

The Mental Health of Looked-After Children

Bright Futures: Working with Vulnerable Young People

**A report commissioned by the Mental Health Foundation
based on research by Jo Richardson, Focus, Royal College of Psychiatrists**

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The Mental Health Foundation is very grateful to all those supporting the vulnerable young people’s project, in particular to the Paul Hamlyn Foundation.

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Executive summary

Introduction

Young people coming into the local authority care system will already have had trauma and difficulties over and above those experienced by most of their peers. Most will have suffered abuse or neglect, or experienced bereavement, disability or serious illness in one or both parents. Many are from disadvantaged backgrounds. Being looked after can involve major and sometimes traumatic upheaval. Some young people, especially if they have been moved from their own home, may find it hard to settle and may feel torn or even guilty at being removed from their family, however abusive or neglectful (although some may feel a sense of relief because of their changed circumstances).

Changes and a lack of permanence in the arrangements for many looked-after children are unsettling and can hamper effective work by professionals. The stigma of being looked after and the unhappiness that young people may feel – for example, because they have had to leave their family home – may inhibit their asking for help or wanting to use any facilities or services on offer. Social care staff often have difficulty in finding appropriate placements that meet basic emotional, physical and cultural needs of looked-after young people.

Research shows that more looked-after children have mental health problems than other young people, including severe and enduring mental illness. But their mental health needs are frequently unnoticed and unmet.

Background

In 2000, the Mental Health Foundation (MHF) established a project to explore the mental health needs of four key groups of young people at risk of developing mental health difficulties. These groups comprise young offenders, pupils with emotional and behavioural difficulties, looked-after children and homeless young people. This vulnerable young people project forms part of the Mental Health Foundation's continuing work on children and young people's mental health.

Research on current policy and practice with respect to the mental health needs of each group was commissioned by the Mental Health Foundation. The focus of the research was England but the issues and findings will be relevant to interested parties across the UK. Full reports have been prepared for each group and issued for consultation. A combined final report will be published in early 2003.

This report is based on research by the Royal College of Psychiatrists' research group, Focus, and looks at work that is addressing the mental health needs of looked-after children, who are a particularly vulnerable group. The report also presents areas of concern and proposals for change.

Methodology for the original Focus research

A literature search for this report was conducted in 2001 on the databases Psychinfo, Medline, Caredata (www.elsc.org.uk/bases_floor/caredata.htm), Chiddata, Embase and Cinahl for the years 1991 to 2001. (The databases are all available in most academic libraries. A version of Medline, PubMed, is available free online at www.ncbi.nlm.nih.gov/entrez/query.fcgi.)

The following government and voluntary sector internet sites were also searched: Department of Health (www.doh.gov.uk) and its Quality Protects (www.doh.gov.uk/qualityprotects) and Social Services Inspectorate sites (www.doh.gov.uk/scg/ssi.htm), Department of Education and Employment – now the Department for Education and Skills – (www.dfes.gov.uk), Joseph Rowntree Foundation (www.jrf.org.uk) NSPCC (www.nspcc.org.uk), National Children's Bureau (www.ncb.org.uk), Young Minds (www.youngminds.org.uk), Barnardo's (www.barnardos.co.uk), Who Cares? Trust (www.thewhocarestrust.org.uk), Research in Practice (www.rip.org.uk) and the Mental Health Foundation (www.mhf.org.uk).

Mental health needs and services

Research shows that looked-after children generally have greater mental health needs than other young people, including a significant proportion who have more than one condition and/or a serious psychiatric disorder (McCann *et al*, 1996). But their mental health problems are frequently unnoticed or ignored. There is a need for a system of early mental health assessment and intervention for looked-after children and young people, including those who go on to be adopted.

There are also considerable variations in services for this group. However, in recent years, the Government has attempted to address this issue by introducing initiatives aimed at bringing all services up to national standards.

Local authority staff are expected to work with their colleagues in the NHS to address the mental health problems of looked-after children in a climate of insufficient resources and, often, of inter-agency mistrust or confusion. But there are a number of local initiatives that aim to break down barriers and enhance joint working. Moreover, the forthcoming children's national service framework (NSF) should improve joint working by setting standards for children's health services across agencies.

Research also suggests that moving several times from placement to placement (whether it be in a residential or a foster home) is damaging. Stability of placement and education is crucial.

There are a number of factors that are hampering improvements to services:

Language and stigmatisation

A looked-after young person may feel 'labelled' and stigmatised by a mental health diagnosis, in addition to the stigma of being looked after. (Nonetheless, having their mental health problems recognised may provide a sense of relief for a looked-after child or adolescent, as they can then begin to understand their problems and seek help.)

Funding

Because services for looked-after children have been under-resourced in the past, even recent increases cannot alter the fact that a large investment is still required to bring about necessary major changes. The aim of this report is not to propose an additional sum but to point to changes that are needed, some of which will have significant resource implications.

It is important to remember that the costs of *not* improving the mental health of looked-after children can be significant, too, and not just in individual or social terms. The lifetime (up to age 28) cost of each individual who had conduct disorder at age 10, for example, is £100,000 more in services than those without conduct disorder (Knapp *et al*, 1999).

Joint working

Currently all organisations in different sectors have to reach their own targets. More needs to be done to introduce common targets – although the children's NSF (England) should make a significant difference by setting standards that cross organisational boundaries. Difficulties also arise over which agency pays for what, over lines of accountability and because of poor communication between agencies. All of these areas need to be clarified and improved upon.

Foster carers

It is not always possible to put young people, especially those who need to be removed from their family home in an emergency, in entirely appropriate placements. This is exacerbated by a shortage of foster carers, particularly for certain groups, such as ethnic minorities. Moreover, the children, who may have suffered abuse, neglect, bereavement or parental illness, may act in difficult, disruptive or challenging ways that foster carers find hard to deal with. More needs to be done locally and nationally to recruit foster carers and then train and support them.

Recruiting and retaining social workers

There are huge problems in recruiting and retaining social workers, especially in London and the south of England, and staff turnover is high. This can lead to potentially dangerous gaps in services, as well as instability and inconsistency, for children and for foster carers.

Making sure that policy informs practice

Managers need to make sure that frontline staff are kept up to date about national and local policies and receive proper notice of or training on, for example, government guidance, good practice and local authority management action plans. Staff need to know what they should be attempting to achieve and by what means.

Advocacy

A lack of formal advocacy or the absence of someone constant to confide in, perhaps because of multiple placements and high staff turnover, all militate against looked-after children getting adequate support.

Child and adolescent mental health services (CAMHS)

Health problems – mental and physical – are easily missed, not least because some children are moved several times while being looked after. Research suggests that looked-after young people, who have suffered abuse or neglect, bereavement or parental illness, have greater mental health problems, including significant psychiatric disorders, than the general population.

Yet, the hurdles for getting CAMHS are significant. Assuming that a young person has someone to turn to or someone spots that they are having difficulties, they usually still have to see a sympathetic GP before they can be referred to specialist services. Even if they then get onto a CAMHS waiting list, they may well have moved to a different foster or residential placement, or even out of local authority care, by the time their appointment comes up. Moreover, a shortage of key staff further limits young people's chances of getting appropriate help.

