

The Framework for Integrated Care

A catalyst for change to
enhance services for children
and young people at risk



Anna Freud

Acknowledgements

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Introduction

The Framework for Integrated Care is a set of evidence-informed guiding principles and practices. These principles can act as a catalyst for cultural and organisational change and a template for genuine integration of services for children and young people in some of the most complex situations, who are at high risk of harm, and who may display particularly high-risk behaviours.

This paper is aimed particularly at those across health, education, social care, youth justice, voluntary and charitable services involved in commissioning, managing and delivering support services for these children and young people. In addition to outlining the Framework for Integrated Care, this paper aims to explain some of the challenges of providing integrated care for this group of children and young people, why the systems of support designed to help might struggle to do so effectively, and how the Framework for Integrated Care is an attempt to do things differently and promote meaningful and sustainable change in the way support is offered.

Understanding the challenge

How helping systems can become unhelpful

There is a cohort of children and young people in extremely complex situations who present with high-risk behaviours, alongside significant vulnerability. Such behaviours can include persistently staying away from home, violence, self-harm, harmful sexual behaviour and firesetting. As a cohort, they experience some of the highest levels of need and health and social inequalities. These needs are often defined as 'complex', as they are multiple, persistent, severe, interconnected and frequently framed by adversity and family and social contexts. Unless these needs are addressed, such children and young people are at significantly increased risk of negative social, physical and mental health trajectories across their lifespan. This pattern is not unique to the UK and similar patterns of need occur in many other countries (Fuggle et al., 2023).

Although each child and young person has their own individual and unique story of what has happened to them and contributes to their 'complex situation',

there are some common themes within many of their backgrounds. There is an almost universal story of unmet needs emerging from exposure to repeated and continuing high threat experiences, adversity and trauma within their developmental environment and within their local community. This may include:

- adverse childhood experiences (ACEs)
- developmental trauma
- domestic violence
- experience of marginalisation, discrimination or disadvantage
- exposure to violence or criminal behaviour
- relationship and attachment disruption
- exploitation by untrustworthy adults
- multiple transitions (including instability in accommodation and key relationships).

The needs that arise from these experiences are interconnected, long-term and impact significantly upon the everyday

life of the children and young people and their ability to live a safe and fulfilling life within the community around them. These experiences often lead to the development of significant distress, 'adaptive' strategies and behaviours that are seemingly unhelpful and perceived as 'high risk'.

However, such strategies and behaviours may well have enabled the child or young person to survive within their environment (for example, coping with or numbing emotional distress through self-harm or substance misuse, or identifying with violent others as a way of feeling protected and safe). At the extreme, these strategies can include violence and aggression; self-harm; persistent absence and difficulties in trusting help from supportive adults; fire-setting; difficulties with eating and harmful sexual behaviours (Rogers and Budd, 2015).

These behaviours often generate high anxiety for adults trying to help. They become the focus of concern, so that the children and young people are frequently labelled as 'high-risk', 'dangerous' or 'anti-social'. In addition, by the very nature of their developmental stage and the complexity of need, such children and young people are also vulnerable to harm and exploitation from others, and can be described as presenting with 'high risk, high harm and high vulnerability.'

What can easily be lost in the turmoil of such situations is the recognition that the high risk behaviours that frequently generate high anxiety in others are associated with states of mind that are powerfully connected to previous experiences and relationships. For example, children and young people who have experienced abuse may be very sensitive to social shame and humiliation and such feelings increase vulnerability to violent behaviour (Dolezal et al., 2022).

Given some of the experiences and behaviours described, the large majority of the children and young people in this cohort have not had the opportunity

to experience stability in their care, relationships and living accommodation and many may not be living with their families. For some, their liberty will be restricted. Ten per cent of children and young people in care had three or more placements in one year (NSPCC, 2021). As described in the Independent Review of Children's Social Care (MacAllister, 2022), children and young people may move between friends and family members or be required to live transiently in residential or foster care, spend time in supported accommodation, residential school, secure children's home, secure training centre, secure school, youth offender institution, inpatient mental health setting, or unregistered community 'placement'. They may be placed in these settings under a range of legal frameworks, including the Mental Health Act (1983, amended 2007), The Children Act, 1989 (Section 17, Children in Need; Section 20, Children Accommodated; Section 25, Secure Accommodation; Section 31 Care orders and Interim Care Orders), and the Criminal Justice Act, 2000 (e.g Detention and Training Orders).

