**Stage 2**

**How an organising frame of child development will ensure the best standards of health care for looked after children\***

**April 26th 2018**

*Using the attached agenda to shape the day, these brief notes do not do justice to the rich and lively discussion that ensued. However, they hopefully capture some of the key themes of the day so that comparisons can be made with other Stage 2 sessions and they can be used to stimulate ideas and further dialogue for Stage 3 in September.*

**Introduction**

There was a broad view that, whilst narratives have changed over time, the prevailing ones (both explicit and implicit) around looked after children and their families are generally negative, stigmatising and deficit-orientated. Examples include an over-emphasis on:

* The individual pathology of parents and family dysfunction (‘blame, shame & punishment’).
* A child’s behaviour whereby the problem is located in the child (‘mad, bad & dangerous’).

Overtime, there have been differing attitudes to how much time, resource and effort should be given to working with families in which children have been exposed to adversity, particularly as to how long parents should be given to evidence ‘change’. We currently seek to make decisions about permanent, alternative care timeously, with the hope’ that the new placement will add to developmental recovery. However, despite our best intentions, there was a prevailing view that our current systems, processes and practices don’t routinely provide the stability and coherence that children need and we don’t help them to make sense of their experiences and develop a coherent sense of who they are.

Points raised in discussion throughout the day included:

**1. As a set of professionals that make up the ‘care system’, we need to develop a clearer narrative on the impact of children who experience adversity and ensure that this narrative underpins our thinking and interventions**

* We were very taken with the idea of understanding children’s behaviour as a reflection of ‘adaptation’ to their environment rather than being ‘disordered’. Seen as having allowed the child to ‘survive’, there is a possibility of change (neuroplasticity) within the context of nurturing relationships.
* We need a more sophisticated understanding of the impact of adversity, particularly developmental trauma, on both the mind and the body and what interventions / activities help children and adults to re-orientate onto a healthy developmental trajectory. Examples of Dan Hughes’ Dyadic Developmental Psychology (DDP) and Blaustein and Kinniburgh’s Attachment, Regulation & Competency (ARC) were mentioned.
* There was broad consensus about the centrality of relationships as the main vehicle by which children learn to understand their world differently and their place within it. Evidence from care experienced young people and adults identify little things that demonstrate that they are ‘being held in mind’ as making a difference.
* Eamon McCrory’s idea of ‘latent vulnerability’ was seen as potentially significant as it challenges prevailing practice of identifying ‘symptoms’ to meet the criteria for a disorder and it offers a view that mental ill-health is not inevitable if appropriate support is provided.
* Michael Tarren-Sweeney’s concept of ‘felt security’ really chimed with participants. The need to identify and pay attention to what lies beneath this was seen as vital e.g.
* We make assumptions that because we use the same words, especially around attachment, that we have a shared understanding. Conversations with colleagues suggest otherwise.
* We need to move away from binary positions e.g. social v medical model, as these do not serve children’s interests who have real medical need as well as experiencing adversity.
* Having a common understanding of the components of a child developmental frame would help to make change easier.

**2. We need to develop a shared, accessible language that both reflects children’s experiences and is hopeful about the possibility for change and recovery**

* We need to review some of the language that was used around early brain development research that implied that adversity becomes hard-wired and is not open to change. Equally we need to be cautious about the use of the language of risk, trauma, vulnerability, disorders etc. Although they serve a function, they are deficit-based and potentially stigmatising. In addition, they may create a sense of inertia / paralysis that may lead to practitioners to think that change is not possible.
* We need to move away from the idea of wanting to ‘fix’ the child to one of helping a child develop a coherent story of what has happened to them. For those that experienced trauma, we are not able to change that history but we can assist children to experience it in a different way.
* This should include focusing on their assets that have helped them to survive. A number of participants emphasised that looked after children are ‘remarkable’ and ‘unbelievable’ given what they have had to deal with so much loss and change. It was suggested that adults should start from the assumption that someone is a great person and then be curious about why they are behaving in a certain way, rather than projecting their own ideas, sometimes using detrimental language. Caution was advised around language as children absorb our descriptions and then begin to believe they are an intrinsic part of who they are. The use of the acronym LAC was particularly disliked.
* We need to turn to children and young people themselves to consider what a more positive narrative could look like.

