

Section One: What support helps to maintain or improve children and young people's mental health and wellbeing?

The Consortium of Adoption Support Agencies (CASA) represents a network of specialist providers delivering therapeutic services to adopted children, young people, children living within Special Guardianship Order (SGO) arrangements, and their families across England. CASA members include highly experienced clinical psychologists, psychotherapists and multidisciplinary practitioners who have developed their expertise over many years of direct work with adoptive and SGO families.

This response draws on published research, sector evidence, and the professional expertise of CASA members. CASA collectively holds a significant concentration of specialist knowledge in developmental trauma, attachment, neurodevelopmental complexity, therapeutic parenting, and family-based intervention. This expertise has been built through years of clinical practice, training, supervision, continuing professional development, service evaluation and innovation. It is a critical part of the current support system for adopted and SGO children and their families.

The nature and complexity of need:

Adoption and special guardianship can be profoundly positive routes to permanence. Adopted and SGO children should never be defined solely by their early experiences, nor described in ways that suggest they are inevitably damaged or unable to thrive. With the right family relationships, school environments and specialist support when needed, children can recover, develop and flourish.

However, it is equally important not to minimise the level of need. Many adopted and SGO children have experienced multiple and cumulative adversities, including neglect, abuse, loss, instability and disrupted caregiving, often during critical periods of development. Some children have experienced forms of adversity that most people will not encounter across a lifetime. These experiences do not make children inherently “broken” or defined by deficit; rather, they are children whose development has been shaped by circumstances outside their control, and who deserve timely, skilled and properly resourced support. This is consistent with wider evidence on adverse childhood experiences, which demonstrates a cumulative relationship between early adversity and later mental health, physical health and service engagement outcomes (Felitti et al., 1998; Hughes et al., 2017; Bellis et al., 2024; Madigan et al., 2024).

Care should also be taken in policy and practice language more broadly. The ways in which children, families and their needs are described can shape both expectations and access to support. Language which inadvertently frames children as damaged, or parents and carers as overly demanding or responsible for systemic pressures, risks undermining engagement and obscuring the reality of need. A balanced approach is required; one that recognises both the strengths of families and the legitimacy of the support they require.

Evidence consistently shows that adopted children are overrepresented in mental health settings and have higher levels of emotional, behavioural and relational difficulties than non-adopted peers (Purrington, Goodall and Lynch, 2023). Adoption UK's consultation guidance, drawing on Adoption Barometer data, reports high levels of diagnosed need among adopted children, including social, emotional and mental health needs, attachment difficulties or disorders, sensory processing difficulties and ADHD (Adoption UK, 2025). Evidence relating specifically to SGO children is less developed, but clinical experience across CASA strongly suggests that many children living in SGO arrangements present with similarly complex and overlapping needs.

A substantial body of developmental and attachment research helps explain why these needs can be so significant. Early adversity can affect the developing brain and nervous system, particularly in areas linked to emotional regulation, stress response, social engagement and relational trust (Bowlby, 1988; De Bellis, 2001; Perry, 2006; Siegel, 2012). Where early caregiving has been inconsistent, frightening, neglectful or absent, children may develop heightened sensitivity to threat, difficulties trusting adults, and challenges regulating their emotions and behaviour. These are often adaptive responses to early environments, not wilful misbehaviour or isolated behavioural problems, nor evidence of current deficient parenting.

This developmental understanding is essential. It explains why many adopted and SGO children require interventions that go beyond generic parenting advice, surface-level trauma awareness or short-term behavioural strategies. Support must be capable of addressing the child's relational world, their sense of safety, their capacity for co-regulation, and the caregiving relationships that support recovery.

Parents, carers and families are central to recovery

Adoptive parents and special guardians play an extraordinary role. They provide permanence, stability and commitment to children who may have already experienced profound loss and disruption. Many do so while navigating behaviours, emotions and needs that can be confusing, frightening or exhausting, particularly when wider systems do not understand the impact of early trauma.

Parents and carers should not be positioned as the problem. They are often the child's most important therapeutic resource. However, they need the right support around them to sustain this role. Research on DDP, for example, shows that interventions often involve caregivers actively and that improvements in child wellbeing are closely linked to changes in caregiver understanding, confidence and relational capacity (Burch et al., 2023; Wingfield and Gurney-Smith, 2019). In Burch et al.'s longitudinal study, improvements were observed in both child difficulties and caregiver wellbeing, although the authors rightly note the need for further research and the limits of causal claims (Burch et al., 2023). Another relationally based model that supports parents to better understand and respond to gaps in their child's development arising from early disruption is BUSS (Building Underdeveloped Sensorimotor Systems). A recent service evaluation conducted by Newcastle University involving 468 families who received BUSS between 2015 and 2022 reported statistically significant improvements in children's emotional regulation, sensorimotor functioning, behaviour, parent-child relationships, and goal attainment (Close, Fouweather and Teare, 2026), further illustrating the potential value of integrative, caregiver-inclusive approaches.