These children and young people who have experienced adversity rarely present with a single 'problem', and their needs are infrequently explained by a sole explanatory label or diagnosis. Often in an attempt to understand, there is a desire to find a label or to place them into a certain 'pathway' to make sense of their needs, to bring clarity, manage our own anxiety and to determine the appropriate intervention or support. However, individual diagnoses, labels and pathways, whilst sometimes being helpful, are at risk of being seen in isolation and may be overlapping and even contradictory. It would not be unusual for the same child or young person throughout the course of their childhood, having presented to multiple services and practitioners, to have attracted a range of diagnoses that may include:

- conduct disorder
- post-traumatic stress disorder
- attention deficit hyperactivity disorder (ADHD)
- autism spectrum condition
- attachment disorder
- depression
- bipolar disorder
- mixed disorder of conduct and emotions
- emerging personality disorders.

Similarly, they may also have attracted multiple labels based on their behaviour such as: violent, young offender, self-harmer, gang member, bully, victim, vulnerable, dangerous and exploited. Even the term ‘complex’, which is used within this paper can be seen as misleading and problematic.

Such a diagnostic or label-led approach in isolation is often observed to be a simplification, highly problem focused and rarely takes into account protective factors or resources that the child, or the community around them might possess or might be available to help build a more positive future. Furthermore, where a child or young person has been given multiple labels or diagnoses, they often serve to lose meaning, leading to the ‘prescription’ of multiple overlapping, but disjointed interventions that add to the confusion. Most importantly, in a fast-paced, reactive system of support, they can reduce the child or young person and their needs to a list of labels, pathways and interventions, rather than helping to understand and validate them, their unique story and the wider complex situations they are trying to navigate.

It is clear that the needs of children and young people (and indeed any human being) in such situations are inevitably multiple, complex, interlinked, dynamic and frequently overwhelming. The needs may include basic human needs such as warmth, food, housing and belonging, but also overlap and exist across multiple ‘helping’ domains such as mental health,

neurodevelopment, learning, relationships, social and practical. By the time such children and young people’s needs are recognised and acknowledged by services, they have often become ‘persistent’ (rather than transient) and severe. Children and young people may have experienced multiple attempts to help, albeit piecemeal, which although, whilst well-meaning, have been inconsistent and contradictory and only served to reinforce mistrust, confusion and re-traumatisation.

As a result, the care of the children and young people described frequently falls between gaps of service provision. They may not meet the ‘thresholds’ or criteria that enable them to access services. They often get referred or passed between and within the systems of support over time, frequently driven by the labels or diagnoses ascribed to them (Kirby, 2024). What seems clear, is that their needs can rarely be met effectively by one service in isolation. Such levels of complexity require a truly integrated system approach, providing co-ordinated support from different agencies working across social care, mental health, education and youth justice services.

Traditional and current approaches to care

In our well-meaning attempts to help, the interventions offered to this group of children and young people are often ‘prescribed’ based on the child or young person’s label or identified problem behaviour (e.g., offence-focused intervention, anger management, violent offender intervention) or a primary diagnosis viewed in isolation. Such interventions are usually based upon a single therapeutic approach (such as attachment based approaches, cognitive behavioural therapy (CBT), or pharmacology). Many of these interventions are delivered piecemeal focusing on the problem as something located within the individual (such as faulty or distorted thinking, problems

managing emotions or relationships and difficulties problem-solving), without necessarily taking into account their wider cultural, social and community context and interconnected nature of the needs presented. Furthermore, such individually-focused therapeutic approaches may be hampered by their delivery in isolation from other interventions and systems of support. As a result of this approach, children and young people and their behaviours are rarely understood in their wider context, running the risk of less effective interventions which do not necessarily address the underlying causes of the needs presented.

Adolescence is a period of development, risk, opportunity and change, and continues well into the early twenties (Backes and Bonnie, 2019). These essential changes can lead, even in the general population, to temporary spikes in risk-taking behaviours, intense emotions, and difficulties seeing the bigger picture and making well thought-through decisions. An essential part of development at this stage of life is the need to test out and develop one's own point of view, in preparation for the move towards adulthood. When supporting children and young people who have experienced adversity, it is important to understand them in the context of their cognitive and emotional development and tailor that support accordingly (e.g the Trauma Recovery Model, Skuse and Matthew, 2015). However, despite the evidence supporting the notion that 'adolescents are not mini adults', across many of our services there at times appears a lack a shared developmental perspective. Children and young people appear all too often to be treated as if they were 'mini adults', with interventions applied from evidence drawn from adult populations, and limited shared recognition of their stage of social, emotional and cognitive development.