**3. We need to change the way we organise and deliver services that can respond flexibly to a child’s individual developmental needs.**

* There were a number of questions throughout the day of why we continue with a system that is not fit for purpose and unable to meet children’s developmental need. It was stated that because our current system is overwhelmed, practice often feels like box-ticking and servicing the requirements of monitoring systems. In particular, there was concern that our care system compounds children’s difficulties rather than assisting them to recover. There was some consensus around the need for cultural change, in which developmental need was the main driver for action.
* Similarly, there were multiple comments about need to see children as individuals with unique experience.Looked after children should not been seen as a homogenous group as there is a danger of creating a sub-class.
* Equally, there is a risk of underestimating the complexity of children’s lives and thereby denying the additional time and space that is required to understand those lives and build trusting relationships. Whilst there was a discussion about life-story work, and its importance in capturing the ‘every-day’ as well as it being seen as discreet work, the overall feeling is that sufficient time, space and credibility was not ascribed to this type of work.
* Echoing Michael Tarren-Sweeney’s notion of ‘unnatural childhoods’ the microscope under which looked after children, their families and carers live was seen to be particularly unhelpful. The examples of case notes, recordings in residential and foster care and assessment reports were noted for special comment. There was a strong sense that children’s developmental needs were frequently absent from these narratives that carry significant weight both in the present day and for decades to come, particularly in how children begin to understand themselves. The need to develop more sensitive ways of holding children’s memories was seen as a priority.
* We need to constantly think for looked after children, what would you want for your own child?’ Although we now have legislation around corporate parenting, decisions are made about looked after children that we would not want for our own children. This should not be so.
* There was a strong thread throughout the day of needing to move to holistic, multi-disciplinary teams around the child where there is a shared understanding of roles and responsibilities of each discipline. This would help to counter the role confusion and uneven influence that occurs within care planning and how differing boundaries, funding priorities and thresholds can create fracture and division, particularly for children who are placed out of area.
* There is also a need to be thinking much earlier in a developmental oriented way long before a child becomes looked after. This suggests that services focused on early prevention and intervention need to be equally as developmentally-informed.
* Whilst there is an appetite for change in pockets of health provision, there was a view that there seems to be little dialogue in the health realm about the needs of children who are looked after and that they are not given sufficient priority. Comment was made about the need to re-imagine what health means for children and their carers in the long term and to acknowledge that CAMHS is currently unable to meet the developmental needs of looked after children.
* It was recognised that educational provision has the ability to provide a measure of stability for children who are experiencing change elsewhere in their lives, however, it was felt that there needs to be greater inclusion not separation in schools and that teaching could be re-framed as getting children ready to learn and responding to developmental needs.
* Finally, the issue of funding cannot be ignored. Working with children who have multiple and complex needs in a developmentally-orientated way will require considerable financial funding, particularly as so many gaps in provision currently exist e.g. mental health, speech and language etc. However, ACE studies clearly evidence the significant cost societally, economically and personally if unresolved trauma is not addressed at its early stages.