Supporting parents and special guardians is therefore not an optional extra. It is part of supporting the child. Robust adoption and SGO support must include work with caregivers, family relationships, schools and wider professional systems. Relational trauma must be addressed through safe, attuned and sustained relationships. This is consistent with developmental research highlighting the importance of attunement, rupture and repair within caregiving relationships in supporting emotional regulation and development (Tronick, 2007).

The system around the child

Children's outcomes are shaped by the system around them: family, school, health, social care, community and identity networks. For adopted and SGO children, these systems are often under significant pressure.

Schools may lack the flexibility or understanding required to respond to trauma-related behaviours. This is often not due to lack of commitment, but reflects wider systemic pressures, including high pupil-to-adult ratios, curriculum demands and funding constraints, which limit the capacity of schools to provide the level of individualised, relational support that many adopted and SGO children require. Health services, including CAMHS, may not have the capacity or specialist adoption expertise required to work effectively with relational and developmental trauma. Social care services are frequently stretched, limiting their ability to provide sustained and formulation-led support.

There has been a welcome increase in trauma-informed language across public services. However, CASA members' experience is that this knowledge is often inconsistent and, at times, superficial. Awareness of trauma does not equate to the ability to assess, formulate and intervene safely with children whose difficulties are complex, relational and developmental. Trauma-informed language without specialist competence risks creating the appearance of understanding without the depth required for effective support. This distinction is important. Trauma-informed practice requires more than awareness; it requires organisational commitment, skilled staff, appropriate supervision and systems that actively respond to the impact of trauma (Public Health England, 2018; Anna Freud National Centre for Children and Families, 2021).

The support that works best is therefore not simply "more services", but better integrated, specialist, formulation-led support around the child and family.

What we mean by robust and specialist therapeutic support

Therapeutic support should not be understood as a child sitting in a therapy room indefinitely. Nor should it be reduced to a brief intervention that assumes complex developmental trauma can be resolved quickly.

For adopted and SGO children, robust therapeutic support means the right intervention, at the right time, for the right reason, based on careful formulation. Some children may need a focused intervention at a particular point. Others may need repeated or different forms of support across development as new issues emerge around identity, relationships, education, contact with birth family, adolescence, or transition into adulthood. While some children may require longer-term or recurring input, this is not about indiscriminate or open-ended therapy, but a developmental model of support, where the nature, intensity and duration of intervention are guided by need.

Adopted adults should also not be forgotten. Evidence from the APPG Adoptee Voices Inquiry highlights that adopted young people and adults continue to describe needs relating to identity, health, wellbeing, education and belonging beyond childhood (APPG for Adoption and Permanence, 2026). A system that only thinks about childhood intervention risks missing the lifelong nature of adoption and special guardianship experiences. This is particularly important because adoption-related needs may change over time, including around identity, belonging, birth family relationships, loss, and becoming a parent oneself.

Robust and specialist support is characterised by:

- deep knowledge of developmental trauma, attachment, neurodevelopment and family systems;
- the ability to build trust with children who may be highly mistrustful of adults;
- work with caregivers as central participants, not peripheral observers;
- skilled formulation rather than standardised, one-size-fits-all responses;
- appropriate professional training, supervision and accountability;
- understanding of adoption and SGO-specific issues, including identity, loss, loyalty, contact and family narratives.

This is highly skilled work. It cannot be replicated through short courses or generic trauma-informed training alone. Developmental trauma theory further supports this position, highlighting that children with complex trauma histories often present with difficulties across emotional, behavioural, relational and cognitive domains, requiring integrated and developmentally informed intervention rather than single-model or purely behavioural responses (Van der Kolk, 2005; Cohen, Mannarino and Deblinger, 2004).

Evidence-based practice and practice-based evidence

CASA supports evidence-based practice. Children and families deserve interventions that are safe, purposeful and evaluated. However, evidence in this field must be understood in the context of the

complexity of need and the realities of applied clinical work.

The evidence base for family-based interventions with adoptive families is developing. Purrington, Goodall and Lynch's systematic review found preliminary support for integrative interventions involving sensory activities, attachment-based play, DDP, EMDR and therapeutic input with children and parents, while also noting that risk of bias in the available literature limits the strength of conclusions (Purrington, Goodall and Lynch, 2024). This is important: the evidence is promising, but further research is needed.

Similarly, qualitative research into DDP suggests that parents report increased understanding of their child, changes in parenting approach, greater acceptance and improved relational connection (Wingfield and Gurney-Smith, 2019). More recent work exploring children's experiences of DDP found that children highlighted attunement, playfulness, trust-building, relational repair and caregiver involvement as important aspects of therapy (Christopher, Cresswell and Davies, 2025).

In addition, emerging trial-based research, including the ongoing RIGHT study, is beginning to explore the effectiveness of DDP-informed approaches using more structured methodologies. While findings are still developing, this work represents an important step towards strengthening the evidence base for relational, attachment-focused interventions within adoptive and kinship populations.