Unfortunately, whilst integrated working and co-ordination of support are often recommended, they have proved extremely

difficult to achieve in practice. The complex, severe, and multiple needs of this group of young individuals, coupled with the reduced effectiveness of evidence-based approaches in the context of multiple risk factors (Norcross et al., 2016), scarcity of specialised psychosocial resources, and heightened stress levels in the service context, considerable challenges in devising effective supportive strategies remain. Our attempts to manage and address the levels of complexity, distress and risk that some children and young people experience, whilst well-meaning, have all too often resulted in systems of support that are fragmented, overly prescriptive and despite attempts to integrate, frequently work in 'siloed' isolation. The separation in provision within and between support organisations has led to a lack of shared understanding, consistency and underpinning therapeutic rationale. Significant conflict is common between and within the systems of support, and between the teams and individuals providing that support, further entrenching the lack of joined up working and poor communication (Talbot et al., 2023). Ultimately, the young person may experience inconsistency and discontinuity of care which at best maintains their difficulties and at worst, causes further harm.

Making sense of the dysfunction

Nobody intentionally designed these support systems to be fragmented in this way, and there is now a growing recognition and understanding of the challenges. This opens up opportunities to work towards more integrated solutions. We have begun to understand a little more about how, despite the best of intentions, any system of support can evolve over time to be less helpful than it was intended to be. All people (including both children and young people and practitioners) who find themselves under significant stress or 'threat' are likely to experience a common range of predictable responses to a greater or lesser extent. Such responses include

difficulties with:

- feelings of safety and trust
- emotional management
- thinking and decision making
- communication
- authority
- a confused sense of justice
- grieving
- anticipating the future (hope) (Bloom, 2018).

Through a common psychological process, sometimes called parallel process (Bloom, 2010), such feelings and responses can be passed on to one another, often unconsciously. For example, when you walk into a room where there has been an argument, despite not being made aware what has happened, you can start to feel uncomfortable. Therefore, if practitioners or children and young people spend enough time with someone who is experiencing anger, high anxiety or distress, they may themselves start to feel angry, anxious or distressed - and this can work both ways. So often unconsciously, children and young people's anxiety and stress responses can be mirrored by practitioners, and practitioners' anxieties and stress responses can be mirrored by the children and young people they are trying to help. Furthermore, this process can occur between practitioners and their managers and between one organisation and another. Unless there are effective

systems of support in place to help recognise, manage and safely contain these anxiety responses, individuals, teams and whole organisations can start to re-enact some of the chronic stress and threat responses displayed by the children and young people they are trying to support. Over time, individuals, systems and whole organisations can become unconsciously and vicariously organised around the impact of chronic stress. Practitioners, children and young people, senior managers and teams, despite the best of intentions, can become caught in unhelpful practical and interpersonal dynamics - struggling with perspective taking and polarised opinions, decision-making, communication, isolation and feelings of safety, hope and optimism. Such helping systems and those individuals within frequently become overly focused on action, are often crisis driven, reactive and hyper-aroused, and can experience breakdowns in communication, becoming increasingly controlling, and repeating and re-enacting past mistakes. This further adds to the stress levels of all involved, impacting on the wellness of those helping and negatively impacting on the consistency and effectiveness of care and support offered for children and young people. Such organisational dysfunction can be understood as the organisation's collective vicarious response to trauma – an 'organisational trauma' response leading to the development of a trauma-organised system of care (Bentovim, 1992).

What is the Framework for Integrated Care?

The Framework for Integrated Care grew out of this understanding of individual and organisational trauma responses and the numerous attempts to help that precede it. It is in many ways, nothing new - much of what the Framework for Integrated Care guides in practice already exists or has already existed in pockets of effective psychologically-informed and trauma-responsive practice. The Framework for Integrated Care does not propose to reinvent the wheel therefore – but it seeks to provide a coherent narrative and scaffold that allows for more consistent application of innovative and effective working practices and collaborations that stretch across traditional agency boundaries.

It provides permission to think and do things differently where necessary and promotes genuine integration, collaboration and co-production. The guiding philosophy, principles, and essential elements of the Framework for Integrated Care can be used in multiple ways to inform cultural system change and practice - and importantly, to sustain such changes over time. As such, the Framework assumes a reorientation of services, tailored to more effectively meet the needs of children and young people.

The Framework for Integrated Care is a guiding framework, not a model, and purposely does not adhere to a rigid, standardised delivery model - as there is assumed to be no single right way to implement such change - although there may be some short-cuts that it can help with. Instead, the Framework for Integrated Care acknowledges the necessity for services to be based on local strengths and accommodate a range of interventions at individual, organisation, commissioning and community levels that align with the desired outcomes the Framework for Integrated Care seeks to promote.