**4. Whilst there will be need for some direct work with children, we need to pay greater attention to the caring environment around the child**

* Given that many children who are looked after have experienced trauma and maltreatment in the context of home and parental relationships, it is vital that attention is paid to helping children (re)connect to birth parents and /or alternative carers through the delivery of attuned, predictable relationships. A more detailed and nuanced understanding of attachment is required. In addition, resilience is nurtured through the scaffolding provided by the care and wider social network around the child.
* We need to develop a more robust narrative and evidence base around what works for children, families and carers. The importance of everyday routines and rituals and the use of simple, teachable moments should not be under-estimated.
* Michael Tarren-Sweeney’s concept of ‘in-built impermanence’ resonated with many participants and suggests a significant re-think around the purpose and processes around foster care in particular. Its impact on promoting stability, long-term commitment of carers and children’s abilities to develop ‘felt-security’ is considerable.
* Greater support for all forms of alternative care is required, including adoption. This cannot be time-limited but needs to be responsive and flexible to children and carers changing needs over time. As part of this, more attention needs to be paid to recruitment & preparation, matching processes, transitions between care placements etc. and goes beyond providing training.
* For a truly preventative approach, greater work needs to be done with children and their families prior to them becoming a looked after child. Many parent’s difficulties arise out of their own backgrounds of adversity and unresolved trauma. Is there sufficient resource in the system to address this? Even if children require alternative care, it is important for a child’s identity that they are given a sense that their parents aren’t ‘bad’.
* We should be realistic around ‘change’ in a given timeframe whilst ensuring that unreasonable drift and delay is avoided. Concurrency planning should be explored more widely.
* For children who do require to alternative care, narratives around preferred forms of care need to change. There is a tendency to describe foster care as the gold standard, whereas there is considerable stigmatisation of kinship care and residential care is often presented as a ‘last resort’.
* It is important that attention is paid to the relational ‘dyad’ between child and alternative carer rather than a focus on changing the child’s behaviour.
* Lessons from MCR pathways suggests that the most important thing for young people who participate in the programme is that the person isn’t being paid – unconditional positive regard.

**5. We also need to pay more attention to the developmental needs of staff**

* There was some discussion about workers’ use of the term ‘the system’, the writing of reports in the third person and the use of hard facts and diagnosis and whether this is a way of protecting their own emotions and distancing ourselves from the pain of children’s experience.
* Many front-line workers feel quite powerless to influence decisions at a senior level and there was some discussion around who are the key decision makers who can affect change.
* This emotional impact on staff needs to be recognised by employers and managers and staff need to be given appropriate time to reflect in protected supervision / support sessions.

**6. Recognition that there are tensions between different parts of the system that prevent working in a developmental way**

* Major structural issues around funding, staffing, capacity and restructuring have had a significant impact on the delivery of services and the ability to implement developmentally orientated practice. The reality is that decisions are often dictated by cost rather than what is in the best interests of children.
* Greater priority is given to a child’s physical and legal security over that of their felt security.
* How can we build the potential of predictive and preventative research / work and routine evaluation into our systems and how this fits into a service set-up that is focused around the treatment of disorders?
* There is conflict between promotion, prevention & early intervention work with that of outcome-based funding.
* The system is overly preoccupied with ‘the past’ and ‘with risk’ and ‘the future’. We don’t pay enough attention to the ‘live’ journey of children in the here-and-now.
* There is an over-emphasis on performance targets, numbers and outputs which translates as ‘box ticking’. The system is less concerned with the quality of work and relationships, in particular these feel secondary concerns to management.
* There is too much variation in what we do. Every area operates differently and there is no national picture.
* Are the long term implications of adversity really being listened to? Where is the increase in resources for prevention?
* Navigating the balance of the rights to family life and rights to safety and protection. This is complicated by inconsistencies in the quality of care, impermanence etc. We cannot know, until we have hindsight, whether we balanced the rights well.
* The nature of our work means that we are constantly grappling with dilemmas e.g. how do you practically manage the logistics of keeping a large sibling group together?
* There is a real tension in our descriptions and assessments of looked after children’s experience. How do we balance our knowledge of the hardship that some children face well into adulthood with the fact that some children thrive is alternative care and do very well in later life. This is also evident in report writing where legal documents need to highlight the evidence of ‘deficit’ to ensure a child’s protection and yet they fail to capture the strengths and qualities that all children possess.
* The tension around our notions of ‘risk’ and whether we are adequately preparing people to live ‘safely’ in society.