Emerging UK-based evaluations of integrative, multidisciplinary approaches also demonstrate promising outcomes. Notably, a growing body of work in this area has been developed through Neuro-Physiological Psychotherapy (NPP), a UK-originated, clinically led, integrative and wrap-around model described by Vaughan, McCullough and Burnell (2016), and implemented and refined over a number of years in response to the needs of adopted and special guardianship families.

Published studies from 2016 include both the original description of the model and early outcome evaluations, with subsequent work providing further evidence, including controlled comparisons (McCullough et al., 2016; Vaughan, McCullough and Burnell, 2016; McCullough and Mathura, 2019). These studies report improvements in children's behavioural regulation, emotional wellbeing and relational functioning, as well as positive changes in caregiver confidence and family dynamics. This body of work is particularly valuable in demonstrating how integrative, formulation-led approaches can be delivered in real-world settings with children who present with complex and overlapping needs.

Further research is ongoing, including emerging work exploring outcomes for specific groups such as children with FASD, which may provide additional insight into the applicability of neurodevelopmentally informed, integrative approaches.

As with much of the evidence in this field, these studies are grounded in service-based evaluations and smaller-scale samples, reflecting the realities of working with complex populations in applied settings. They therefore make an important contribution to a growing and evolving evidence base, offering valuable insights into effective practice.

There is also a broader consideration in relation to how evidence is conceptualised within policy. Current approaches often prioritise evidence linked to individual, manualised therapeutic modalities. While this has value in some contexts, it does not fully reflect the nature of effective intervention for adopted and SGO children, where needs are typically complex, overlapping and developmentally embedded.

In practice, effective support is rarely delivered through a single, discrete modality. Instead, it is integrative, formulation-led and responsive to the child and family's evolving needs. This may involve combining elements of different therapeutic approaches, alongside direct work with caregivers, systemic intervention, and engagement with wider networks such as education and social care.

An emphasis on modality-specific evidence therefore risks creating an artificial distinction between approaches, and may inadvertently exclude or undervalue interventions that are integrative in nature. It

may also lead to commissioning decisions that prioritise fidelity to a model over responsiveness to need. For children with complex developmental trauma, this is unlikely to result in optimal outcomes.

This is why CASA believes policy must draw on a broad evidence framework, incorporating published research, clinical expertise, service evaluation, outcomes data, and the lived experience of children, young people, adults, parents and carers. Randomised controlled trials are an important component of evidence-based practice, but they are not the only valid form of evidence, particularly in complex, real-world therapeutic contexts where children rarely present with single, neat diagnoses.

Specialist capacity and workforce risk

Over the past decade, the Adoption and Special Guardianship Support Fund (ASGSF) has supported the development of a specialist sector with deep expertise in adopted and SGO children's needs. This may not have been the Fund's explicit purpose, but it has been one of its most important outcomes.

Specialist providers have developed clinical models, supervision structures, multidisciplinary teams, training pathways, outcome monitoring and practice knowledge specifically adapted to adoption and SGO contexts. This expertise has been built over time. It cannot be recreated quickly within Regional Adoption Agencies or local authorities without significant investment in workforce development, clinical supervision, therapeutic governance and specialist leadership.

There is a real risk that reducing access to specialist therapeutic support, or replacing it with lower-intensity provision, would destabilise this expertise. Skilled clinicians may leave the sector. Organisations that have developed specialist adoption and SGO services may become unsustainable. Children and families may then be left with support that is easier to commission but less able to meet need.

This is not simply a workforce concern; it is a safeguarding and outcomes concern. Inappropriate or insufficiently informed intervention can lead to disengagement, escalation, ruptures in trust and further distress for families. For children whose early experiences have already involved relational harm, poorly matched or poorly delivered support can reinforce the very difficulties services are intended to address.

The consultation places emphasis on multidisciplinary teams. CASA supports multidisciplinary working, but "multidisciplinary" must mean more than several professionals being present. Effective multidisciplinary provision for adopted and SGO children requires genuine integration of psychological, therapeutic, educational and social care expertise, with specific experience of adoption, special guardianship, developmental trauma and complex family systems.

Why government should invest

This is an area where government has a real opportunity to make a long-term difference. Adopted and SGO children are children for whom the state has already played a decisive role: through care proceedings, permanence planning, adoption, special guardianship and post-order support. There is therefore a clear public responsibility to ensure that permanence is not treated as the end of the story.

Investing in robust, specialist adoption and SGO support is not about protecting provider income. It is about protecting children's futures, supporting parents and carers to sustain families, and reducing the likelihood that unmet need escalates into school exclusion, family breakdown, mental health crisis, or adult difficulties that could have been mitigated earlier.

