ASSOCIATION OF CLINICAL PSYCHOLOGISTS

The Association of Clinical Psychologists is the representative professional body for clinical psychologists. We seek to promote the profession and its members, explaining the role and competences of clinical psychologists to healthcare managers, commissioners, policy makers and politicians, the general public, and not least, our service users.

Our aim is to empower clinical psychologists to provide a psychological influence and perspective in order to improve the wellbeing and quality of life of service users and the general public.

We do this by promoting evidence-based psychological principles and opinion as applied to contemporary issues in health and social care at national and local levels. The ACP UK is also available to provide timely and authoritative comment and advice to government, policy makers and the media.

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Association of Clinical Psychologists response to NICE Looked-after children and young people

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):	**Association of Clinical Psychologists**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	**None.**
Name of person completing form:	**Dr Miriam Silver, Consultant Clinical Psychologist**

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Type		[for office use only]	
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.
Example	3	55	The draft scope currently excludes people who have already been diagnosed. We feel this group should be included because….

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1	general	general	Looked After Children are at significant risk of lifelong difficulties in a range of areas because of the experiences that brought them into Care. 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 caregivers that then become the template for all future social relationships. A lack of health attachment experiences coupled with exposure to abuse and/or trauma can lead to anxiety, depression, low self-esteem, behaviour problems, relationship problems, aggression and difficulties managing emotions. Compounding this, the incidence of learning disabilities, ASD and ADHD is higher in Looked After Children. This mixture of attachment difficulties, mental health needs, challenging behaviour, risk, developmental issues and learnt responses to trauma and adverse events mean that Looked After Children have a higher incidence of numerous negative outcomes including over 50x greater risk of ending up homeless, in prison, receiving inpatient mental health treatment, having substance abuse issues, or having their own children removed into Care. If the guidance is able to grapple with some of the economics, it can be demonstrated that early, effective interventions save costs in the longer term, as well as improving the lives of children in care and their subsequent families. However, very little is known about the needs of the children receiving services, and how their needs or the services they are given effect their prognosis in adult life, beyond the fact there is a huge unmet mental health need (around 50% of children in care have a diagnosable mental health condition and a further 25% have mental health needs that don't reach a specific diagnosis, but only on eighth of those receive mental health services). 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 does not identify need reliably [1]). It is therefore very difficult to know what placements and interventions are effective.
2	general	general	It is not possible to separate the attachment needs from mental health or other needs of Looked After Children. Therefore we have concerns about the fact that this guidance is separate from the guidance for Attachment (NG26), and feel substantial cross-referencing between the two documents will be required.

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3	general	general	We need to ensure that all services that provide for the health and mental health of Looked After Children and Care leavers are integrated with local authority social care provision, and that staff from a health background with particular expertise about the psychological needs of this population are able to offer training and consultancy to their social care colleagues so that the whole workforce is aware of the impact of trauma and attachment, and the impact of adverse childhood experiences on various aspects of life trajectory. We also need trauma informed systems and appropriate support for a workforce that will be exposed to secondary trauma.
4	general	general	It is important to see the needs of these population groups in their socio-political context. Looked After Children and Care Leavers are predominantly from lower income families, who have been affected disproportionately by austerity policies. Most Looked After Children have experienced multiple Adverse Childhood Experiences, and their presentation and vulnerability to mental health conditions reflects this. It is important to note that the poor outcomes for Looked After Children and care leavers reflect these early adversities and the increased prevalence of learning difficulties and neurodevelopmental disorders in this population, rather than their experiences within the Care system. So whilst we would want to make placements and services assist their recovery as effectively as possible, we would want to resist simplistic comparisons to the general population, which only add to the stigma for this group. Similarly, these are not children and young people for whom a “mental illness” model makes sense, because they are for the most part making adaptive responses to dysfunctional experiences. Services addressing behaviour, emotional wellbeing, relationships, risk and development need to be universal and non-stigmatising. At every stage professionals should recognise that these children and young people have learnt strategies that have helped them to survive their experiences of trauma and lack of parental care, and not denigrated for their subsequent challenging behaviour.

5	general	general	When considering how services can meet the needs of Looked After Children and Care Leavers there is a need to acknowledge that numbers of children in Care are rising, and costs are also rising, with the majority of placements now being in the private sector. At the same time, preventative and community interventions have been cut. There has been a 60% drop in funding for non-statutory services (IFS, 2018). This lack of early intervention means that services are only addressing difficulties as they reach crisis levels. Children are reaching services later, and coming into care later, and this means that across the board services are dealing with higher levels of complexity, and intervening later in children's lives than would be ideal. There have also been changes in the recognition of emotional harm, and more proactive work with younger children following the tragic deaths of infants like Baby P. The use of secure units has also shifted away from "welfare" placements and been prioritised for more serious offending, meaning that many young people with more complex needs are now accommodated in residential care.
6	general	general	Clinical Psychologists with expert knowledge of the sector have written comprehensive guidance about what services for Looked After Children should include, in the publication 'Delivering psychological services for children, young people and families with complex social care needs' [2] and we hope that this can be drawn to the attention of the reviewing committee. There is also a good model of recognising and addressing these complex and intersecting needs that has been developed in the secure sector [3]