Rather than providing a fixed set of rules or a list of actions to tick off, the Framework for Integrated Care, consistent with trauma-informed approaches and practices, represents a shift in ideology and approach to service provision. It moves away from approaches that simply seek to 'fix' children and young people in isolation, to those that try to understand them and the helping system in their wider context and intervene in a more integrated, consistent and effective way. It cannot simply be put into a treatment manual which prescribes helper behaviour. It is not owned by anyone - its development has been supported by practitioners, children and young people as part of the co-production process. The Framework is not aligned to any single treatment approach, but draws from multiple ideas and learnings that have come before including human development, trauma, systemic and attachment perspectives.

The primary goals of the Framework for Integrated Care can be categorised into two groups:

- those targeting changes in children and young people
- those focusing on improving and enhancing the context of their lives (which often involves supporting the adults around them to make significant changes too).

The former includes improving wellbeing, mitigating high-risk behaviours and alleviating distress, while the latter encompasses facilitating psychologically informed and trauma responsive organisational and relational practices, promoting trusting relationships, engagement in education and learning, and increasing the stability of where the young person is living. The anticipated outcomes of the Framework of Integrated Care include:

- fostering a mutual understanding of needs between practitioners, supportive adults, children and young people
- implementing well-coordinated interventions
- promoting multidisciplinary professional practice
- providing highly integrated care
- and establishing a supportive network around the child or young person, including specialist services.

These outcomes are projected to enhance transitions to other services, increase vocational opportunities, and facilitate the attainment of personal goals. The expected benefits encompass improved coordination of the entire system, reduced re-traumatisation, enhanced well-being and safety for children and young people, and strengthened relationships both among practitioners and between practitioners and children and young people.

The Framework for Integrated Care is based on six overarching principles which underpin practice and organisational culture. These have been brought together into a coherent narrative, informed by evidence, that hopefully makes sense to practitioners, children and young people. It is intended to guide future integrated service commissioning, service design and service delivery, drawing on what we know at this point in time. It continues to evolve as we learn.



The principles are:

1

Every interaction matters

Fostering consistent trusting relationships with children and young people and families, and between practitioners, leaders and organisations.

2

Trauma-informed, not trauma-organised

A commitment to building and sustaining trauma responsive organisations and promoting practices that aim to reduce the negative impacts of trauma on children and young people and those individuals and organisations supporting them.

3

Integrating perspectives, enabling collaboration and co-production

Ensuring a focus on embracing multiple perspectives in the pursuit of effective collaboration and co-production of services.

4

Front-line practitioners are key facilitators of change

Emphasising and supporting the role of front-line practitioners (e.g., youth workers, foster carers, support workers, teachers, coaches) and their relationships with the children and young people as crucial facilitators of change.

5

Understanding behaviours in context

Developing a shared understanding of a child or young person's behaviours and needs and guiding intervention through an exploration of their story in context (formulation).

6

The Rule of 167

Positively influencing day to day care.

Principle 1

Every interaction matters: trusting relationships as intervention

Drawing on the wide evidence-base supporting the transformational and positive effects of attachment-informed, safe, consistent, trusting relationships throughout our lives (Peterson and Park, 2007), the Framework for Integrated Care views building and sustaining relationships at all levels as a key intervention and 'therapeutic' in its own right - every interaction matters. It also acknowledges how conflict and dysfunction is inevitable in relationships, particularly when threat and anxiety is high, and how our responses (individual and organisational) can help with, or at times hinder effective support.

All supportive adult relationships with children and young people are therefore considered opportunities for learning, constructive social interaction and thinking and emotional skill-building. The approach provides permission for and highlights the value of simply 'being with' rather than 'doing' an intervention (being therapeutic rather than delivering therapy), as the development of children and young people's skills in managing friendships, social networks, emotions and supportive relationships is deemed critical for progress in achieving various individual goals.

The Framework for Integrated Care does not just emphasise the importance of positive relationships between adults, children and young people. It encourages an intentional focus on supporting and working on improving relationships between the adults, practitioners, leaders and agencies supporting children and young people and the relationships between support agencies and their wider communities.



Principle 2

Trauma-responsive, not trauma-organised

A second key principle of the Framework for Integrated Care is alignment with trauma-informed care and a commitment to building trauma-responsive organisations. Trauma-informed Care has been extensively adopted by numerous services for vulnerable children, young people and adults, although its precise definition often remains ambiguous. Fallot and Harris (2009) suggested that trauma-informed care should be underpinned by five core values:

- safety
- trustworthiness
- choice
- collaboration
- empowerment.

Importantly, trauma-informed Care focuses not only on the needs of the client group, but also on applying these principles to the relationship between the organisation and its staff, making it a whole systems approach that requires senior managers to understand and adopt trauma-responsive practices.