Cost matters, and public money should be used responsibly. However, short-term cost reduction should not drive decisions about the type or level of support provided. Where intervention is insufficient, delayed or poorly matched, needs are more likely to intensify, with greater human and financial cost over time. Properly targeted specialist support is therefore not a luxury; it is a necessary investment in recovery, stability and long-term wellbeing.

Summary

Adopted and SGO children should not be defined by adversity, but neither should their needs be minimised. Many have experienced profound and cumulative developmental adversity and require support that is specialist, relational and formulation-led.

The most effective support recognises the child within their family, school, community and lifelong identity context. It supports parents and carers as central to recovery. It draws on a broad evidence base, including research evidence, clinical expertise, practice-based evidence and lived experience. It values and preserves the specialist capacity that has developed through the ASGSF, rather than inadvertently replacing it with lower-level support that cannot meet the same needs.

CASA has concerns regarding the framing of “over-medicalisation” within this context. For adopted and SGO children, the predominant risk is not excessive clinical intervention, but the under-recognition and under-treatment of complex developmental, relational and psychological need. Where this occurs, children and families may face delays in accessing appropriate support, with needs escalating over time.

For government, the question is not simply how to reduce immediate expenditure, but how to invest wisely in a critical part of society: children and families where the right support can make a profound difference to healing, stability and future life chances. Early and lower-intensity support has an important role; however, it must sit alongside - not replace - access to specialist intervention where need is identified.

Proposal 1: Develop a baseline offer of parenting support and training at the point of adoption and kinship care

Response: Strongly disagree

CASA strongly disagrees with this proposal as currently framed, as it risks overemphasising parenting support as the primary mechanism for meeting the needs of adopted and special guardianship (SGO) children. While strengthening support for parents and carers is essential, this alone is unlikely to address the level and complexity of need described in Section 1.

Adopted children experience significantly higher rates of social, emotional and mental health difficulties than their peers, alongside elevated levels of attachment and neurodevelopmental need (Purington, Goodall and Lynch, 2023; Adoption UK, 2025). These needs are frequently rooted in early adversity affecting brain development, stress regulation and relational functioning (Bowlby, 1988; Siegel, 2012), and therefore require interventions that are relational, specialist and developmentally informed.

CASA recognises that supporting parents and carers is critical. Evidence suggests that caregiver understanding, attunement and relational capacity are key components of effective intervention (Burch et al., 2023; Wingfield and Gurney-Smith, 2019). However, parenting support alone cannot address the underlying developmental and relational impacts of early trauma, and is therefore insufficient as a primary response for many children.

While the proposal does not explicitly position parenting support as a gateway, there is a clear risk that, in practice, it may be implemented as a default or first-line intervention. In systems where lower-intensity support is prioritised, this can lead to delays in accessing specialist therapeutic support, particularly where thresholds for escalation are unclear. Evidence on adoption disruption highlights the consequences of unmet or insufficiently addressed need (Selwyn, Wijedasa and Meakings, 2014).

CASA’s position is that parenting support should form part of a tiered, needs-led system, rather than being

positioned as the primary response. Families should be able to access support that is proportionate to need, including timely access to specialist therapeutic intervention where indicated by formulation.

A more effective approach would therefore integrate parenting support within a broader system of care, ensuring that children and families receive the right support at the right time, for the right reason.

Proposal 2: Strengthen peer and community support for adopted children and parents

Response: Strongly disagree

CASA strongly disagrees with this proposal as currently framed, as it risks overstating the role of peer support in meeting the needs of adoptive and special guardianship (SGO) families, without sufficient recognition of the level of specialist intervention required for many children.

CASA recognises that peer support can play a valuable role in reducing isolation and providing emotional support for parents and carers. However, it cannot be understood as a therapeutic intervention. It does not provide the level of assessment, formulation or clinical expertise required to address the developmental and relational impacts of early adversity described in Section 1 (Purrrington, Goodall and Lynch, 2023).

Adoptive parents, kinship carers and special guardians are often highly skilled, resilient and deeply committed. Many are already required to navigate complex systems, coordinate support and advocate for their children in order to access appropriate provision. This reflects both their strengths and gaps within the current system. Without appropriate professional support, there is a risk that strengthening peer support may inadvertently increase the expectation that parents manage complex needs without sufficient clinical input. Peer support should reduce isolation, not transfer responsibility for navigating complex clinical and systemic needs onto families themselves.

There are also important considerations in relation to safety and effectiveness. Peer support is not typically delivered within a framework of clinical supervision or governance. In the context of developmental trauma, where relational responses are critical, evidence highlights the importance of structured, relationally informed and professionally supported intervention (Bowlby, 1988; Siegel, 2012). Without this, there is a risk that well-intentioned advice may not align with the specific child's needs or may inadvertently reinforce difficulties.

While the proposal does not explicitly position peer support as a substitute for specialist services, there is a risk that, in practice, it may be used to fill gaps in provision where access to therapeutic support is limited. This is particularly relevant for SGO families, who already experience more variable access to specialist services.