Summary of recommendations

- There is a need for a system of early mental health assessment and intervention for looked-after children and young people, including those who go on to be adopted.
- Long-term stability in placements and schooling must be viewed as a high priority.
- There is a need for more research on this population, especially in the following areas:
 - the prevalence of general and specific psychiatric disturbances and the use of mental health services and long-term outcomes, including UK-wide and longitudinal studies
 - different needs and problems of girls and of boys
 - specific needs and problems of children from minority ethnic groups and different faith groups
 - the value of early intervention and outcomes of different treatments and therapeutic approaches
 - what protects some looked-after children from developing mental health problems.
- Common physical and mental health problems are often not identified nor adequately managed. The following need to take place:
 - forthcoming government guidance for England on the health of looked-after children (following the consultation paper, *Promoting Health in Looked-after Children*) must be integrated into practice straight away
 - children must be registered with a GP within 24 hours of becoming looked after; their health care records must follow them promptly

- uptake and delivery of annual medical assessments must be improved
 - a comprehensive central CAMHS database should be set up as a matter of urgency, so that it is clear what services are available and where. This needs to be widely accessible and kept up to date
 - CAMHS must be reviewed, as they have been in Scotland, so that local services become more needs led
 - social services should have access to designated clinicians.
- Services should be delivered in a more sensitive, age-appropriate way that promotes choice.
 - More needs to be done locally and nationally to recruit foster carers. Foster carers need training in and support for dealing with mental health problems and should also be offered regular respite care.
 - Staff in all agencies working with looked-after children need specialist mental health training.
 - Mental health services should offer regular advice and consultation sessions locally to interested parties.
 - Councillors and senior managers in all services must ensure that staff at all levels are made aware of and act on policy changes.
 - Despite great improvements, joint working needs to be better. Barriers between health and social services must be addressed as a matter of urgency and social services and education services need to work together to enable young people to remain in education. Schools should have a designated link teacher; personal education plans should include mental health difficulties. New partnerships and improvements are also needed for children with complex and multiple needs, such as disabled looked-after children with mental health problems.

Preface

The Mental Health Foundation is a leading UK mental health and learning disability charity, focusing on research and policy and practice development. The Foundation's Bright Futures programme was established in March 1997 with the launch of a major inquiry into the mental health of children and young people in the UK. The report of the inquiry, with wide-ranging recommendations for change, was published in 1999. The report was well received. Feedback to the Foundation shows that it has influenced debate and the development of policies and practice relating to the mental health of children and young people.

The Bright Futures inquiry and report were, however, only the first phase of work for the Foundation in the area of children and young people's mental health. They have provided the catalyst for the Foundation's work in this important area in a number of ways. The second phase of the programme involves a number of projects in key areas identified in the Bright Futures report, including:

- promoting mental health in schools
- early intervention for children and young people at risk of developing mental health problems
- improving support for young people in crisis
- focusing on the mental health needs of vulnerable young people.

What is the Bright Futures vulnerable young people's project?

In 2001, the Mental Health Foundation secured funding from the Paul Hamlyn Trust to review the mental health needs of four particularly vulnerable groups of young people:

- looked-after children
- young offenders
- homeless young people
- young people with emotional and behavioural difficulties.

The aim of the work is to identify ways in which the mental health of vulnerable young people can be protected and enhanced and also ways in which those experiencing mental health problems can be better supported. The geographical focus of the project has been England, but many of the issues raised are relevant across the UK.

The first phase involved reviewing both the mental health needs of each group and the extent to which current policy and practice in England addressed these needs. This was achieved by:

- commissioning four papers from experts
- calling for evidence from policy makers and practitioners
- consultation with service users.

Based on the above, the Foundation has published four discussion papers, which were sent out for consultation.

The results of the consultation process will inform an overview report on the mental health needs of vulnerable young people in the UK, which will be launched at a conference in spring 2003. This final report will include recommendations for change, which will be disseminated to key policy makers and practitioners across the UK. The Foundation also intends to campaign to have the recommendations implemented in order to improve the mental health of vulnerable young people.

Maddy Halliday

Director Scotland and UK Development

Mental Health Foundation

1 Introduction

Focus and scope of the report

The *Bright Futures* report (MHF, 1999) highlights several groups of young people, for whom there are specific mental health concerns. One such group is looked-after children. This report aims to examine research and policy relating to the mental health needs of this group in England, look at whether and how these needs are being met and provide messages for improving policy and services. While this report has an English focus, it should be of interest across the UK.

This report has been consulted upon. The results of the consultation will be included in a forthcoming overview report covering all four groups of vulnerable young people (those with emotional or behavioural difficulties, those who are looked after or homeless, and young offenders).

Definitions

Looked-after children

'Looked after' is a term introduced by the Children Act 1989 in England and Wales and Children (Scotland) Act 1995 to cover children in the care of local authority social services departments, either voluntarily accommodated or compulsorily in care because of a court order. It includes young people in foster or residential homes and those still with their own parents or kin but subject to care orders.

Mental health

The terms 'mental health' and 'mental health problems' have been used throughout this report to cover the range of types of problems that children may experience. The usage follows Mental Health Foundation definitions, which state that children who are mentally healthy have the ability to:

- develop psychologically, emotionally, creatively, intellectually and spiritually
- initiate, develop and sustain mutually satisfying personal relationships
- use and enjoy solitude
- become aware of others and empathise with them
- play and learn
- develop a sense of right and wrong
- face problems and setbacks and learn from them.

(MHF, 1999, p6).

Mental health problems in children include emotional, conduct, depressive, hyper-kinetic, developmental, eating, habit, somatic and psychotic disorders and post-traumatic syndrome. They may be mild and transitory or have serious, longer lasting effects (MHF, 1999, p6).

Rationale

Looked-after children are a group of particularly vulnerable young people whose mental health needs are known to be greater than those of the general population (Utting *et al*, 1997) and whose problems often are not diagnosed and remain untreated (McCann *et al*, 1996). Services for these young people are also problematic as they can be a mobile population with complex needs.

In order to tackle these issues, a substantial proportion of recent central and local government funding has been allocated to the development of services for looked-after children in England. The national priorities guidance for 1999/2000 (Department of Health, 1998a), issued to the NHS and to social services authorities, set targets for building up core child and adolescent psychiatric services. The Quality Protects programme (Department of Health, 1998b) has made resources available for initiatives for these children, which can include the development of mental health services. Joint working between health and local authorities is now mandatory and many are now pooling budgets.

Research methodology

A literature search for this report was conducted in 2001 on the databases Psychinfo, Medline, Caredata (www.elsc.org.uk/bases_floor/caredata.htm), Chiddata, Embase and Cinahl for the years 1991 to 2001. (The databases are all available in most academic libraries. A version of Medline, PubMed, is available free online at www.ncbi.nlm.nih.gov/entrez/query.fcgi.)

The following government and voluntary sector internet sites were also searched: Department of Health (www.doh.gov.uk) and its Quality Protects (www.doh.gov.uk/qualityprotects) and Social Services Inspectorate sites (www.doh.gov.uk/scg/ssi.htm), Department of Education and Employment – now the Department for Education and Skills – (www.dfes.gov.uk), Joseph Rowntree Foundation (www.jrf.org.uk) NSPCC (www.nspcc.org.uk), National Children's Bureau (www.ncb.org.uk), Young Minds (www.youngminds.org.uk), Barnardo's (www.barnardos.co.uk), Who Cares? Trust (www.thewhocarestrust.org.uk), Research in Practice (www.rip.org.uk) and the Mental Health Foundation (www.mhf.org.uk).

