

About BAAF

The British Association for Adoption and Fostering (BAAF) is pleased to respond to this consultation. BAAF is the leading charity and membership organisation in fostering and adoption in the UK. We:

- promote the highest standards of child-centred policies and services
- speak out on behalf of looked after children
- influence UK-wide policy and legislation
- provide much-needed information and advice
- promote greater public understanding of adoption and fostering
- support our members in their work

BAAF's main activities are the development, promotion and advocacy of best policy and practice; the provision of advice and information to our members and to the general public; training, consultancy and seminars; child placement services including *Be My Parent* online. We also publish a quarterly professional journal, *Adoption and Fostering*, books and guides for professionals, academics, parents and carers and research studies. The main users of our services are our members comprising local authorities across the UK, voluntary adoption agencies, independent fostering agencies and also individual social care, legal and health professionals, and carers.

We are submitting this response in respect of general aspects of CAMHS provision, and have therefore not attempted to address the consultation questions concerning local service provision.

General Comments

BAAF welcomes the opportunity to respond to this much needed review of CAMHS; we will confine our comments to the provision of CAMHS for looked after and adopted children, including working with their carers. While in recent years there have been some encouraging improvements in provision in some areas, there is still considerable need for improved access, consistency in provision of services, and effective interventions for a particularly vulnerable group of children who experience a complex mix of factors which impact on emotional, behavioural and mental health and well-being.

Areas which CAMHS need to address in improving their services for looked after and adopted children include:

- understanding of the needs of this vulnerable group
- extent of the problem
- their structure and resourcing within wider CAMHS services
- specialised training and experience for CAMHS professionals
- prevention and early intervention
- access to services

- multi-agency working

The children

For all children, mental health is directly linked to their experience of loving parent/s who are sensitive and responsive to their needs over the course of their childhood and adolescence whatever genetic influences there may be. The experience of family membership and belonging, opportunity and resources are core to these processes. For children in public care, much of this cannot be relied on and for many, parenting may have been abusive or neglectful or broken down to such an extent that the normal developmental pathways and family life are not available at all. While it is the primary duty of services to establish a permanent family arrangement for the child – either by returning them back home with their parents or wider family, or adoption, permanent fostering or special guardianship, the delays and very great difficulties of doing so are well known. The negative impact that this has on children’s development and physical and mental health can be profound. The route to addressing this issue is primarily in securing the child with carers who can make a lifelong commitment to them. It is well established, that the younger the child is, the more likely this is to happen successfully. For young people in their adolescent years, this can be very difficult indeed yet they form the greater part of the looked after children’s population. For them, the current expectation that they leave for ‘independent living’ at best or into youth custody or adult mental health provision is not acceptable in a modern society.

The question for CAMHS services is how to play a part in facilitating and contributing to the process of family finding and supporting children and young people and their carers with the various mental health difficulties they may encounter before, during and after the family finding process. This may include:–

- contributing to the assessment of babies, pre-school age children, children of school age and adolescents to ensure that speedy decisions are made and implemented that enable children to be placed in secure, stable, loving and permanent families. The long term consequences of not having a mental health contribution to this critical process can be very severe.
- Providing, with others, direct support and intervention to help carers develop the conditions that promote the child’s development and enable them to make use of opportunities appropriate to their needs and capacities. This includes programmes that mitigate the risk of placement disruption.
- Providing, with others, evidence based interventions or programmes that address specific issues such as attachment disorders, the impact of maltreatment including trauma, loss and separation, the membership of complex family structures including contact with birth parents, separated siblings, the wider birth family and other people of

significance and the development of a secure identity based on ethnic heritage, language, sexuality and religion.

Alongside these fundamental issues of family placement for children separated from the birth families are the range of identified clinical conditions that are known to be particularly prevalent for this population – learning difficulties, autistic spectrum disorders, conduct disorders, inattention and overactivity, depression, self harm and psychosis. Other children and young people separated from their birth families may not present the effects of disrupted lives and the lack of a permanent family solution through identified clinical conditions but the disruption to their development may present itself through other factors such as poor educational attainment or offending.

Where children are not in permanent family placement, the provision of assessment and intervention services can be particularly difficult when there are changes of placement, changes of local authority or PCT area and changes of social worker. Children and young people can easily fall between the competing commissioning arrangements of public bodies especially when there is no clear advocate for their needs.

