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British Psychological Society response to NICE

Looked-after children and young people

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Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for NICE to contact us in the future in relation to this inquiry.

Please direct all queries to:-

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Email: consult@bps.org.uk Tel: 0116 252 9936

About this Response

The response was jointly led on behalf of the Society by:
Nigel Atter, British Psychological Society Policy Advisor.

With contributions from Dr Miriam Silver, Dr Allan Skelly, Dr Alicia Fairhurst, Dr Lisa Shostak, Lisa Mahoney from the Division of Clinical Psychology and Dr Simone Fox and Robin Jordan from the Division of Forensic Psychology

We hope you find our comments useful.

Kathryn Scott
Director of Policy, British Psychological Society

Looked-after children and young people

NICE National Institute for Health and Care Excellence

Consultation on draft scope – deadline for comments by 5pm on 11/02/19

Email: LACYPupdate@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly or arrive after the deadline. In addition to your comments below, we would like to hear your views on these questions: 1. Are there any cost saving interventions or examples of innovative approaches that should be considered for inclusion in this guideline? Developing NICE guidance: how to get involved has a list of possible areas for comment on the draft scope.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	**The British Psychological Society**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	Not Applicable
Name of person completing form:	**Nigel Atter, Policy Advisor**
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Comment No.	Page number or **'general'** for comments on the whole document	Line number or **'general'** for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, as your comments could get lost – type directly into this table.
1	General	General	Looked after children – are at significant risk of lifelong difficulties in a range of areas. Research confirms that childhood abuse, neglect and dysfunctional families can change neurological development in children and make it harder for children to develop healthy attachment relationships with appropriate adults. Attachment difficulties can lead to: anxiety; depression; behaviour problems; aggression and difficulties managing emotions.
2	General	General	The incidence of learning disabilities, ASD and ADHD is higher in looked after children. Educational and social outcomes are poor with these neuro-developmental vulnerabilities, especially where they are compounded by the considerable incidence of abuse/neglect. In addition, exposure to trauma is higher, and early nurturing experiences may have been missed. This means that there is increased risk of mental health problems. However, services do not routinely measure these kinds of needs in looked after children (except annually with the Strengths and Difficulties Questionnaire that has ceiling effects in this group, is not sensitive to change, and has limited breadth and depth).
3	General	General	See, 'Delivering psychological services for children, young people and families with complex social care needs' by M. Silver, K. Golding, & C. Roberts (Paper 8 in What good looks like in psychological services for children, young people, and their families - The Child and Family Clinical Psychology Review, Summer 2015). https://www1.bps.org.uk/system/files/user-files/DCP%20Faculty%20for%20Children,%20Young%20People%20and%20their%20Families/public/cfcpr_3.pdf

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4	General	General	**The Centrality of Attachment in the care of Looked After Children** The draft scope currently excludes assessment of attachment difficulties and attachment based interventions on the grounds that this is covered in separate NICE guidelines (NG26). NG26 is comprehensive, it should be closely integrated, or at least heavily cross-referenced, to the proposed guideline. Establishing physical and emotional safety, and other aspects of beneficial attachments, should be central to the care and support of these children, many if not most of whom, by definition, have lacked such factors in their pre-care lives. The draft scope itself quotes a rate of 63% of abuse and neglect as reasons for entering care. Such maltreatment is known to disturb the basic ability of children to build trust in others, and affects physiology in terms of brain development and physical responses to stress (Teicher, 2003; Bernard & Dozier, 2010), hence the priority need for attachment-based interventions as early as possible in the care process. The draft scope proposes: • Supporting care and placement stability • Interventions to promote positive relationships • Supporting the holistic well-being of children and young people • Supporting learning needs. All of the above are powerfully affected when children are maltreated or neglected by caregivers who lack the skill or who for other reasons present children with hostile or preoccupied responses to stress. This is even worse when caregivers are actively abusive, which may cause disorganisation of the attachment behavioural system. NG26 explains the theory and research comprehensively and also recommends a range of evidence based interventions depending on the age and situation of the child: video interaction guidance, training and support for foster carers, therapeutic play sessions for school age children, education programmes, and identification of key attachment alternative figures. NG26 also explicitly guides intervention away from genetic testing and medication as responses to attachment difficulties. Therefore, we would welcome assurance that the guidance will ensure that attachment factors are addressed by those following the guidance. References:

			Bernard, K. & Dozier, M. (2010). Examining infants' cortisol responses to laboratory tasks among children varying in attachment disorganisation: stress reactivity or return to baseline. *Developmental Psychology*, 46, 6, 1771-1778. Teicher, M., Andersen, S., Polcari, A., Anderson, C., Navalta, C. & Kim, D. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience and Biobehavioral Reviews*, 27, 1-3, 33-44.