This report presents the findings from individual research projects identified through the above search. The methodological quality of individual studies has not been assessed. The evidence base for child and adolescent mental health and social care is fairly poor for looked-after children, when compared with some other specialties. There are a number of factors that contribute to the relatively small evidence base for looked-after children. They are a fairly difficult group to study. Frequent changes of placement and in social work staff, poor school attendance and young people's mistrust of formal initiatives all present problems for researchers.

Evaluating mental health outcomes for looked-after children is a complex process, as their problems may arise from a combination of interrelated causes. It is very hard to disentangle the effects of family, social and environmental factors when trying to measure the impact of their having been looked after.

Of the research studies that are included in this paper, the sample sizes are relatively small. There have been no longitudinal studies on the mental health problems of this population. There have been, however, a few longitudinal studies examining the effect of adoption and fostering on the well-being of children and young people in the UK. These outcomes do not specifically relate to mental health problems, although they do provide important information.

2 Clarifying the issue

Demographics of looked-after children

According to the Department of Health, there were approximately 58,900 looked-after children in England at 31 March 2001, 1.4 per cent more than the previous year (58,100). This compares with an average annual increase of 4.4 per cent in the previous three years. By far the largest proportion (62 per cent) were being looked after because of abuse or neglect; the next largest category was family dysfunction (10 per cent), then family in acute stress (7 per cent), then parental illness or disability (6 per cent).

In 2000 and 2001, 55 per cent of looked-after children were boys. Of the looked-after children at 31 March 2001, 82 per cent were white, 7 per cent were black or black British, 6 per cent were of mixed ethnic origin, 2 per cent were Asian or Asian British, 3 per cent came from other ethnic groups.

The number and proportion of younger children has increased in recent years, although there is evidence to suggest that this pattern might be changing. At 31 March, 2001, 43 per cent of all looked-after children were under 10 years old, compared with 40 per cent in 1997. Between 31 March 2000 and 31 March 2001, the largest percentage increase was in babies under one, an increase of 5.2 per cent (Department of Health 2001b).

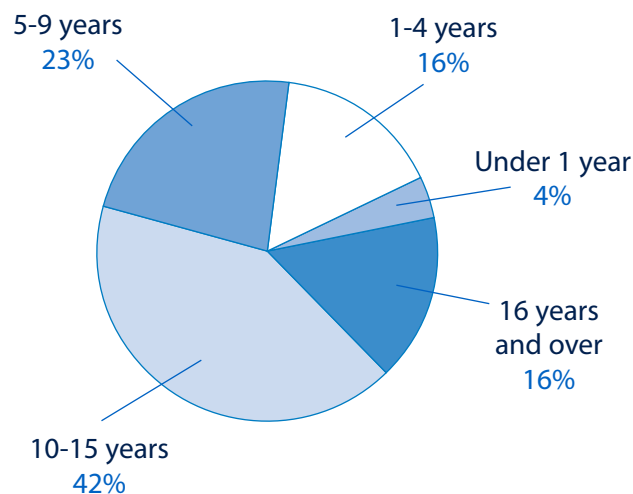


Figure 1. Children looked after at 31 March 2001, by age
(source: Department of Health, 2001b)

Figure 2 shows where children were placed at the end of March 2001: 38,400 were looked after in foster placements (up 500 on the previous year); 6,400 were looked after in children's homes (including secure units); 3,400 were placed for adoption, compared with 3,100 a year earlier; 6,900 were with their parents; 3,890 were in other placements (for example, supported hostels, residential schools or residential employment).

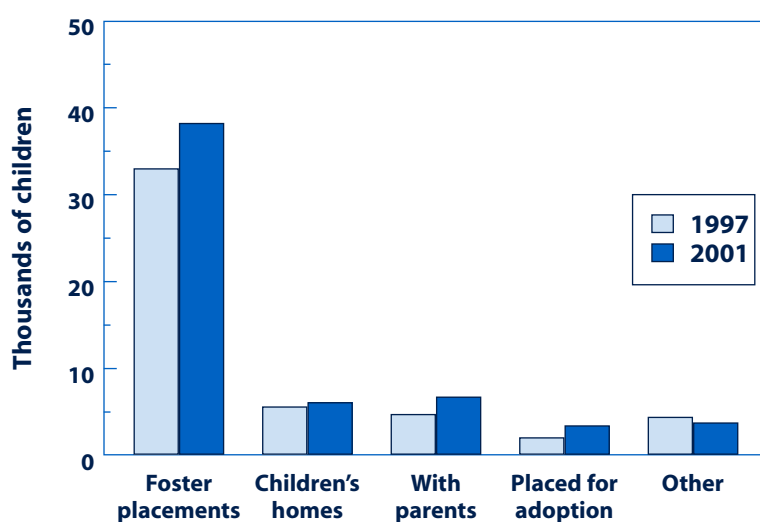


Figure 2. Children looked after at 31 March 1997 and 2001, by placement
(source: Department of Health, 2001b)

How long are children looked after?

The average length that a child was looked after continuously by a local council was 711 days during the year to the end of March 2001. This was up by 13 per cent on the previous year. This average increase is the result of a number of different factors:

- the increasing use of care orders and the decline in voluntary agreements (children under a care order tend to stay much longer than those voluntarily accommodated)
- the decline in numbers looked after for very short periods (that is, a fortnight or less)
- the increase in the number of children remaining in public care until their 18th birthday.

Around one third (32 per cent) of looked-after children left care after eight weeks or fewer during the year ending 31 March 2001; just over half (55 per cent) had been looked after for more than six months. However, around 4 per cent of the children who left care during that year had been looked after for a decade or more. (The figure of those in care for 10 years or more actually rose by 8 per cent over the year.) (Department of Health 2001b.)

While the circumstances of some children dictate that they need to remain looked after, social services and the Government acknowledge that some children and young people remain in the care system for too long. This can have an adverse affect on their mental health and well-being and is an area that requires further investigation and action.

Figure 3 shows the average duration as a looked-after child for those under 18 years in England, for the previous year (ending March 2000).

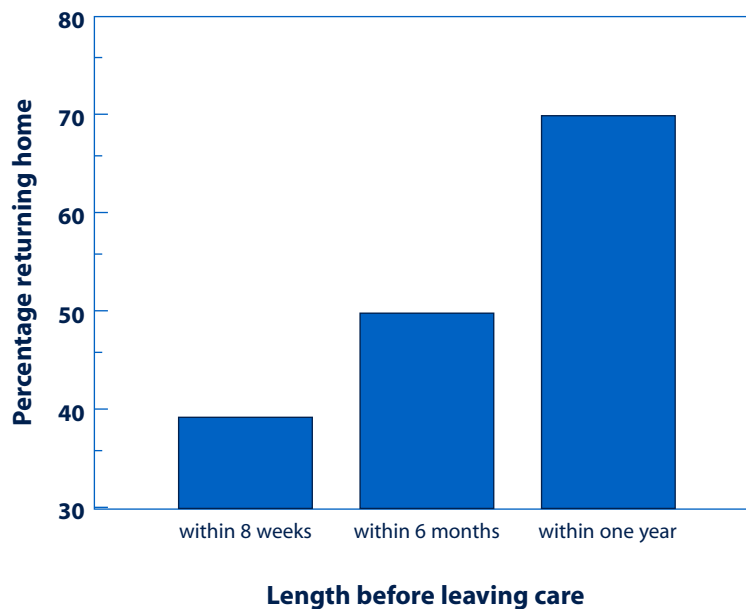


Figure 3. Length of time being looked after in 2000
(source: Department of Health 2000a)

The mental health of looked-after children

“Looked-after children, especially those in residential care, are identified as a group whose mental health needs are known to be greater than those of the general population of the same age” (Utting *et al*, 1997). The first study by McCann *et al* (1996) examined the prevalence and types of psychiatric disorder of all the adolescents aged between 13 and 17 years who were looked after by Oxfordshire council. These adolescents had been looked after for an average of 2.9 years. Figure 4 shows the weighted prevalence rate of psychiatric disorder for this group compared with a control sample.