The Framework for Integrated Care adopts a broad definition of trauma that recognises how experiences may overlap and intertwine and encompasses Post traumatic stress disorder, social trauma, the impact of multiple life threats, abuse, racism, discrimination and exposure to violence, all of which are common experiences for children and young people in complex situations. The Framework for Integrated Care emphasises that children and young people's traumatic experiences often involve the misuse of power, wherein individuals and organisations with responsibility for and authority over a young person may have contributed to the trauma they have endured. This connection between trauma and misuse of power, understandably results in a loss of trust by children and, young people and their communities losing trust in those who are supposed to protect

and care for them. It also highlights the risk of re-traumatisation and the subsequent exacerbation of mental health needs and relational problems - a risk supported by several studies suggesting that residential interventions may worsen mental health and behavioural difficulties (Ko et al., 2008; Racine, Killam, and Madigan, 2020).

There is a small emerging body of evidence supporting the effectiveness of trauma-informed organisational change programmes. Some common components of effective programmes include:

- an allocated budget
- a community of practice representing staff and people with lived experience
- ongoing training and support for staff
- changes in physical space and care practices.

Programmes that included at least four components of trauma-informed change were able to evidence improvements in some psychological, behavioural and health outcomes for some clients and staff (Emsley et al., 2022, Lewis et al., 2023).

The Framework for Integrated Care recognises the importance of tackling trauma-organised cultures and constructing and sustaining trauma-responsive organisations to reduce the likelihood of adverse outcomes for children and young people. This trauma-responsive philosophy is embedded across the other principles of the Framework for Integrated Care, encompassing a degree of empowerment and co-production of support, the role of safe relationships in fostering safety and trust, the significance of understanding traumatic experiences as part of one's broader narrative or story (formulation), and the necessity to adapt environments in response to individual needs.

Principle 3

Integrating perspectives, collaboration and co-production

The Framework for Integrated Care characterises collaborative practice in two ways. First, as establishing positive, consistent and supportive relationships between practitioners and children and young people, emphasising mutual collaboration and co-production. Second, as the necessity for enhanced collaboration across teams and services to deliver more effective care.

Collaborative practice with children and young people is a component of numerous evidence-based interventions, and the required knowledge and skills have been outlined by Crispin Day and colleagues in the Family Partnership Model (Day, Ellis, and Harris, 2015).

The principle of empowerment is integral within this approach, fostering a more balanced power dynamic within relationships and emphasising mutual learning between children and young people and those adults supporting them which draws on each other's strengths, experience and knowledge. In this way, bespoke interventions and solutions to complex situations can be co-produced, not just at an individual, and at a service level. Implementing this principle in a service context that involves taking decisions that are sometimes outside of the child or young person's control is undoubtedly challenging.

To support collaboration, co-design and co-production, front line practitioners receive training in engaging children and young people in the psychological principles of trauma-responsive care and undergo regular supervision to assist them through active listening and expressed empathy based on a shared understanding of their needs. There is substantial evidence to support the value of such an approach

(Gillard et al., 2012). From this foundation, practitioners play a crucial role in helping children and young people navigate the system, better comprehend the rationale behind decisions and the support offered, and make collaborative decisions about how best to meet their needs.

In addition, and as important as focusing on collaboration with children and young people, enhancing collaboration between practitioners and between agencies (or integrated care) is highly prioritised within the Framework for Integrated Care. This approach aims to establish an effective support system around children and young people with multiple needs, necessitating integrated care. Such a strategy aligns with the UK's healthcare initiatives, including the establishment of integrated care boards (ICBs) that combine governance from health and social care perspectives (NHS, 2021). There is considerable empirical support for integrated care improving effectiveness of interventions, enhancing patient experience and increasing engagement, and increasing service continuity and accessibility (Lambert et al., 2017).

As discussed previously, the Framework for Integrated Care makes explicit how, when working with high levels of distress, organisations can become trauma-organised, which can increase the risk of conflict between organisational leaders and within leadership systems.

Just like within a family, where the leaders (or parents) of a system of support are in conflict, there is an increased risk of inconsistencies and disruptions in the care they provide and a negative impact on those that they care for.

Principle 4

Frontline practitioners as key facilitators of change

The Framework for Integrated Care is essential in facilitating individual and relational transformation for children and young people. Within the Framework, relationships between front line practitioners and the children and young people they work with are of paramount importance. Although not all practitioners are expected to become therapists, they should be expected to be therapeutic (effecting positive change) and therefore must be well supported and equipped to cultivate the necessary conditions for change.