These problems can be compounded when children's experience of any adult in authority is marked by suspicion and distrust. Children in public care are at greater risk of being excluded from service provision and in the course of time, excluding themselves. Children and young people who have learnt to manage living in traumatic environments through self-reliance, compliance and care-giving behaviours are less likely to be seen as at risk for poor mental health and emotional well-being and therefore are less likely to attract the attention of services. Referrals are more likely to be made for children demonstrating more challenging externalising behaviour or more overt signs of internal distress such as self-harming behaviour.

The argument above is equally relevant to other groups of children and young people who may or may not have been or may come into care at some point but are separated from their birth families. These include those in private fostering arrangements, those in youth custody, unaccompanied asylum seeking children, trafficked children and disabled children in long term residential provision.

Understanding the developmental and mental health needs of children separated from their birth families, the importance of finding a permanent family solution for them and the long term consequences for the child or young person and their carers is fundamental to effective provision of CAMHS. This must be a priority objective and influence service structure and resourcing, access to services, type and duration of interventions, and specialised training of all professionals. Clinic based treatment models must be complimented by outreach services in settings where children and families more readily present themselves. This includes community based provision such as children's centres, schools, general practices and youth service provision and specialist services such as fostering agencies, adoption support teams and family support provision.

The concept of mental health and ill-health carries very great stigma for most children and adolescents. For children separated from their families and for those in permanent family placements, this stigma can be one more insult heaped on an already damaged sense of self and self esteem. The barriers to effective engagement and the provision of user friendly services must be addressed. Where clinics have high numbers of failed appointments, effective strategies need to be put in place to address this, to explore why, and how to positively engage with children and their families.

Extent of the problem

Research has consistently demonstrated that the population of children on the edge of care, in care or discharged from care has much higher levels of emotional and mental ill health and difficulty than the general population. Recognition of the large numbers of children and families requiring some type of support and /or intervention is an essential prerequisite to the provision of adequate services, and planning for appropriate increases in skilled and experienced workforce.

Structure & resources

Across the country the mental health needs of looked after and adopted children are met in different ways, including:

- CAMHS professionals seconded to multi-agency teams
- specialist posts within CAMHS teams
- children and young people receive normal service with needs not differentiated from other children and young people

As stated in the section above, meeting the needs of looked after and adopted children within specialist CAMHS teams can be problematic when their needs do not fit with either dominant medical diagnostic and treatment models, or with current business models. Attempting to quickly move children and families through the system, focusing on short term interventions, most commonly cognitive behavioural therapy, and rapid symptom resolution, utilising checklists like HONOSCA as measures of 'effectiveness', does not work. These are measures & timescales entirely inappropriate to these children and their families. Instead bio psychosocial assessment and intervention in the form of stable committed support from CAMHS over a 'developmental' timescale, even when there are not specific 'symptoms' to be addressed, have been found to be more helpful.

Particular problems can be experienced by adoptive families in accessing relevant CAMHS services for while the child or children may be a part of that family, their history will be rooted in the earlier experiences and their development related to those experiences. Assessing the complex aetiology of their development is crucial.

It is also important to acknowledge the considerable needs of those children and young people who live in residential placements because they have grown adverse to family life and their needs are too great to be met by family placement. Much specialised residential therapeutic provision has been lost in recent years, and this must be addressed.

Specialised training

CAMHS professionals at all tiers of service require specialised training in the needs and social circumstances of children separated from their birth families including those looked after and adopted children. There is also a need for specialised training at tiers one and two for social care and health professionals (such as social workers, health visitors, school nurses and specialist nurses for looked after children) who come into contact with these children and families. The promotion of emotional well being, the development of resilience and the conditions that contribute to mental health are as important as specific programmes of specialised intervention.

Prevention and early intervention

The circumstances of many looked after children when they arrive in care, the uncertainty about their plans, lengthy care proceedings and difficulties in finding appropriate permanent placements make the provision of effective early intervention very difficult. Foster carers are left to meet the child's basic needs including establishing significant relationships with them but often with little sense or guidance as to how far that should or might go. All children need to be in placements where the carers are able to be appropriately sensitive to the child's needs for emotional safety, and stimulation. This includes understanding the ways some children are resistant to, or avoid letting adults know about their needs. The provision of 'therapeutic parenting' so that children can recover from their early unsatisfactory traumatic experience of being parented and subsequent separation from birth family is vital.

For example, an infant is born heroin addicted and comes into care at birth. She is then placed in foster care for over a year whilst assessments are undertaken leading to a plan for adoption. During this year the child receives good quality health care that treated her addiction and monitored her development, but no specialist parenting was provided. Consequently she arrived in her adoptive home aged 14 months resistant to being cuddled and comforted, avoiding eye contact, only settling if rocked in a chair, and indiscriminately friendly. She did not know how to elicit care and comfort from her parents, demonstrating an avoidant style of attachment relating.