CASA's position is that peer support should form part of a comprehensive, tiered and professionally supported system, complementing - but not replacing - access to specialist therapeutic intervention.

Proposal 3: Provide proactive support for adopted and kinship children at key life stages

Response: Disagree

CASA disagrees with this proposal as currently framed, as it risks oversimplifying the nature of need for adopted and special guardianship (SGO) children by suggesting that support can be effectively structured around predefined life stages. While key transitions are important, this approach does not fully reflect the

ongoing, cumulative and highly individual nature of need described in Section 1.

CASA recognises that transitions such as starting school, moving to secondary education, adolescence and early adulthood can present particular challenges, and it is appropriate that services are responsive to these periods. However, evidence indicates that the impact of early adversity is not static, but can emerge or re-emerge across development as children encounter new environments, relationships and developmental tasks (Siegel, 2012).

Crucially, these needs do not present in a uniform or predictable way. Children's experiences, histories and developmental trajectories vary significantly, and therefore require individualised, formulation-led responses, rather than approaches based on standardised timing or delivery models.

In this context, there is a risk that support offered at key life stages may be overly standardised, for example through toolkits, online resources or short-term workshops. While these approaches may have value in increasing awareness or providing general guidance, there is limited evidence regarding their effectiveness in addressing complex developmental and relational needs. As outlined in Section 1, these needs are often relational, developmental and cumulative in nature, and require flexible, specialist intervention tailored to the child and family (Purrrington, Goodall and Lynch, 2023).

A model which prioritises targeted support at predefined stages, without ensuring flexible access to appropriately skilled intervention, risks creating gaps in provision. It may also result in children and families receiving support that is not sufficiently matched to their needs, particularly where difficulties arise outside of expected transition points. Evidence highlights that where support is insufficient or poorly matched to need, families may experience escalating difficulties and increased pressure over time (Department for Education, 2014).

CASA's position is that support should be developmentally informed, flexible and formulation-led, rather than based on a one-size-fits-all model. Families should be able to access support when it is needed, based on assessed need, rather than timing alone.

It is also essential that support available at key life stages includes access to specialist therapeutic intervention, where required. For children with complex developmental trauma, transitions may amplify underlying difficulties, and effective support will often require more than general or targeted provision.

A more effective approach would therefore combine responsiveness to key developmental stages with a flexible, needs-led system, ensuring that children and families can access the right level of support at any point, rather than only at predetermined times.

Proposal 4: Enhance plans to better meet children's needs, setting clear expectations for families and services via Practice Guides

Response: Strongly disagree

CASA strongly disagrees with this proposal as currently framed, as it risks creating the appearance of clarity and consistency through structured planning, without ensuring that plans are grounded in sufficiently specialist, formulation-led understanding of children's needs. While CASA supports clearer and more consistent planning, there is limited evidence that the introduction of practice guides or enhanced planning processes alone leads to improved outcomes for children.

CASA recognises the importance of clear, transparent and regularly reviewed plans. Families should have a clear understanding of what support is available, how it can be accessed, and what different services are responsible for delivering. However, clarity of process does not in itself ensure that support is appropriate,

effective or sufficient.

Children affected by developmental trauma require integrated, formulation-led intervention, delivered by practitioners with specific expertise in attachment, trauma and neurodevelopment. NICE guidance emphasises the importance of attachment-informed, relationship-based assessment and intervention for children who have experienced early adversity (NICE, 2015).

There is a risk that practice guides and structured planning processes may prioritise consistency and transparency over depth of understanding. Plans may clearly outline services, eligibility criteria and professional responsibilities, but without specialist assessment and formulation, they may not accurately reflect the complexity of children's needs or the type of support required. In such cases, clarity does not equate to effectiveness.

There is also a well-recognised gap between what is set out in plans and what is actually delivered in practice. Without clear expectations regarding the provision of support identified through assessment, there is a risk that plans describe an offer that is not consistently realised for families. This raises important questions about whether support is truly needs-led, or constrained by local resource and funding pressures.

The proposal also places emphasis on coordinated input across services. CASA supports coordinated and multidisciplinary working. However, effective coordination is not simply the documentation of multiple professionals within a plan. It requires:

- integrated, clinically informed intervention
- coordination around a shared formulation
- delivery within a framework of clear clinical leadership

Without this, there is a risk that services operate in parallel rather than as an integrated system, resulting in fragmented support that does not adequately address the child's needs.

There are also significant workforce considerations. Specialist expertise in this area has developed over time, supported in part by the Adoption and Special Guardianship Support Fund (ASGSF). This includes clinical skill, supervision structures and service-level knowledge.

The proposal does not address how this expertise will be maintained or replicated within standardised planning frameworks or practice guides. Specialist therapeutic skills cannot be rapidly developed without significant investment in training, supervision and experience (NICE, 2015). There is therefore a risk that plans may be developed without sufficient specialist input, leading to support that is poorly matched to need.