Within the Framework for Integrated Care, psychologically-informed interventions targeting mental health needs are not regarded as the sole responsibility of specialist clinical staff. Front line practitioners (e.g., youth workers, teachers, support workers) who spend the majority of time with children and young people, are viewed as primary facilitators of change. Frontline staff are expected to consistently follow up with children and young people to ensure their needs are met and conduct real-life monitoring of progress towards goals, as well as the frequency of high-risk behaviours.

Goal-based interventions are considered a crucial aspect of the Framework for Integrated Care. Supporting children and young people's objectives related to improving emotional regulation is a typical example of this practice and necessitates practitioners having an understanding of each individual's unique challenges, their specific coping strategies and their goals in this regard. The Framework for Integrated Care emphasises the need for those with key relationships with children and young people (e.g., teachers, youth workers, foster carers, families, carers and the wider community) to adapt to individual

intervention plans for such plans to be effective. The Framework for Integrated Care approach aims to foster positive interactions that redirect children and young people from established patterns of unhelpful behaviour, while minimising the tendency to view interactions in purely behavioural terms. This is achieved by supporting key relationships, ensuring that each child or young person has an agreed plan of support based on a collaborative understanding of their strengths and vulnerabilities (as a result of their experiences). This is a complex task in a context where children and young people may understandably harbour high levels of distrust towards those offering support, given their likely lengthy histories of difficult relationships with adults and authority figures.

As suggested, such an approach requires a commitment to supporting frontline practitioners with high quality training, shared learning and reflective practice opportunities, and supervision to develop a culture of psychologically-responsive practice and reduce the potential negative impact of vicarious trauma for staff. There is widespread professional consensus about the value of reflective practice in working with vulnerable populations of need and the benefits of reflective practice have been substantiated by numerous studies across various health need groups (Fordstat (2012), Shea et al., (2022)).

Principle 5

Understanding behaviours in context - shared understanding and formulating 'my story'.

The Framework for Integrated Care approach suggests that all behaviour can be understood within its context, emphasising the importance of understanding the needs and actions of children and young people and the adults around them through their narrative histories (or life stories). For children and young people with multiple presenting problems involving multiple agencies, effectiveness is likely to be improved if everyone involved in supporting the young person has a shared understanding of their difficulties came about and how they are maintained, alongside a shared-awareness of how trauma can impact the support offered.

One of the primary aims of the Framework for Integrated Care is to provide each child or young person and those supporting them with a clear and coherent narrative about their needs, based on their individual life experiences (what's happened to them) and a coherent plan to address these needs and provide hope for the future.

The collaborative development of a shared understanding, sometimes called 'formulation' or 'My Story', encapsulates the child or young person's core challenges, explores their underlying causes, and integrates psychological understanding to interpret them. It should also include reference to what help has been provided before and by whom, how it may have helped or hindered, and what in the support being offered currently may or may not be maintaining some of the needs. This 'plausible account' of the child or young person's circumstances is meaningful to both the individual and those trying to support them, transcending specific labels or diagnoses. Importantly, this does not mean that labels or diagnoses are ignored

entirely, but they are not viewed in isolation or become the primary or sole driver of interventions - rather, the diagnoses or labels are incorporated into the broader story where helpful. Such a perspective is reinforced by The Power Threat Meaning Framework (Johnstone et al., 2018), which similarly advocates for an understanding of an individual's distress and behaviour in the context of their life experiences and wider societal influences, and offers an alternative perspective to more traditional models of understanding based primarily on psychiatric diagnosis.

The formulation (the child or young person's story in context) should then drive a flexible intervention plan based on the shared understanding developed. This plan can be revised and reformulated as needed. Developing collaborative, psychologically-informed formulations is a complex task, requiring the integration of psychological knowledge. It should be further supported by regular supervision and reflective practice for those involved, enabling formulations to be refined as interventions progress. This is a widely supported approach based on professional consensus of good practice, even though the precise evidence for the benefits of individualised formulations remains somewhat inconclusive. The Framework for Integrated Care formulation approach aims to provide significant benefits, such as enhancing knowledge about children and young people and their circumstances, increased empathy and confidence, and greater understanding and satisfaction with the intervention plan for those involved.