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7	3	8	The major omission in this list is Ofsted. With the majority of residential placements and fostering agencies now in the private sector, there is an acute need for quality control. The “marketplace” of placements, particularly in the residential care sector, means that there is great variation in the quality of placements, and very different models of care delivery. The lack of supply means that commissioners and social workers are often forced to choose between a very limited range of available placements, with huge financial pressures that influence the choice. This is an ineffective way to match the placement to the needs of the child or young person. Ofsted inspections serve as the only quality control in this system, yet inspectors are not experts in mental health or attachment, and often struggle to identify what defines a good placement and what needs to be done to improve poorer placements, beyond the more concrete elements of process and procedure. The system of inspection was strongly criticised by the National Audit Office in 2014 for failing to drive up standards in more than a decade. In response Ofsted issued new guidance in 2015 to promise to focus more on the quality of care. They want to see placements that have higher aspirations for the child or young person, where professionals and carers have identified their needs and know how they are progressing in addressing them. It is our belief that this issue has been insufficiently addressed, and that Ofsted inspectors will require training and guidance to serve this function. It will therefore be an important role of this NICE guidance if it can help provide knowledge and structures that Ofsted adopt for this task.

8	7	4	We welcome the move to make the guidance inclusive of care leavers. However, we would note that not all Care leavers are able to transition to independence, and this is dependent on needs, with some young people with significant physical or learning disabilities or mental health problems requiring ongoing supported living after leaving statutory care services. We would also note that Staying Put entitles Looked After Children to remain in Care until 21, and Care leavers are entitled to services until the age of 25, whilst current CAMHS provision and other elements of services cut off at 18. This needs to be addressed in the guidance, with all services for Looked After Children extending to 21, and new services for Care leavers created that extend this further to 25. Consideration needs to be given about appropriate ways to deliver the services to young adults, and align them with social care provision. Recommendations should include support and training for the Personal Advisors for Care leavers.
9	7	4	We did not see acknowledgement of children and young people impacted by foetal alcohol or drug exposure in the guidance, and would encourage their inclusion as this is a significant area of need in this population.
10	7	4	It is important that the guidelines also consider young people who are involved in the criminal justice system or in secure placements. These are mentioned as settings on page 6 line 1, but not as a specific group who may have different or additional needs. We would recommend that specific consideration is given to young people involved in the criminal justice system. The Secure Stairs model has already developed good practice in this regard [3].

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11	5	7	We welcome specific mention of children with additional needs such as intellectual disabilities and neurodevelopmental disorders (such as autism spectrum conditions), but want to ensure that these are considered in terms of their placement and mental health needs as well as their special educational needs, and would recommend that this group are mentioned as a specific category and not just subsumed within a wider bullet point about special needs. Children with intellectual / learning disabilities are at heightened risk of adverse childhood experiences, with abuse and neglect becoming known in the lives of 30% according to an epidemiological study [4], 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 [5]. These needs are often missed when children's presentations are assumed to reflect missed education or the impact of abuse and neglect, but need to be screened for more reliably, especially in the population of children placed in residential care, where 20-25% of children have a learning disability.
12	5	5	We welcome the scope acknowledging the specific group within the Care system of young people who have been subject to child sexual exploitation, as their needs can be very different to other Looked After Children. Instead of having a heightened readiness for fight or flight, sexually exploited children can often down-regulate their arousal system, making them poor at judging risk. They can also have complex responses to their abuse, feeling loyal to partners, or ashamed of their physical responses, or confused about their sexuality or negotiating future sexual relationships. Some amongst this group have also been groomed to be recruiters amongst their peers, and need very specific care and management to keep both them and their peers in placement safe.

13	5	4	We welcome the acknowledgement that unaccompanied asylum seeking minors have very specific needs that may differ from the general population of Looked After Children. This group have particular specific challenges that the guidance will need to address, that include exposure to unsafe environments, war, torture and trafficking. The incidence of PTSD is particularly high in this population (61.5% of male and 73.1% of females who are unaccompanied [6], and 19-54% of refugee children more broadly [7]). Services to meet the needs of this population group need to be culturally appropriate, and to have sufficient resources to address the extent of need. Secondly, we need to extend these services to other groups of immigrant children in the Care system who have similar needs, despite not falling into this category (perhaps because they came to the UK with relatives) and consider this a template for services for other immigrants who may also be traumatised by the system, because they are seen as unwanted migrants rather than genuine asylum seekers, despite all the evidence suggesting this is a highly traumatised population. Immigrants may face issues about right to remain, and the harm that uncertainty about right to remain in the UK can do to already traumatised children, and where children do not enter the care system immediately on arrival they may not be able to access specialist services. There are also potential issues about placement locations, as certain regions have specialist services and expertise, but may not be resourced to take on a disproportionate number of young people, whilst other regions have few people from diverse cultures and therefore lack culturally appropriate services. There can also be challenges around identifying age accurately and the consequent inclusion or exclusion of individuals in need from services, which can be very distressing for professionals who just want to help the young people involved.