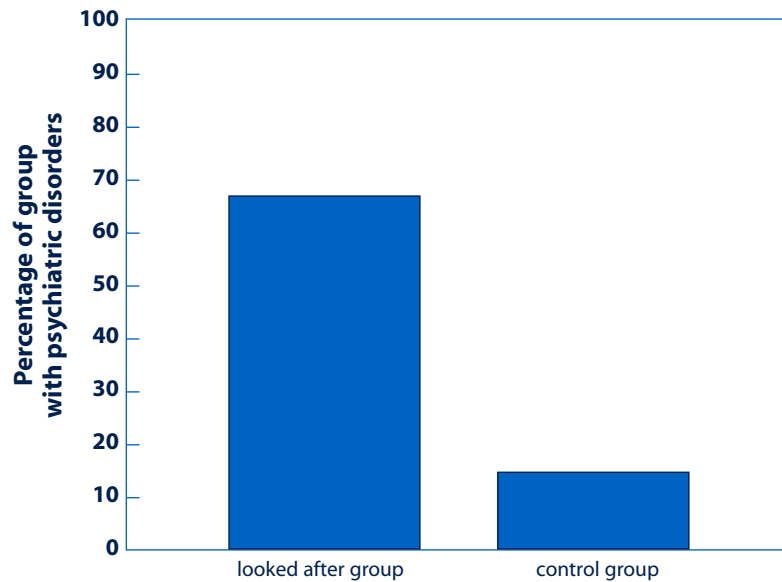


Figure 4. Psychiatric prevalence in looked-after adolescents aged 13 to 17 years, compared with control group (source: McCann *et al*, 1996)

The most common diagnosis among the adolescents was conduct disorder (28 per cent), followed by overanxious disorder (26 per cent). Twenty-three per cent suffered from major depressive disorder, compared with 4 per cent of controls; 8 per cent were diagnosed as having unspecified functional psychosis. The authors of this study note that significant numbers of these young people had multiple difficulties, reflecting the complexities of their problems. A significant number were also suffering from severe, potentially treatable disorders that had gone undetected.

Dimigen *et al* (1999) sought to gain information about the mental health of some children at the time they entered local authority care. They looked at 89 children attending for a health assessment within six weeks of becoming looked after during the study period. Seventy completed questionnaires were returned by the carers or staff members accompanying each child, whose average age was 9.6 years. Twenty-six of these children were in residential units and 44 were in foster care. Figure 5 shows the number of children being looked after by the local authority and the rate of severe conduct disorder among them. Figure 6 shows other psychiatric disorders experienced by these children.

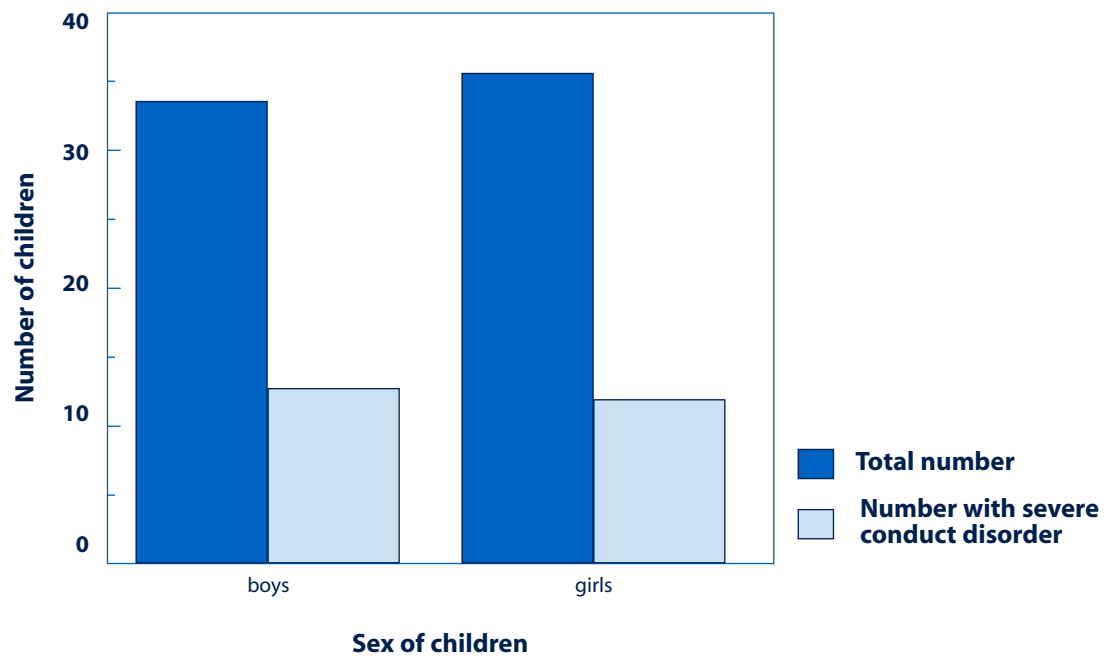


Figure 5. Number of children entering the care system with severe conduct disorder (source: Dimigen *et al*, 1999)

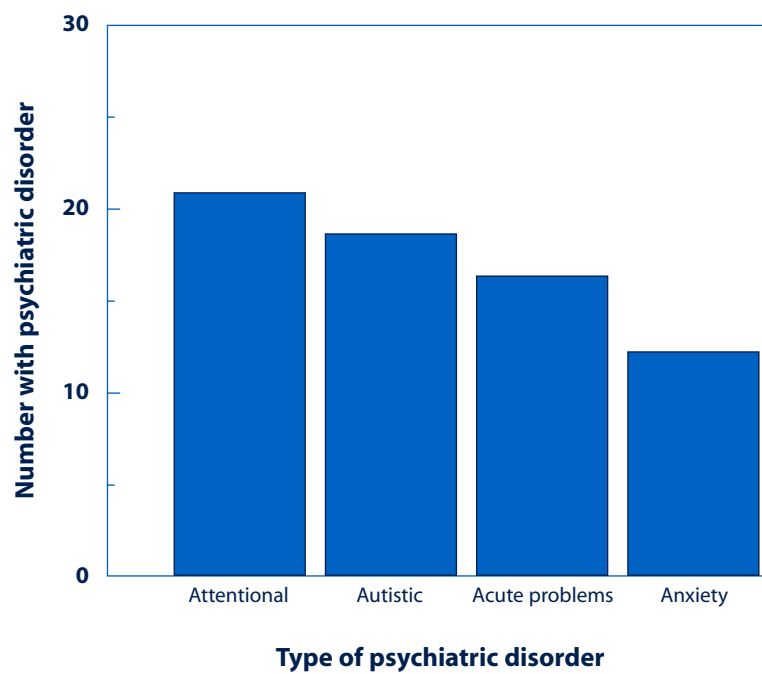


Figure 6. Types of psychiatric disorder reported by accompanying carers/care workers of children entering the care system (source: Dimigen *et al*, 1999)

Co-morbidity was found in over a third of these children. The findings show a significant proportion of children entering the care system with a serious psychiatric disorder but not being referred for psychological help. This highlights the need for a system of early intervention for this group of vulnerable young people.