In the context of developmental trauma, poorly matched or insufficiently informed intervention may contribute to escalation or reinforcement of difficulties (Department for Education, 2014).

The proposal also assumes that greater involvement from existing services, including the NHS and schools, will improve outcomes. While this is a positive ambition, evidence suggests that many adoptive families currently experience significant challenges in accessing appropriate support within these systems. Adoption UK data indicates that only 29% of 16–25-year-old adoptees who had accessed CAMHS support felt it made a positive difference, and around half of adoptive parents do not believe that their child's teachers have a good understanding of adopted children's needs (Adoption UK, 2025). This raises important questions about whether improved planning alone is sufficient to address the current gaps in expertise and capacity.

The proposal also does not sufficiently account for families who reach crisis point. While structured planning and early support are important, adopted and SGO families may experience sudden escalation in need driven by developmental transitions, external stressors or cumulative pressures. In these situations, timely access to specialist, intensive support is critical. Planning frameworks must therefore sit alongside clear

pathways for crisis intervention, rather than assuming that needs can be fully anticipated or managed through planned support alone.

CASA's position is that planning processes should be formulation-led, clinically informed and sufficiently flexible to respond to the individuality and changing needs of each child and family. Practice guidance may support consistency, but it must not replace the depth of specialist understanding required to ensure that plans are meaningful, appropriate and effective.

A more effective approach would build on existing specialist provision, ensuring that planning and coordination processes strengthen, rather than replace, the expertise that has been developed across the sector. Integrative, wrap-around models provide examples of how coordinated support can be delivered in practice, combining therapeutic intervention with caregiver support, school liaison and multidisciplinary formulation (Vaughan, McCullough and Burnell, 2016).

Proposal 5: Standardise needs assessments for adopted and eligible kinship children. Commission social care, health, and education support based on their needs

Response: Strongly disagree

CASA strongly disagrees with this proposal as currently framed. While we support the aim of improving the quality and consistency of needs assessments, it is not clear from the proposal whether this refers to social care-led assessments, clinical assessments of therapeutic need, or a fully integrated model combining both. This distinction is critical, as each serves a different function and requires different levels of expertise.

As outlined, the proposal appears to move towards a standardised, multidisciplinary assessment model linked to commissioning pathways. While greater consistency and integration are important, there is a significant risk that this approach may not adequately capture the complexity and individuality of need among adopted and special guardianship (SGO) children.

Children within this cohort frequently present with multiple, overlapping needs, including emotional, relational and neurodevelopmental difficulties (Purrington, Goodall and Lynch, 2023). As outlined in Section 1, these needs are shaped by early adversity and may evolve across development. Effective assessment therefore requires skilled, formulation-led approaches, rather than reliance on standardised frameworks alone.

In particular, there is a risk that the move towards standardisation may reduce reliance on specialist, formulation-led assessment of therapeutic need. For children who have experienced early adversity, understanding need requires more than the application of structured tools or frameworks. It requires clinical expertise, developmental understanding, and the ability to integrate information across relational, psychological and neurodevelopmental domains.

NICE guidance highlights the importance of comprehensive, relationship-based assessment for children who have experienced early adversity (NICE, 2015). However, in practice this requires skilled clinical judgement and formulation, rather than reliance on standardised approaches alone.

While the proposal emphasises “evidence-based” assessment, there is a risk that this is interpreted narrowly, privileging standardised or measurable approaches over professional judgement and clinical expertise. This may result in needs being underestimated, misunderstood, or insufficiently explored, particularly where presentations are complex or do not align neatly with predefined categories.

CASA supports the involvement of multidisciplinary teams in assessment. However, as outlined in Proposal 4, multidisciplinary working must be genuinely integrated and clinically led, rather than consisting of parallel

professional inputs. Effective assessment should result in a shared, coherent formulation that informs intervention, rather than a collection of separate perspectives.

The proposal also links standardised assessment to commissioning decisions. While alignment between assessment and provision is important, there is a risk that rigid pathways may develop, where children are directed into predefined interventions based on assessment categories, rather than receiving support tailored to their individual needs. This may limit flexibility and reduce the ability to respond appropriately to complex or evolving presentations.

There are also important considerations in relation to equity. SGO families in particular often experience more variable access to specialist assessment and support. A system which relies on standardised processes may inadvertently reinforce these inequalities, particularly where nuanced or less visible needs are not fully captured.

CASA's position is that assessment processes should be evidence-informed, formulation-led and sufficiently flexible to reflect the individuality of each child and family. Standardisation may support consistency, but it must not replace the depth of understanding required to identify need accurately.

A more effective approach would retain flexibility for specialist, formulation-led assessment of therapeutic need, rather than introducing standardised models which may constrain professional judgement and limit the ability to respond appropriately to complex and evolving needs.

Proposal 6: Require clinical adoption support therapies to be compliant with NHS evidence standards. Ensure all interventions are well evidenced and assessed.