5	General	General	**Looked after children with intellectual / learning disabilities – their emotional and behavioural needs** The draft scope proposes to support learning needs in terms of readiness for school, helping the child learn, and supporting entry to further or higher education. The draft scope suggests that two-thirds of children who are looked-after have 'special educational needs', of which a significant proportion will have an intellectual or learning disability. Children with intellectual / learning disabilities (ID) are at heightened risk of adverse childhood experiences, with abuse and neglect becoming known in the lives of 30% according to epidemiological study (Sullivan & Knutson, 2000), though much abuse is likely to be unreported. Children with ID are 5.3 times more likely to be neglected, 2.9 times more likely to be emotionally abused, 3.4 times more likely to be physically abused, and 6.4 times more likely to be sexually abused (epidemiological study in the UK by Spencer et al., 2005). The scope needs to consider the special clinical and educational needs of children with learning disabilities. These include the need to: • Advocate for Positive Behavioural Support (PBS) as a core model of care in all settings for children who show behaviours that are causing concern, understanding both proximal and distal causal triggers and proximal maintaining factors (i.e. access to sophisticated functional analysis); • Ensuring that a Behaviour Support Plan is established with specialist leadership and co-produced as far as possible with the person and their 'Circle of Support'. Please refer to NG11 for further guidance. • Promote Trauma-informed care; there is a great need to increase awareness that trauma can affect the learning of children with and without disabilities. Please note, trauma is particularly implicated in children with intellectual disabilities, due to the much heightened risk of adverse experiences. This should address current physical and emotional safety where necessary, developing new relationships that provide these conditions, with space to express and explore trauma-related behaviours. There may be a need for specialist clinical support where the trauma is associated with current high arousal responses, or where serious mental health issues are present, e.g. interventions that promote lower physical arousal, interventions that promote containment in

			caregivers, psychological therapy or such as Cognitive Behaviour Therapy, Dialectical Behaviour Therapy, or Psychodynamic Therapy (direct or proxy as appropriate). For further details of current psychological therapies offered to people with intellectual disabilities in the UK, please refer to Beail (2016). • Promote awareness of attachment and how to create environments that promote attachment security in children who may have lacked this previously and who also have intellectual disabilities that make connection and reciprocity more complicated, e.g. because emotions are harder for the caregiver to read (British Psychological Society, 2017; Ciccetti & Serfica, 1981). This itself can predispose to "fright without solution" and disorganisation of attachment (Schuengel & Janssen, 2006). • Consider how to address repeated competitive and educational failure can have significant effects on the psychological well-being of children with learning difficulties and disabilities. References: Beail, N. (2016*). Psychological Therapies and People with Intellectual Disabilities*. British Psychological Society: Leicester, UK. British Psychological Society (2017*). Incorporating Attachment Theory Into Practice: Clinical Practice Guideline for Clinical Psychologists working with People who have Intellectual Disabilities*. Leicester, UK. Cicchetti D. & Serafica F.C. (1981). Interplay among behavioural systems: illustrations from the study of attachment, affiliation, and wariness in young-children with Downs syndrome. *Developmental Psychology*, 17, 36–49. Schuengel, C. & Janssen, C.G.C. (2006) People with mental retardation and psychopathology: Stress, affect regulation and attachment; A review. *International Review of Research in Mental Retardation*, 32, 229–260. Sullivan, P.M. and Knutson, J.F. (2000), Maltreatment and disabilities: a population-based epidemiological study. *Child Abuse and Neglect*, 24, 10, pp. 1257-73.

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			Spencer, N., Devereux, E., Wallace, A., Sundrum, R., Shenoy, M., Bacchus, C. & Logan, S. (2005). Disabling conditions and registration for child abuse and neglect: a population-based study. Paediatrics, 116, 3, 609-14.
6	General	General	**Looked-after Children with Disabilities and Transition to Learning Disability Care Services** The draft scope proposes preparing children and young people for leaving care. This will include many young people with intellectual disabilities moving to supported living arrangements (or independent living with regular contact from specialist learning disability services). For children with disabilities, who are specified to be within scope, the guidance needs to take account of specialist placements that may be commissioned by social and health services badged as Learning Disability Specialist Services. Important considerations are: • How to ensure that Care Services hand over to Supported Living Arrangements for young adults in a manner that promotes continuity in positive relationships, promotes placement permanence when this would be beneficial and/or preferred, and provides the full range of occupational, leisure and social activities that are consistent with good quality of life. Poor transition arrangements for this vulnerable group of people (especially in relation to lack of communication between teams and agencies) can potentially, but unnecessarily, lead to poor outcomes.

