that over three out of five children in the North do not have access to this service.[26] It has also been estimated that 45% of psychotherapy workforce is based solely in Greater London.[27] The ACP believes that there should be 1.3 per child psychotherapists per 100,000 of the general population or 1 per 10,000 of the under 19 population.

38. Looked-after children now have priority for school places and this has made a significant difference to their educational attainment. However the situation as regards their mental health needs is very different. Many, perhaps the majority of looked-after children do not receive the treatment they need. Most mainstream CAMHS cannot provide treatment for children during court proceedings or while awaiting long-term placement, adoption or rehabilitation. This is a period when a therapeutic intervention can make a crucial difference.

39. Following the recommendations of Lord Laming, many Local Authorities have set up designated multi-disciplinary

mental health teams for looked-after children.[28] In order to meet the complex needs of this vulnerable client group, these services provide multi-systemic interventions in line with findings from child development research and attachment theory that children's' paramount need is for secure, continuous and stable relationships.

40. These services provide fast response multi-disciplinary assessment; placement support; treatment including psychotherapy for children in transition; consultation to carers, social workers and professional networks; training, audit and research.[29] These specialist services are responsive to local contexts and work within or alongside social services. There is substantial variation across regions in the provision of these services. Emerging good practice in this area needs to be built on.[30] Good practice guidelines should be drawn up by existing specialist CAMHS to inform development of services across the country so that there is equity of opportunity for children irrespective of location.

41. Specialist CAMHS provision should also be developed for 'children in need' or children on the edge of care. Resources need to be made available so that these vulnerable children and families are not denied services. Specialist assessment is needed to identify children who can safely remain with their family given the right support, and those children whose emotional or physical welfare can only be ensured by taking them into care. Currently, specialist services for this high-risk population are under-developed or non-existent. These families struggle to access mainstream CAMHS but rarely have the opportunity of specialist help.

42. We endorse the view that the needs and wishes of the child should be paramount in care planning. However, we know from clinical experience that children who have been subjected to severe neglect, deprivation and abuse are often unable to make informed decisions about their care. Many children cling to abusive carers and would not choose to leave them. Only when they have been able to settle in foster care are they able to recognise that a different kind of life is possible. Child psychotherapists have an important role in assessing children and families where there are serious child protection issues and providing treatment once children are in new placements.[31] Children's expressed wishes should be acknowledged and taken into account, but should not determine care planning.

43. Increasingly child psychotherapists are playing a role as expert witnesses in specialist assessments for court where complex issues to be investigated include the degree of significant harm suffered by the child, the child's emotional, social, psychological, educational and therapeutic needs, the relationship between the child and each birth parent and other family members, the relationship between the siblings. Often these children are caught in a conflict of loyalties, and whilst they may state in words their wish to return to their birth family, what lies beneath the surface is communication (often in the form of play or drawings) that contradicts the words. They can show how they are only too aware that, sadly, their parents are not able to prioritise their children's' needs over their own. [32]

44. Child psychotherapists make recommendations that can be useful for making decisions about permanency for judges in the family courts and also for adoption panels when matching takes place. They also advise on issues relating to contact with family members, and can consult to family centre workers who supervise contact sessions so that the effect of the contact on each child can be carefully thought about. Contact sessions can have a destabilizing effect on placements, but can also, when they go well, be of benefit to the child. Social Services colleagues often need help assessing the quality of the contact in terms of its effect on the child – leading up to contact visits, as well as the effects after the contact. More resources and specialist training are needed to develop and extend this work.

45. The ACP welcomes the government's intention to extend local authorities' duties to young people in custody and in residential placements.

46. The ACP applauds the government's proposals to extend provision for young people leaving care. Current policy expects our society's least equipped young people to be the most 'independent', at an age when most young people are in regular contact with their families.

Appendix A: Association of Child Psychotherapists

The Association of Child Psychotherapists (ACP) is the independent professional body for the training and regulation of child and adolescent psychotherapists in the UK. It is recognised by the Department of Health.

Its principal objectives are to achieve excellence in child psychotherapy education, training and research, and to increase the availability of child and adolescent psychotherapy throughout the UK.

Founded in 1949, the Association has 765 members who work in a wide range of public settings including schools, hospitals, Surestart, CAMHS, and specialist CAMHS for looked-after children and young people, as well as in private practice. Most child psychotherapists work in multi-disciplinary teams and many provide training and supervision for colleagues in Social Services, education and health.

The six-year practice-based doctoral level training of child and adolescent psychotherapists gives them a unique insight into the emotional and psychological world of children. Their training is based on the detailed observation, study of child development and of conscious and unconscious communication[1]. Their work is informed by a broad evidence base, multi-disciplinary teamwork and specialised clinical experience.

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