Response: Strongly disagree

CASA strongly disagrees with this proposal as currently framed, as it risks applying a narrow definition of "evidence" that does not reflect the complexity of therapeutic work with adopted and special guardianship (SGO) children. The issue is not whether evidence matters, but what forms of evidence are appropriate for complex, relational and developmental interventions. This approach risks excluding a significant proportion of currently commissioned specialist adoption support interventions, many of which are widely used, clinically informed, and valued by families, but do not yet meet narrow NHS evidence criteria.

CASA fully supports the principle that interventions should be evidence-informed and subject to appropriate scrutiny. However, the proposal appears to prioritise NHS-aligned evidence standards, which are typically based on randomised controlled trials (RCTs) and manualised interventions. While these approaches are valuable in some contexts, they do not fully capture the nature of therapeutic work required for children who have experienced early adversity.

As outlined in Section 1, adopted and SGO children often present with complex, overlapping and developmentally embedded needs. Interventions in this context are typically relational, flexible and tailored to the individual child and family. This type of work does not always lend itself to standardised models or large-scale RCT methodologies, and is not always readily or appropriately captured within standardised research designs, particularly where ethical and practical constraints limit the use of controlled study designs.

There is increasing recognition within health and psychological research that over-reliance on hierarchies of evidence privileging randomised controlled trials may not be appropriate for complex, relational interventions, particularly in child and family contexts (Greenhalgh et al., 2014; Kazdin, 2008).

There is also a growing body of research supporting the effectiveness of relational, attachment-informed and trauma-focused approaches, including practice-based and longitudinal evidence (Burch et al., 2023; Wingfield and Gurney-Smith, 2019). In addition, systematic reviews highlight the importance of family-based and integrative interventions for adoptive families, even where the evidence base is still developing (Purrrington, Goodall and Lynch, 2023).

Clinical expertise is a core component of evidence-based practice, alongside research evidence and the needs of the individual child and family. In other areas of healthcare, the professional judgement of highly trained clinicians is recognised as essential in determining appropriate intervention. This principle should apply equally within adoption and trauma-informed therapeutic work, where specialist knowledge and experience are critical to effective practice.

NICE guidance provides an important framework for understanding attachment and trauma-informed intervention (NICE, 2015). However, it does not encompass the full range of specialist approaches currently used in adoption support, nor does it fully reflect the complexity of real-world clinical practice in this area.

There is therefore a significant risk that requiring therapies to meet NHS evidence standards may inadvertently exclude effective, specialist interventions that are widely used and valued within the sector. This may reduce the range of support available to children and families, and limit the ability to respond flexibly to individual need.

CASA is also concerned that such an approach may discourage innovation and the continued development of practice-based evidence. Many specialist services have developed their approaches over time in response to the needs of adopted and SGO children, supported by clinical expertise, supervision and ongoing evaluation.

CASA's position is that therapeutic provision should be evidence-informed, but not restricted to a narrow definition of evidence. A broader understanding is required, which includes:

- practice-based evidence
- longitudinal and service-level outcome data
- clinical expertise and professional judgement
- emerging research in complex trauma and attachment

A more effective approach would ensure that evidence standards are sufficiently flexible to accommodate the complexity of this field, while maintaining appropriate levels of quality assurance and accountability.

Proposal 7: Devolve Adoption and Special Guardianship Support Fund funding and responsibility to regional and/or local decision makers

Response: Strongly disagree

CASA strongly disagrees with this proposal as currently framed, as it risks introducing greater variability and inconsistency in access to support for adopted and special guardianship (SGO) children and their families. While CASA recognises the intention to improve strategic commissioning and local responsiveness, these benefits must be carefully balanced against the risks of fragmentation and inequity.

The current Adoption and Special Guardianship Support Fund (ASGSF) provides a nationally administered mechanism for accessing therapeutic support which, despite its limitations, has enabled a degree of consistency in access to specialist provision. Moving towards regional commissioning arrangements introduces a significant risk of fragmentation, with potential variation in thresholds, decision-making processes and availability of services across different areas.

As outlined in Section 1, adopted and SGO children often present with complex, developmental and relational needs which require timely access to specialist intervention. Evidence indicates that where support is insufficient, delayed or poorly matched to need, families may experience escalating difficulties and increased risk of breakdown (Department for Education, 2014). A system in which commissioning decisions are made at a regional level may therefore increase the likelihood of inconsistent or delayed access to appropriate support, resulting in a postcode lottery for children and families.

There is also a risk that regional commissioning arrangements may reduce access to specialist therapeutic provision. Where commissioning is locally determined, there may be a tendency to prioritise existing or generalist services, rather than ensuring access to practitioners with specific expertise in trauma, attachment and neurodevelopment. NICE guidance highlights the importance of specialist, relationship-based intervention for children who have experienced early adversity (NICE, 2015). Specialist knowledge and clinical expertise in this field has developed over time and cannot be rapidly replicated without substantial investment in training, supervision and experience.