7	General	General	There is a growing evidence base that the needs of looked after children and young people do not fit into neat diagnostic categories. The challenges they have in reaching the best possible outcomes/ the futures they deserve can most usefully be understood in relation to the multi-systemic factors. All of which impact on the likelihood of successful outcomes (including individual factors related to their own mental health, learning needs, physical health - but key systemic factors such as placement stability, consistency of approaches of staff/care givers, schools etc.). It is therefore vitally important when assessing the evidence base that it is not just consider in silos- e.g. interventions for mental health difficulties, interventions for learning needs etc. but in terms of what the whole system interventions needs to be. For more detail of what this might look like in practice in residential and secure settings, as an example, please refer to: Jenny Taylor, Lisa Shostak, Andrew Rogers, Paul Mitchell, (2018) "Rethinking mental health provision in the secure estate for children and young people: a framework for integrated care (SECURE STAIRS)", Safer Communities, Vol. 17 Issue: 4, pp.193-201.
8	4	Sec 3.1	Include children re-entering care after adoption breakdown.
9	4	Line 22	The draft scope needs to consider the differing emotional and psychological needs of unaccompanied asylum seeking young people in local authority care as distinct from the experiences, emotional and psychological needs of other looked after children.
10	6	17	Draft scope should also consider interventions which currently do not have RCT evidence base but have well documented practice-based evidence to date and emerging research-based data e.g. Dyadic Developmental Practice (DDP) and consider interventions at wider system level/ service delivery model e.g. therapeutically trained LAC social care teams with integrated CAMHS input.

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11	6	20 (3)	Assessment of 'mental health' within this scope needs to look beyond current diagnostic frameworks and traditional CAMHS service models which can exclude or pathologise children and young people who have experienced relational or early trauma. There needs to be a focus on the concept of developmental trauma, emotional health and wellbeing needs being the responsibility of everyone (to be aware of) and responding to (e.g. creating) a therapeutic environment around the young person rather than relying on 1:1 therapeutic interventions.
12	7	Line 14	Some clinical conditions will have significant impacts on the other aspects such as stability, care health, relationships etc. Foetal Alcohol Spectrum Disorder being a prime example of this.
13	9	Line 9	This section lists exclusions. We note that Foetal Alcohol Spectrum Disorder is not mentioned in any of the exclusions for pre-existing pathways, suggesting that this condition is overlooked entirely.
14		Sec 3.5	Barriers and facilitators to successful outcomes in youth offending programmes are not covered. Current schemes aimed at deterring at risk youth from becoming offenders do not make allowances for the specific social emotional and health needs that are common to LAC children.
15	12	29-30	'significant people in their lives' should be broader than the current list including friends, key workers, college tutors etc. as only by thinking about the eco system all around LAC/care leavers can the best most sustainable positive relationships be found.
16	13	Line 7	Additional item: disruption rates amongst care placements, both foster care and children's homes.
17	2	Line 2	The transition from residential care to independent or supported living is often a very challenging and frightening time for young people. Services for 18+ care leavers are scarce and need to be improved.

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18	7	Line 16	Although this topic is not covered by the scope, it should be noted that pathways from children and young people services (e.g. CAMHS) to adult services, are often poorly configured, or absent altogether. This creates challenges for individuals who may already be difficult to engage. Existing models of service delivery for this cohort need improvement.
19	General	General	There is no mention of trauma informed care or practice in the Scope. From a criminal justice perspective, that this is an omission. Criminal justice professionals should have an awareness of the specific needs/issues of looked after children.
20	General	General	Working with children and young people who are significantly traumatised as a result of their pre-care experiences has a significant impact on staff. Staff support and resilience is a subject that warrants consideration in the scope.
21	General	General	The main outcomes used are educational attendance/attainments and social outcomes. The main omission in the scope is how professionals/services identify and measure needs amongst this group, apart from generalised mental health screening tools.

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			Members recommended the following study interventions, Multisystemic Therapy: Family Integrated Transitions (MST-FIT) - A feasibility study Research report, July 2017, Stephen Butler, Alisa Anokhina, Karolina Kaminska, Charlotte Watmuff, Peter Fonagy – University College London/Anna Freud National Centre for Children and Families. The programme was developed as an adaptation of Multisystemic Therapy (MST), an American-based intervention which uses principles of cognitive and behavioural therapy, motivational interviewing, and mindfulness to help young offenders return home after a period of incarceration. The study can be found here https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625235/Multisystemic_Therapy_Family_Integrated_Transitions_-_Study.pdf Treatment Foster Care Oregon UK (TFCO-UK) is an evidence based treatment programme for children and young people aged between 3-17 years. The programme is aimed at those with complex and antisocial behaviours that often put them at risk of placement disruption or for older children, possible arrest. Further information can be found here https://www.evidencebasedinterventions.org.uk/programmes/multidimensional-treatment-foster-care KEEP stands for Keeping Foster and Kinship Carers Supported. This 16 or 20 week training programme, is delivered by two KEEP trained facilitators in 90 minute sessions to groups of 8-10 carers. KEEP is developed specifically by Oregon Social Learning Center for foster and kinship carers. In the UK Special Guardians also access the programme. Please see https://www.evidencebasedinterventions.org.uk/programmes/keep

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