A further study by Phillips (1997) examined social workers' views on the mental health needs of a sample of foster children. The social workers surveyed thought that 80 per cent of the children needed treatment from a child mental health professional – but only 27 per cent received it. The reasons given in the study for not referring for treatment were placement instability, inadequate child mental health resources and insufficient local authority funding.

A mental health service specifically for looked-after children was established in Birmingham in 1995. The aims of the service were to provide assessment, brief psycho-social interventions, support and advice for staff and families and referral to longer term services (Arcelus *et al*, 1999). Butler & Vostanis (1998) studied the characteristics of referrals during the first six months of the service. Thirty-two referrals were made: 18 male and 14 female. It was a multi-racial group, aged from 10 to 17 years.

Thirteen of the girls and 10 of the boys had been abused before entering the care system. When the authors looked at the mental health services the adolescents had previously been offered, they found that only 10 had had any psychological help. Twenty-nine adolescents had ICD-10 diagnoses: all 14 girls and 15 of the boys. Most had mixed affective-conduct disorders. Sixteen youths had features of depressive disorder. Twenty-seven had features of conduct/oppositional disorder. The study notes the failure of the current system to provide stability and nurturing to children and adolescents with often very high levels of need.

There have been very few UK studies looking specifically at the type and prevalence of mental health problems of looked-after children. Koprowska & Stein (2000) suggest the need for longitudinal studies to inform policy and practice. They point out that we currently do not know how many looked-after children are referred to child and adolescent mental health services, how many go on to enter adult mental health services nor how many suffer major mental disorders in later life. Richardson & Joughin (2000) bring together the evidence for a number of mental health problems suffered by this population and offer advice and some solutions to carers and professionals as to managing and treating various mental health disorders.

Cheung & Buchanan (1997) examined the psycho-social adjustment of adults who had been looked after as children. Their study compared this group with two others: people who had and those who had not experienced severe social disadvantage. Those who had been looked after were more at risk of depression than the other two groups, although there were significant gender differences. Women in each of the groups were more at risk than men but the risk lessened as they grew older. However, the risk of depression increased for men who had been looked after as they grew older.

The as yet unpublished national child and adolescent in-patient study (Royal College of Psychiatrists' research unit) found that 12 per cent of the children and adolescents in highly specialised tier 4 in-patient services in England and Wales were from the looked-after population.

This compares with 9 per cent of the general youth population who are using CAMHS (Audit Commission, 1999) and 0.5 per cent in the general population (Meltzer *et al*, 2000), suggesting a higher incidence of severe mental health problems among looked-after children.

Why looked-after children have greater mental health problems

Rutter *et al*'s findings (1975), in a study of children living on the Isle of Wight and in London, identify some of the major risk factors for childhood psychiatric disorders. They were cited in Garmezy (1987) and include severe parental marital distress, low social status, overcrowding or large family size, paternal criminality, maternal psychiatric disorders and admission into foster homes. Garmezy's study shows that one risk factor on its own makes little difference, two risk factors increase the likelihood of a disorder four times, and four factors increased the risk tenfold.

Bebbington & Miles (1989) found that, prior to being looked after, only a quarter of children were living with both parents, three quarters of their families were in receipt of income support, over half were living in poor neighbourhoods and only one in five lived in owner-occupied housing. Their research also shows that looked-after children were more likely to have more siblings, young parents, parents from different ethnic backgrounds and live in overcrowded homes. The cumulative effect of these factors is to increase substantially the chances of being looked after: from one in 7,000 to one in 10. The single factor cited by Bebbington & Miles (1989) as being the most highly correlated with entry into the care system was a child coming from a "broken family".

A House of Commons health select committee report (1998) identifies abuse or neglect as being the reason for being looked after in 20 per cent of cases in 1996. Increasingly, the fact that some looked-after children have been victims of sexual abuse is being recognised as a reason why they exhibit such very difficult behaviour (Cooper, 2000). According to Cicchetti & Toth (1995), being a victim of abuse may distort four areas of a child's functioning: emotional resilience, attachment, sense of self and peer relationships.

The relationship that a child forms with their parent or first carer is extremely important and helps to establish a pattern of behaviour, feelings and expectations, which will affect the child's future relationships. Abuse or neglectful early parenting for any number of reasons – for example, because a child's primary carer is chronically unwell, is badly affected by marital breakdown or is imprisoned – is likely to leave children unable to develop secure early attachments or form new relationships on a secure footing (Howe, 1995). Most looked-after children are therefore already vulnerable to mental health problems by the time they enter public care.

In the past, the care system has sometimes compounded these problems. A series of child abuse scandals in residential homes in the 1970s, for example, will have done untold psychological damage to the young people in their care. However, a properly run care system, including residential homes, can help protect children's and young people's mental well-being. Security, safety, adequate housing, food, clothing and educational support all increase a child's resilience. The offer of acceptance and affection by carers and care staff may in itself lead to improved self-esteem in the child (Cooper, 2000).

Outcomes for looked-after children

Every year, several thousand young people leave the care of local authorities when they are just 16 or 17, although the proportion aged 18 has risen over the past few years. (Around 6,800 young people aged 16 and over left care in the year ending 31 March 2001. Fifty-three per cent were 16 or 17; 46 per cent were 18 or over, although almost all of those ceased to be looked after on their 18th birthday.) In the general population, the average age for leaving home is 22.

High levels of early pregnancy and parenthood, mental ill health, loneliness and risk-taking behaviour occur among young care leavers. Half the young people leaving the care system are unemployed and one in five experience some form of homelessness within two years of ceasing to be looked after (Broad, 1998; Biehal *et al*, 1995). The Department of Health (1999a) reports that a quarter of young people leaving care have some kind of disability and between one quarter and nearly one third (25 to 30 per cent) of young women leaving care are teenage parents.

A study carried out by Saunders & Broad (1997) reports that, from a sample of 48, 17 per cent of care leavers (who were mostly female) had long-term mental illnesses or disorders, including depression, eating disorders and phobias. Thirty-five per cent had deliberately harmed themselves since the age of 15; 60 per cent had thought about taking their own life and four out of 10 had actually tried. Thirty-one per cent had referred themselves to services for help with their mental health problems; of these, 77 per cent had not found services useful.

In the report, *When Leaving Home is Leaving Care* (SSI, 1997), care leavers in England are reported as saying that they generally had no difficulty in getting primary health care services. However, they did not know how to get advice about or help with healthy living, safe sex and their emotional development. Care leavers also reported problems with the referral systems, particularly the timescales, within adult mental health services.

Educational outcomes for care leavers are also alarming. In 2000/1, 63 per cent of care leavers had no formal qualifications (Department of Health 2001b). Biehal *et al* (1995) found that between 12 and 19 per cent of care leavers go on to further education, compared with 68 per cent of the general population. The Government's social exclusion unit (1998) reports that: "The permanent exclusion rate among children in care is 10 times higher than the average and as many as 30 per cent of children in care are out of mainstream education through exclusion or truancy."

Reasons for the high levels of exclusion include the fact that looked-after children rarely have one adult consistently acting as an advocate for them with education services; they often have problems at home which affect their concentration at school; they may suffer prejudice at the hands of other pupils and teachers; their schooling may be subject to large gaps while placements are being set up and placement changes may force them to change schools. According to Morgan (1999), two out of three children who move to a foster home change school and 80 per cent of looked-after children whose placements break down change school again. These moves inevitably lead to disruption and problems settling in to new schools.