In addition, regional commissioning models may reduce flexibility in how support is accessed and delivered. Children and families require support that is responsive to individual need and able to adapt over time. More locally determined commissioning arrangements may constrain this flexibility, particularly where services are pre-defined or budgets are limited.

There are also important considerations in relation to equity. National data highlights variation in access to post-adoption support across different regions, with families reporting inconsistent availability of services (Adoption UK, 2025). SGO families already experience more variable access to specialist support than adoptive families. Increased localisation of commissioning decisions risks further widening these inequalities. This is particularly important because eligible kinship families may already experience less predictable routes into assessment and support than adoptive families.

If commissioning arrangements are devolved to a regional level, it is essential that funding is appropriately protected and allocated based on need. In particular, funding for adoption and special guardianship support must be ring-fenced, with clear expectations that it is used to provide access to specialist therapeutic support, rather than being absorbed into broader or generic service provision. Funding allocations should also reflect local population need, recognising that levels of demand and complexity may vary significantly across different regions. Without such safeguards, there is a significant risk that children and families in higher-need areas may experience reduced access to appropriate support.

CASA's position is that commissioning arrangements must prioritise equity, consistency and access to specialist expertise, ensuring that all children and families are able to access appropriate therapeutic support regardless of location. A move away from nationally administered funding mechanisms should not result in reduced access to specialist provision or increased variability in support.

A more effective approach would retain the strengths of national consistency while improving coordination and quality, ensuring that children and families receive the right support based on need, rather than local availability or commissioning structures.

Proposal 8: Improving value for money to ensure every pound spent is used efficiently, sustainably and on families. Do you agree with this proposal?

Response: Strongly disagree

CASA strongly disagrees with this proposal as currently framed. While value for money is an important consideration in the use of public funds, there is a significant risk that an approach centred primarily on cost-

efficiency may undermine the quality, effectiveness and appropriateness of therapeutic support for adopted and special guardianship (SGO) children and their families.

CASA supports transparency and accountability in the use of public funds. However, these must be balanced with an understanding of the complexity of need and the conditions required for effective intervention.

The value of therapeutic intervention cannot be determined solely by cost. It is intrinsically linked to the quality and appropriateness of the intervention, the expertise of the practitioner, and the availability of appropriate supervision and clinical governance.

As outlined in Section 1, children affected by early adversity often present with complex, overlapping and developmentally embedded needs. Effective intervention in this context is relational, formulation-led and tailored to the individual child and family. It does not lend itself to standardisation or comparison through simple unit cost metrics.

A commissioning approach that prioritises lower-cost provision risks reducing access to specialist expertise and may result in interventions that are insufficiently matched to need. This, in turn, may lead to poorer outcomes and reduced overall efficiency.

Short-term cost comparisons do not adequately capture the long-term impact of therapeutic intervention. Where needs are not effectively addressed, there is an increased likelihood of escalation, including school exclusion, placement instability, mental health crisis and involvement with other high-cost services.

Conversely, timely access to high-quality, specialist intervention can support stability, improve functioning and reduce the need for further intervention over time. In this context, higher upfront costs may represent better long-term value.

An approach to value for money which does not take account of these longer-term outcomes risks being both clinically and economically unsound.

Children within this cohort frequently require coordinated, multidisciplinary input that extends beyond a single intervention model. As set out in Section 1, effective support often includes therapeutic work with the child, direct work with caregivers, and engagement with the wider network, including education and social care.

These elements are central to achieving meaningful outcomes and should not be viewed as optional or excessive components of care. Cost benchmarking approaches that do not adequately reflect the complexity of this work risk incentivising simplified or reduced models of provision that are less effective.

There is a risk that measures intended to improve efficiency may inadvertently reduce the effectiveness of intervention. For example, limiting caregiver involvement or reducing the intensity of intervention may undermine progress where relational work is central to change.

Similarly, delivery models that do not adequately consider the conditions required for effective therapeutic work may result in reduced engagement or limited outcomes. Where this occurs, apparent short-term savings may lead to inefficient use of resources overall.

- Commissioning decisions should be led by clinical effectiveness, quality and appropriateness of intervention
- Value for money should be assessed in relation to long-term outcomes, not solely short-term unit costs
- Benchmarking approaches should not constrain access to specialist or higher-intensity provision where required
- Investment in integrated, multidisciplinary support is essential to meeting complex need effectively

CASA supports the responsible and efficient use of public funds. However, a narrow focus on cost risks undermining the effectiveness of support and failing to meet the complex needs of adopted and SGO children and their families.

A sustainable approach to value for money must prioritise interventions that are clinically effective, appropriately delivered and responsive to individual need. This is not only essential for children and families, but also represents the most efficient use of resources over time

Submitted on behalf of the Consortium of Adoption Support Agencies (CASA), reflecting the views of contributing member organisations.



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