A much better start in life could have been achieved for this child had it been possible to place her with a specially trained foster carer who understands the components of early child development including the essential part that she

plays in this and is supported by a highly skilled health visitor and social worker who have direct access to advice and support from mental health professionals.

Similarly, urgent attention must be focused on the plight of many older children who would benefit from early intervention. BAAF frequently hears reports of the 'double bind' whereby a CAMHS service states that a child who is not yet in a secure placement cannot receive therapy, yet without intervention to address emotional and mental health difficulties, it is not possible to obtain a secure placement. Although this may have some foundation in theoretical models, it overlooks what else can be done in the interim to educate and support the carers and /or the professionals surrounding the child.

Access to services

Access to CAMHS services is not consistent for looked after and adopted children. Service provision is highly variable and in some regions may have evolved idiosyncratically over time. It can be extremely confusing for professionals seeking a service, particularly when planning for a child who is moving to a placement in another area. The introduction of the CAF has had some advantages to it but there is clearly a need for further development to ensure that it is fit for purpose. Referral systems and priorities need to be readily understandable by professionals, families and children and young people themselves.

There continues to be a need for joint training between CAMHS professionals and others to ensure that there is a common language, understanding of assessment and treatment systems and the overall plan for the child or young person. Unless professionals have received additional training adoptive families often report finding specialist CAMHS inaccessible with a failure of professionals to understand the impact of adopting a traumatized child on the family over time.

Inter agency working

It is critically important that professionals understand the roles and responsibilities of partners in other agencies, and participate in joint training to build a common purpose, language and strategies. .

Issues of consent, confidentiality and information sharing can interfere with good inter-agency working, and processes must be developed to address these difficulties. For example, a young person aged 14 years is living in a children's home. The child is voluntarily accommodated but the mother is not working well with the local authority. An appointment letter for this young person is sent to the mother who does not inform the Children's Home. The young person is asking when she will get her CAMHS appointment, but when

her key worker approaches the CAMHS team she is told that they do not have permission to discuss this with her.

Good Practice

There are many models of good practice in the way CAMHS services are offered to looked after and adopted children. Children and young people and their carers need access to a range of interventions that provide support, training and advice for both carers and parents and the professional network around the child, as well as direct interventions with the children and young people. A priority for these interventions is to ensure that children are enabled to live in home and school environments where they feel safe and can develop secure relationships. Tailored interventions with children and their carers are aimed at helping the children build trust in their carers, and so learn to elicit care in straightforward ways. Children who have been traumatized by their previous experience are more likely to benefit from interventions which provide physiological regulation, and support to develop capacity for emotional regulation. Interventions need to enable children to experience increased positive interactions and to increase their capacity for reflective functioning. CBT type interventions can be less successful for these children and young people.

Other services which have offered a highly skilled mental health professional for looked after and adopted children in long term support to individual carers/families, working with groups of carers, & in supervisory/reflective work with social workers have found this to be far more effective than direct clinical work with the children themselves. These services have also found that, given the option, some children or young people will choose to work with the mental health professional after some months or years of working with the carers, once trust has been established

CAMHS services should prioritise long term input to carers, even in the current absence of 'risk' or 'symptoms' suggestive of a primary psychiatric disorder. It is essential that services such as these are designed to meet the needs of looked after and adopted children and their families, rather than the current model which attempts to make the children fit the model.

Other factors

1. It is not clear what the responsibilities are at central government level between the Department of Health and the primary department for children and families – the DCSF.
2. It is recognised that there are very great demands placed on CAMHS services with heightened expectations about what they might deliver often accompanied by uncertain financial planning and commissioning arrangements.

3. Evidence based interventions, while very important, should not obscure the needs that many children and young people have for interventions that do not lend themselves to standard evaluation methodologies.
4. The transfer of young people to adult mental services is often problematic
5. The mental health needs of adult carers need to be taken account of alongside those of children and young people although coordination between these two levels of service provision can be problematic.

Conclusion

CAMHS are a vital part of the service provision for children separated from their birth families. Much remains to be done to develop CAMHS services appropriate to the needs of all children separated from their birth families including looked after and adopted children, and their carers. This will involve identification of good practice in service structure, addressing problems of access and the provision of effective interventions, including health promotion and early intervention. Critically, it will require considerable investment in specialised inter professional and agency training at all tiers of provision, in order to further build workforce capacity.