There is also a link between being looked after and turning to crime. A Social Services Inspectorate report (1997) found that 23 per cent of adult prisoners and 38 per cent of young prisoners had been looked after.

Protective factors

Buchanan (1999) studied how satisfied former looked-after children were in their adult lives. The study shows that those children who had been looked after were significantly more at risk of psychological problems at 16 and depression at 33. However, it also shows that 75 per cent did not have psychological problems at 16 and 80 per cent were not depressed at 33. Therefore, not all young people in the care system suffer from mental health problems or will develop them in later life. It is important to try and ascertain what protects some looked-after young people.

Stability and continuity of care are important factors. Dumaret *et al* (1997) interviewed adults who had been raised in stable foster homes and had received specialist support from a dedicated fostering agency. They found that half of their respondents were socially “well integrated” and 68 per cent were “well integrated” or “average”. Stable placements have been linked with positive outcomes particularly in respect to relationship skills, good education and employment outcomes (Koprowska & Stein, 2000). Biehal *et al* (1995) report that if young people have the opportunity to explore their personal histories, they have higher self-esteem than young people who remain confused about their past.

Treatment for health problems

Research by Ward (1995) shows that parents are more effective in getting resources on behalf of their children than are local authorities on behalf of the children they are looking after. Polnay & Ward (2000) write: “Despite the Children Act (England) 1989 requiring local authorities to monitor children’s developmental progress and to ensure each looked-after child has an annual medical report, expectations remain low and there is substantial evidence that common physical and mental health problems often fail to be identified or adequately managed.” There may be several reasons. First, doctors preparing the reports may not have access to the complete medical or family history. Second, very few young people view their annual assessment in a positive light and many refuse to attend; indeed, the uptake of health assessments is as low as 25 per cent in some local authorities (Butler & Payne, 1997). Third, these children are often excluded from school, so will lose out on any school-based services (including personal, social and health education). Fourth, many placements are not stable and result in a discontinuity of treatment and knowledge, for example, as children move from one family doctor to another.

Movement within the care system is a major factor in children and young people failing to get appropriate GP and specialist health services. Yet, government guidance (Department for Education and Employment and Department of Health, 2000) states that, in assessing a placement’s suitability, consideration must be given as to whether it can meet all a child’s identified health needs as well as their educational needs.

Utting *et al's Children's Safeguards Review* (1997) highlights deficiencies in the care system and in CAMHS. *Children in Mind* (Audit Commission, 1999) shows that links between different children's services providers are often weak and that children's access to services can be highly variable. Anecdotal evidence from *Children in Mind* suggests that social workers are concerned that children have to wait a long time for health service appointments. The report recommends that health authorities and trusts need to establish more consistent provision of specialist CAMHS and need to link their activities with those of other agencies.

3 Current policy and practice

Since 1998/9, a large number of government policies, initiatives and documents have been introduced in England which have an impact on looked-after children and their mental health.

Social care initiatives

The care of looked-after children is the responsibility of local authority social services departments with the Children Act 1989 as the key legislation. Three significant developments in recent years are the Quality Protects programme, the assessment framework and the Children (Leaving Care) Act 2000.

Quality Protects

The Department of Health launched Quality Protects in November 1998, as a key part of its broad social exclusion strategy. This is a major programme, running to 2004, which aims to transform the management and delivery of social services in order to improve the life chances of the most vulnerable and disadvantaged children. Specifically, those are:

- children in need
- children who are looked after by local authorities
- children in the child protection system
- other children requiring support from social services.

In partnership with the Department of Health, local authorities are expected to strengthen their management and quality assurance systems to provide safe, effective and high-quality children's services. Individual English councils' annual management action plans (MAPs) have to show how they will work together with health services, voluntary organisations and other partners to achieve government objectives for children's social services (Department of Health, 1999c). MAPs serve as part of the Department of Health's monitoring and grant approval processes and as key governance and management tools for local councils.

Discrepancies have been noted between various strategic plans that local authorities have to prepare for children, such as MAPs and education development plans. The Department of Health and Department for Education and Skills are also evaluating the degree of consistency between MAPs and education development plans, early years and child care development plans, and behaviour support plans (Department of Health, 2000b).

Funding for Quality Protects comes from the children's special grant, totalling £885m over five years (April 1999 to March 2004).

Quality Protects comprises a number of other projects, including one for black and ethnic minority children and their families. Among the latter's objectives are:

- raising the profile and creating an understanding of the needs of families across government departments
- reframing current practice to focus on the strengths, aspirations and ambitions of families
- turning policy into action
- improving understanding and information on the needs of asylum seekers/refugees.

Quality Protects also includes a children's participation project to encourage young people to take part in planning and delivering services and in decisions about their day-to-day lives. A training pack for front line staff to improve the participation of looked-after children and an increase in advocacy and children's rights services are elements of the project.

See appendix 1 for further details about Quality Protects.

Assessment framework

The framework for the assessment of children and their families (2000) is the mandatory multi-agency means for assessing children in need that was introduced by section 17 Children Act 1989.

Children (Leaving Care) Act 2000

The Children (Leaving Care) Act 2000 was implemented in October 2001. The Act's main provisions are:

- a new duty on local authorities to assess and meet the needs of eligible people aged 16 and 17 who are in the care system or are care leavers. The duty to keep in touch with care leavers rests with the local authority where the young person resides until they are at least 21
- every looked-after 16-year-old to have a comprehensive pathway plan mapping out a clear route to independence
- local authorities to provide personal and practical support to meet the pathway plan objectives
- each young person to have an adviser who will co-ordinate support and assistance
- a new financial regime for care leavers to ensure that they have comprehensive financial support
- continuing assistance for care leavers aged 18 to 21 and beyond, where necessary, especially with education and employment.

Adoption and permanence

Adoption allows children who are unable to return to their birth families a legally permanent new family. Research has shown that children who are adopted up to the age of six months generally make very good progress through childhood and into adulthood. Older children's development can also benefit to varying degrees (Department of Health, 2000c).

Research also suggests that young people living in a stable environment have better outcomes than those who have multiple placements (Buchanan, 1999; Cheung & Buchanan, 1997). Therefore, it is important both to improve stability and quicken processes, such as the adoption of very young children who need to develop attachments with their new primary carers. Indeed, national adoption standards state that a plan for permanence – which does not necessarily mean adoption – must be made at a review occurring when a child has been looked after for four months.

However, there are widespread variations in practice in councils and courts, resulting in delays for many children and adoptive families. Moreover, according to the British Association for Adoption and Fostering (BAAF) and the Department of Health in England and Wales (2000), 89 per cent of adopters are white couples. One in five children with an adoption plan are from black or minority ethnic backgrounds. Black children and mixed race children wait on average five months and eight weeks longer respectively for placement than white children.

The white paper, *Adoption: A New Approach* (Department of Health 2000c), emphasises that more should be done to promote the wider use of adoption for looked-after children who cannot return to their birth parents. It sets out a number of goals for adoption services:

- the focus must be on the needs of the child
- highly skilled professionals should lead a high-quality service delivered to national standards
- focused effort must go into finding a permanent new family for looked-after children waiting to be adopted
- courts dealing with all cases involving children should do so in an efficient and child-centred way
- a range of potential adopters must be encouraged; they should be welcomed and assessed efficiently in an open and fair way
- children and their new families should have access to post-adoption support.