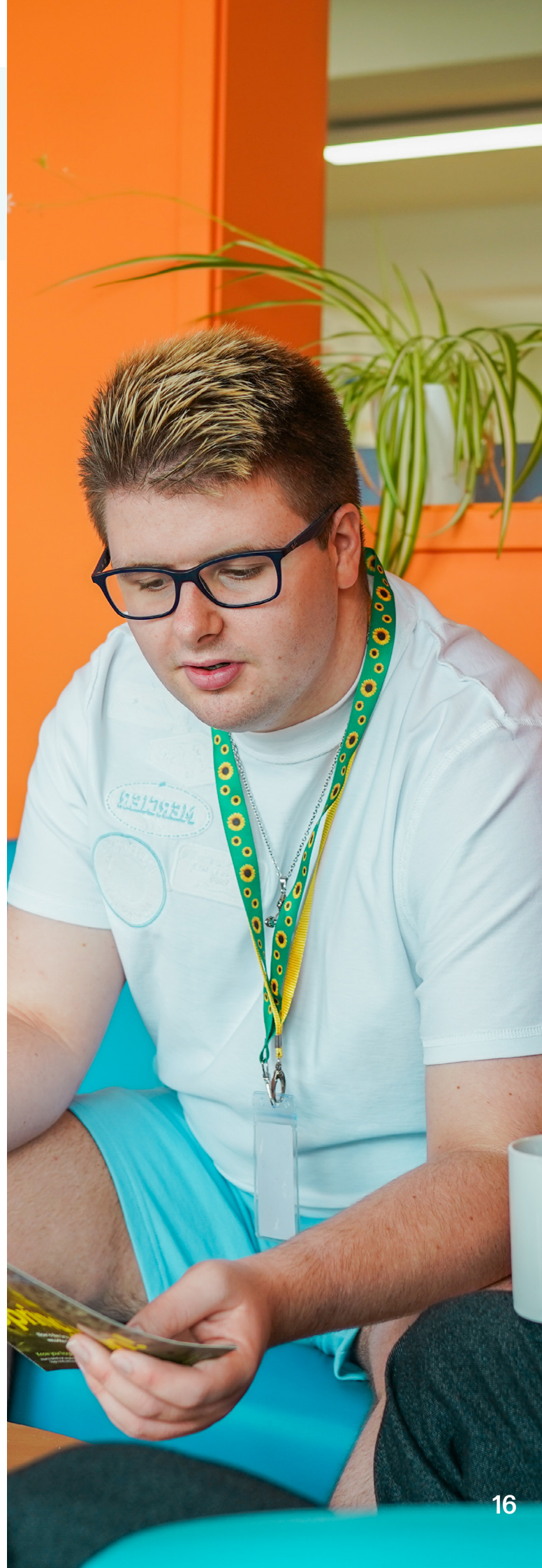
Principle 6:

The rule of 167: positively influencing day to day care

The rule of 167 suggests that of the 168 hours in a week, an hour of that week in therapy with a specialist may be just the tip of the iceberg in effecting meaningful change for children and young people.

The Framework for Integrated Care encourages thinking and practices that attempt to broaden the therapeutic process to influence meaningful change across the other 167 hours. The Framework for Integrated Care emphasises the importance of concentrating interventions on daily interactions between children and young people, their relationships with others and the environments around them, rather than solely providing specialised assistance or direct one to one therapy. This is not to rule out one to one specialist support, but to recognise the limitations of such an approach, and where one to one therapy is indicated, to complement it with therapeutically-informed practical and relational support outside of the therapy room. This focus on supporting positive relationships in the care network (whilst also addressing any that are unsupportive or harmful) is recognised within the NICE guidelines for looked after children and young people (NICE, 2021)

The Framework for Integrated Care approach underscores the necessity of adapting day-to-day interactions and care to accommodate the diverse needs of children and young people, ensuring that interventions derived from shared formulations are supported by the community environment and that the child or young person's goals are realistic and achievable within this context.



The Framework for Integrated Care in practice

Although the Framework for Integrated Care is not intended to be prescriptive, through implementation and learning across a range of settings, both secure and in the community, key elements of practice have emerged as appearing particularly important in supporting more effective operationalisation (e.g. Taylor et al., 2018, Edbrooke-Childs et al., 2022, Atkinson et al., 2023).

These include:

1. Strong, brave and aligned leadership across agencies and organisations and a clear commitment to collaboration and organisational and cultural change over the longer term. This should be aligned to a shared and coherent narrative, and an understanding of the impact of organisational trauma processes at a leadership level. Individual and organisational support for leaders and leadership across agencies can reduce the risk of trauma organisation, while facilitating collaborative and effective leader relationships and promoting integrated, trauma-responsive leadership can support sustainable system change .
2. The development of an integrated community team including practitioners from a wide range of professional backgrounds drawing on specialist mental health and psychological competencies, but importantly including representation of youth workers and advocates from the charitable, voluntary, community and social enterprise sector. The team works to the principles of the Framework for Integrated Care across agencies and organisations to facilitate cross-service coordination, shared formulations and integrated interventions.
3. Interventions at the organisational level being driven by recognition of the impact of organisational trauma as outlined above, and targeted at facilitating integrated leadership, developing trauma-responsive organisational practices and truly supporting and empowering frontline practitioners through:
 - a. collaboration with local commissioners to identify service gaps, and modified eligibility criteria for services
 - b. developing a shared language and coherent narrative for practice that drives trauma-informed policies and practices and creates the conditions and gives permission for people to work in truly integrated and trauma-responsive ways
 - c. the development of cross-agency training, communities of practice, clinical supervision and reflective practice to include all staff (including senior leaders)
 - d. co-production of services with children and young people, staff and wider stakeholders
 - e. psychologically-informed facilitation of the process of shared formulation (understanding an individual's story) to drive intervention.

4. Interventions at the individual level driven by a psychologically-informed shared understanding or 'formulation' of the child or young person's story taking account of their social context and their developmental stage, rather than the diagnostic label or the problem behaviour. These interventions are co-ordinated, bespoke and often psychosocial in nature, and delivered largely through the key relationships developed between frontline practitioners, children and, young people and their families. Where required, specialised mental health interventions are prioritised, along with accessibility to expert neurodevelopmental services.

The Framework for Integrated Care delineates the essential inputs, drivers, activities, outputs, and outcomes for successful implementation whilst acknowledging that these components can be tailored to specific local settings. The primary objective is to ensure that each child or young person owns a clear and coherent narrative concerning their needs and how these will be supported, derived from their unique life experiences, which is comprehensible to them and those trying to support them, and subsequently mitigates the likelihood of difficulties stemming from misunderstandings.

Conclusions

The Framework for Integrated Care provides a set of principles and practices for effectively addressing the psychological and social needs of children and young people in extremely complex situations who often present with highly concerning behaviours. It acknowledges the multifaceted nature of their needs, which extend beyond a single domain (such as mental health, behaviour or education) to encompass a diverse array of developmental, relational, educational, vocational and life challenges. Consequently, the Framework appropriately places integrated care at the core of its approach.

The strength of the Framework for Integrated Care lies in its core principles, which are derived from evidence-based approaches pertinent to the types of problems that children and young people commonly present. The Framework for Integrated Care appropriately considers the context in which it is being applied, avoiding unrealistic, rigid and ideal service requirements that may exceed the resources available and skill levels of those involved in supporting these highly vulnerable children and young people. Instead, it aims to utilise existing resources more effectively by integrating, supporting and enhancing the skills of those who spend the most time with children and young people and have the potential to foster helping relationships.

The Framework for Integrated Care is characterised by its flexible approach, which recognises the complexity of care systems and the need to tailor approaches to local contexts. It gives permission to work with a focus on relationships and 'being with', rather than 'doing to' children and young people. The Framework for Integrated Care does not prescribe a one-size-fits-all method of implementation, but rather sets out the conditions necessary for establishing such an approach.

Three key conditions are highlighted: strong and aligned cross-agency leadership, multi-agency strategic coordination, and the involvement of community-based coordinating teams that work closely with practitioners from various services (including the voluntary sector) to build relationships and enhance collaboration across agencies. These conditions are crucial for the success of whole-system approaches as advocated by the Framework for Integrated Care. Multi-agency strategic leadership is an ambition that commonly promoted in the context of integrated care. In practice, the challenge of achieving this in local contexts is daunting, as all agencies will have separate priorities

and budget pressures that will make conditions difficult for such multi-agency work. The Framework for Integrated Care provides a compassionate framework that engages leaders of services in understanding and addressing the need for integrated practice. The approach is still evolving, has been tested in pilot studies and whilst challenging in practice, appears promising.

The Framework for Integrated Care is about supporting a sustainable change in the culture of mental health and social care for children and young people, creating positive expectations around the needs of a highly vulnerable group and requiring a long term commitment to change. Such an approach fits with the recent All-Party Parliamentary Group report (Davies et al., 2024) that proposes systemic mental health service reform towards a more psychosocial understanding and approach to service delivery. The Framework for Integrated Care is not presented as a perfect answer to the challenges of providing effective support for these children and young people, but it does suggest a way to do things differently. It continues to evolve as we learn. What is clear, is that striving to truly integrate care in a way that is impactful is difficult, and effective implementation of the Framework for Integrated Care requires courageous and aligned leadership at both national and local level to mitigate the impact of trauma and service dysfunction and to address the needs of this very vulnerable group of children and young people. It is suggested that this needs to be considered at all levels of national and local planning for these children and young people, in order that impactful change can be achieved and sustained.



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