14	7	23	We would note that whilst there are guidelines for many individual conditions, the nature of children and young people in and leaving care is such that they have a complex mixture of needs, rather than single conditions. As such, the advice given on a condition-by-condition basis may not be as helpful as overarching guidance that acknowledges the intersection of multiple needs and vulnerabilities. In particular, whilst we note that you refer to the NICE guidelines for PTSD (2018), it is important to recognise that these do not identify interventions for children who have experienced multiple traumas, which is generally the case with LAC (who have typically experienced multiple Adverse Childhood Experiences and often continue to experience traumatic events whilst in or leaving care) and especially the case with the majority of unaccompanied asylum-seeking minors, who often present with extensive and complex experiences of trauma.
15	6	15	Assessment of 'mental health' need within this scope needs to look beyond current diagnostic frameworks and traditional CAMHS service delivery models that are focused on diagnosable and treatable mental health conditions and can sometimes explicitly exclude the sequelae of abuse and neglect. Such services do not work effectively with the more complex and interwoven areas of need in this population and can exclude or pathologise children and young people who have experienced relational or early trauma. There needs to be a recommendation that services focus on the holistic need of the child within a framework that recognises developmental trauma, and wherever possible the interventions and supports offered with younger children should be dyadic and involve the primary carer. The wider network of the child needs to take on the roles traditionally taken on by members of the extended family and friends network of a supportive family. This might include practical support such as hand-me-down furniture or help with decorating, or opportunities to undertake work experience.
16	general	general	We notice there was no mention of service user involvement or service co-design by Looked After Children and Care leavers. This seems to be a significant omission when considering guidance on best practise with a population group. The catchphrase "no decision about me without me" should be particularly relevant in this group, where young people often feel disempowered by decisions being made about them without their input, rather than an active participant in decisions and the design of services.

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17	general	general	We hope that the guidance can look beyond the limited data available in RCTs and also look at emerging practice in the field, recommending the development of research trials of promising interventions and types of therapy. We believe that there is an encouraging range of interventions that have not yet been evaluated, or have not yet been evaluated in child populations. For example, we see promise in interventions such as Cognitive Analytic Therapy, Schema Therapy, Compassion Focused Therapy and EMDR with adolescents and young adults, and Dyadic Developmental Psychotherapy and Family Attachment Narrative Therapy with younger children, but we are aware that the evidence base is still emerging. Conversely we would be wary of extrapolating too much from international studies where social care services may be organised differently and involve rather different population demographics and levels of need.

18	11	12	Any scope, and any guidance developed, needs to start with recognizing the complexity of need, and how multiple areas of need and vulnerability intersect, and have some overarching guidance on meeting the needs that spring from multiple ACEs, a lack of protective attachment relationships and broader social support network, multiple changes in caregiver (and amongst the professional network) and the high incidence of mental health need that this creates. In all relevant services, we need to start with how to identify that need in the first place, and how to prioritise within and between children in terms of the interventions available. The only widely used measure in this population is the SDQ, and this has been shown to be poor at picking up need [1], as well as hitting ceiling effects in this population. It also has little utility in informing treatment decisions, and has poor sensitivity to change when assessing the impact of interventions. Thus it is important for the guidance to recognise the need for specific measures that are properly validated, sensitive to change, and able to reliably identify the needs of this population. The BERRI questionnaire appears promising in this regard [8], and we understand that publications relating to validity, reliability and relationship with other measures will be available by the time the NICE guidance is reviewed.

References			1. Wright, H., Wellsted, D., Gratton, J., Besser, SJ. and Midgley, N. (2019) Use of the Strengths and Difficulties Questionnaire to identify treatment needs in looked-after children referred to CAMHS. Developmental Child Welfare. https://doi.org/10.1177/2516103218817555 2. Silver, M., Golding, K. & Roberts, C. (Paper 9 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 3. Taylor, J., Shostak, L., Rogers, A., and Mitchell, P. (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 4. 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. 5. 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. Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee children: a systematic review. Clinical Child Family Psychology Review, 14(1), 44-56. doi:10.1007/s10567-010-0081-0 7. Hodes, M., Jagdev, D., Chandra, N., & Cunniff, A. (2008). Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents. Journal of child psychology and psychiatry, 49(7), 723-732. doi:10.1111/j.1469-7610.2008.01912.x 8. Silver, M. (2007) BERRI questionnaire. www.BERRI.org.uk

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