The white paper also highlights areas in need of further research, including:

- identifying successful models for post-placement support
- comparing outcomes of long-term foster care and adoption
- stability and lifetime outcomes for children
- models of consortia arrangements
- what motivates people to apply to adopt and what works in attracting them
- good practice in assessing prospective adopters.

The Adoption and Children Bill has since been introduced to speed up adoption and put the needs of children at the heart of the adoption process. A government amendment obliges any court that is considering an adoption order to consider the harm a child has suffered or is at risk of suffering through seeing or hearing the ill treatment of another person.

The Bill includes a new right for adopters to be assessed by their local authority for post-adoption support. However, there is currently no plan for adoptive parents to have the right to receive services, once assessed.

Adoption is not, of course, an appropriate route for all children. Some older children do not wish to be legally separated from their birth families and they may be cared for on a permanent basis, for example, by relatives. Unaccompanied asylum-seeking children may need secure, permanent homes but they may have strong attachments to their families abroad.

So, other routes to permanence are being considered for looked-after children. For example, special guardianship is included in the Bill. This option gives the guardian responsibility for all aspects of caring for the child and for taking decisions about their upbringing. It is meant to provide a firm foundation for a child to build a lifelong, permanent relationship with the person who is looking after them. It will be legally secure, yet preserve the basic legal link between the young person and their birth family. Long-term fostering will remain available for looked-after children who do not want the formality of adoption or special guardianship.

Health service initiatives

Clearly the NHS has a key role to play in the mental health of looked-after children, through both targeted and generic services for children and young people.

Health guidance for looked-after children in England and Wales

Looked-after children and young people generally have greater mental health needs than other children. The *Arrangements for Placement of Children (General) Regulations 1991* and the *Review of Children's Cases Regulations 1991*, which accompany the Children Act 1989, govern the health needs of looked-after children. The Department of Health (1999e) has also produced a consultation document for England and Wales, *Promoting Health in Looked-after Children: A Guide to Healthcare Planning, Assessment and Monitoring*. This consultation document sets out general principles:

- services should aim to promote the future health and well-being of the child or young person and not focus solely on the detection of ill health
- services should be delivered in a way that enables and empowers the child or young person to take appropriate responsibility for their own health
- the health needs of looked-after children and young people should be assessed within a child-centred, holistic framework
- services should be non-discriminatory and promote equality of access and anti-racist practice
- social services departments should fulfil the role of an active, concerned parent in promoting and monitoring the child or young person's health and development and should, where possible and appropriate, actively involve the child and young person's birth parents
- all agencies should recognise that children in public care may need higher levels of parenting and health input in order to achieve the same health outcomes as other children in the population
- the child or young person's informed consent to all health care treatment should be actively sought and recorded in a way appropriate to the child or young person's age and understanding
- services should be delivered in a sensitive, age-appropriate way that recognises the importance of choice and accessibility
- the organisation of services should take account of the needs of a population which experiences frequent moves and should not multiply or compound their disadvantage.

Key to achieving high standards of care is adequate information about a child's health. Information about current illnesses, prescribed medication, allergies, outstanding hospital appointments and disabilities should be collected when a child enters the care system. Health records should be systematically updated. In the longer term, information about the biological family's health, genetic risk factors and the child's own birth should be recorded.

The looking after children record-keeping system allows social workers to note basic health information. It provides a framework for a systematic approach to assessing children's progress, monitoring the quality of care they receive and planning.

Health assessments

Looked-after children are meant to have an initial health assessment within a fortnight of being placed or, when there are grounds for concern, on the day of placement. Staff should record the child or young person's overall development, including evidence of health-threatening behaviour, and any treatment they are receiving. Referrals should then be made for any further investigation or treatment. If, after the initial assessment, it is considered necessary, there is a second stage at 12 weeks. This is the comprehensive health assessment, from which a health care plan is developed to meet identified needs. It should take into account the child's medical and family history and covers psychological and emotional health and any health-threatening behaviours. There is also meant to be an annual assessment by a doctor.

But take-up in some areas is slow and the system could be more flexible. The requirement for the annual assessment to be completed by a doctor, when sometimes a nurse or other health care professional might be appropriate, should be reconsidered. There can be repetition (particularly for disabled children) with similar information being sought at school medicals. There is also considerable variance in the quality of written health assessments.

Health care plans

On the basis of the health assessment, a child is given a health care plan that is integrated into the overall care plan, in discussion with child, their social worker and any foster carer. This should then be implemented and monitored as part of the young person's review. The responsibility for this lies locally with the senior manager for looked-after children. Health care plans cover:

- treatment prescribed and follow-up arrangements
- referrals made to specialist services (for example, hospital, CAMHS, child development centres and community services, such as speech therapy) with arrangements to monitor whether appointments are kept
- any conditions that need review, including by whom and when
- arrangements for health promotion and lifestyle advice, including by whom
- aids and adaptations needed by disabled children.

(Department of Health, 1999e)

The results of the health assessment and care plan should follow the child when placements change or when the child returns home. Genetic information and family history must also stay with the child's personal records. But the Department of Health notes that information is often not transferred with the child (Department of Health, 1999e).

The Children (Leaving Care) Act 2000 requires local authorities in England and Wales to keep in touch with care leavers up to the age of 21 (or up to 24 if they still need help with education or training). An assessment of health need is an essential part of this support. Young people moving to independence need to know what state their health is in (Department of Health, 1999e), as well as advice on taking care of their health.

Staff and foster carers – training and understanding

Staff and foster carers need to develop skills and confidence in preparing looked-after children for health appointments and treatment. Children need to understand whom they are going to see and why, what will happen and what they might need to say or to ask. They need to be offered choices about how, when and whom they see and whether they go alone or have their foster carer or social worker with them. CAMHS and local authority staff should liaise over these appointments to ensure that the young people get as much choice and information as possible and that staff and foster carers have information on the children's condition (where appropriate and without breaking patient confidentiality).

The National Foster Care Association (1999) has developed clear standards for looked-after young people's health care and development. The Department of Health is spending, over three years, £6m to train foster carers and £38.5m on training residential care workers to NVQ level 3, as well as £10m to implement the post-qualifying award in child care for social workers (Department of Health, 1999e).

Out-of-borough placements

Sometimes children are placed outside the boundaries of their local authority. This may be down to a lack of suitable local placements or because a child has highly specialised needs that are best met by, for example, a particular residential school. However, out-of-borough placements can create a barrier to health services (Department of Health, 1999e). Notification of placements – when social workers who are placing a child in another locality inform health staff in the receiving area of the child's move – must be done under the *Arrangements for Placement of Children (General) Regulations 1991*. It is important that notification happens promptly, so that records can be transferred quickly and a child's health needs swiftly identified.

Messages for commissioners

The consultation document, *Promoting Health in Looked-after Children: A Guide to Healthcare Planning, Assessment and Monitoring*, contains messages for service commissioners (Department of Health, 1999e).

“Commissioners of health care (health authorities and primary care groups or trusts) should work closely with paediatricians, GPs, local specialist services, social workers, education professionals,

school nurses, carers and other professionals to plan, manage and monitor the health care of all looked-after children in their geographical area. Health authorities and primary care groups/primary care trusts should ensure that they participate in inter-agency planning and co-operation through children's services plans and Quality Protects management action plans and that clear cross references are made in local health improvement programmes.

"The key factors health commissioners should consider include ensuring that:

- looked-after children in their geographical area are registered with GPs and dentists
 - appropriately trained people are available to undertake health assessments
 - clear arrangements have been made to liaise with other health authorities where a child is placed out of borough or changes placement
 - arrangements are made for the transition from child to adult services, occurring at 16 to 18 for most looked-after children and up to age 21 for some disabled young people
 - if and when children change placement, there are appropriate local arrangements to 'fast track' the GP-held medical records of looked-after children and that any previous waiting times are taken into account if they need to go onto a new waiting list
 - action needs to be taken to ensure that each child gains access to appropriate health services within a time scale that will not be detrimental to their health and that assessment records are copied to GPs and social services departments
 - that there is a possibility of having a designated doctor or nurse for looked-after children."
- (Department of Health, 1999e).

National priorities guidance

The national priorities guidance (Department of Health, 1998a) identifies national priorities, objectives and targets to bring about year-on-year improvement as part of a 10-year programme of modernisation. The document enhances some of the objectives that have been addressed by Quality Protects with the addition of the following specific targets (or performance indicators):

- placements – to reduce, to no more than 16 per cent in all authorities by 2001, the number of looked-after children who have three or more placements in one year
- education – to improve the educational attainment of looked-after children by increasing to at least 50 per cent by 2001 the proportion of children leaving care at 16 or later with a GCSE or GNVQ qualification and to 75 per cent by 2003
- young offenders – to set up new structures for work with young offenders under the Crime and Disorder Act. Multi-agency youth offending teams are to be established by local authorities with social services and education responsibilities, in partnership with health authorities, the police and probation service
- Care leavers – to demonstrate that the level of employment, training or education among young people aged 19 in 2001/2 who were looked after by local authorities in their 17th year on 1 April 1999, is at least 60 per cent of the level among that of all young people of the same age in their area.

Child and adolescent mental health services (CAMHS)

Child and adolescent mental health services are the part of the health service responsible for children's mental health. In 1999, a three-year £85m modernisation fund grant was announced for CAMHS. To obtain a slice of the money, education, health, social services and voluntary groups had to demonstrate joint working.

Most CAMHS are structured in a tiered model, with specialist CAMHS comprising tier 2 to tier 4. Tier 1 services are the primary level of services and include GPs, health visitors, school nurses, teachers, social workers and voluntary organisations. Tier 2 is made up of specialist professionals, such as clinical psychologists, nurse specialists, paediatricians, and educational psychologists, who tend to work singly. Tier 3 offers more specialised services for severe, complex and persistent disorders. Practitioners tend to work in teams, in a community mental health clinic or child psychiatry out-patient service, which include psychiatrists and other therapists. Tier 4 services are highly specialised services, such as residential in-patient facilities.

National priorities guidance outlines key objectives for CAMHS. These are to improve the provision of appropriate, high-quality care and treatment for children and young people by building up locally based child and adolescent mental health services. This should be achieved through improved staffing levels and training provision at all tiers; improved liaison between primary care, specialist CAMHS, social services and other agencies, and should lead to users of services to expect:

- a comprehensive assessment
- where indicated, a plan for treatment without a prolonged wait
- a range of advice, consultation and care within primary care and local authority settings
- a range of treatments within specialist settings based on the best evidence of effectiveness
- in-patient care in a specialist setting, appropriate to their age and clinical need.

(Department of Health, 1998a).

Currently, there is no comprehensive national database of the type, number and location of CAMHS. The Department of Health is, however, doing a mapping exercise of CAMHS in England.

Other health initiatives

Other health initiatives, which have an impact on looked-after children's mental health, are health action zones and health improvement plans.

Health action zones develop innovative local strategies to improve health in deprived areas through partnership working (between health and local authorities and others, such as local voluntary agencies). Their work does not concentrate solely on health and social care services but also on other areas that have an impact on health, for example, employment. Health improvement plans are produced by all local partners (including health authorities and local authorities) in every locality in England. They identify local health needs and outline ways of meeting them.

Education services

Education plays a crucial role in preventing mental health problems, not least by building up a young person's self-esteem and by providing qualifications needed to get employment.

Education guidance for looked-after children

The *Guidance on the Education of Children Looked After by Local Authorities* (in England and Wales) was published by the then Department for Education and Employment and the Department of Health in 2000.

One key element of this guidance is individual personal education plans (PEPs). They should provide a convenient, portable record of a looked-after child's developmental needs, progress, achievements and aspirations. Local authorities should provide young people with a PEP within 20 days of their entering the public care system or of joining a new school.

The guidance recommends that a designated teacher act as a resource and advocate for looked-after children and young people in public care. Local education authorities and social services departments should co-ordinate suitable training for designated teachers and maintain an up-to-date list of designated teachers in schools in their area.

All local authorities should have information about the special educational needs (SEN) of children whom they are looking after. The needs of individual young people should be made known to the SEN co-ordinator, the designated teacher and their foster carer and social worker. PEPs should detail individual needs, such as SEN, and the support that is provided to meet those needs.

The guidance also places a duty on local authorities to establish and maintain a protocol for sharing relevant information about care, placements and education.

Securing an educational placement – generally taken to mean a full-time place in a local mainstream school – is a criterion that must be used in identifying a suitable placement for a looked-after child. The Government expects local authorities to secure a place in a school for any looked-after child within 20 school days.

Other education services

Connexions is a government service that offers advice and support about personal development and careers to 13- to 19-year-olds. One of its priorities is to make a difference to vulnerable young people who need extra help. Social services management action plans have to demonstrate that they are linked into the Connexions service planning structure (Department of Health, 2000b).

Education action zones aim to raise pupil attainment and tackle educational disadvantage in deprived areas, through partnership working.

Joint initiatives

Multi-agency working is emphasised time and time again in government policies and guidance on services. For example, local authorities and health authorities have for some time developed joint children's services plans, with local authorities having lead responsibility. These plans provide the strategic framework for all local children's services. A number of other joint initiatives, which can have an impact on looked-after children, are outlined below.

There are also a number of government national initiatives aimed at combating social exclusion which have had a major impact on local services for children and young people, including those who are looked after by local authorities.

Children's national service framework (NSF)

Plans to develop a national service framework for children's services in England were announced in February 2001 and work is under way, with publication due in 2004. NSFs were created to drive up quality and tackle variations in health and social care services by setting national standards.

The development of the framework is being overseen by a children's taskforce. Six working groups have been established to assist in the formulation of the NSF:

- children needing acute/hospital care
- maternity
- mental health and psychological well-being
- children in need
- disabled children
- the healthy child and young person.

Sure Start

Sure Start is a £1bn initiative – £452m for 1999/2002 with an extra £580m till March 2004 added in last year's comprehensive spending review – billed as "a cornerstone of the Government's drive to tackle child poverty and social exclusion." It brings together services such as health visiting, family support and early learning to offer parents and children in deprived areas advice and help. The aim is to improve the physical, intellectual and social development of babies and young children, so that they are not at a disadvantage by the time they reach school age. By 2004, there should be 500 programmes up and running.

Children & young people's unit (CYPU)

The CYPU was set up to ensure better co-ordination of policies and services for children in England. It is a cross-departmental unit, charged with overseeing the strategy for children and young people across government, administering the children's fund (for preventing poverty and social exclusion) and encouraging joint working. Politically, it comes under a strategic Cabinet committee on children and young people's services, as well as a minister for young people.

Child and adolescent mental health project board

The project board forms a bridge between the Department of Health's mental health taskforce and its children's taskforce. (Both were set up to improve health services and oversee, for example, implementation of relevant parts of the Government's 10-year NHS Plan.) The key priority is to reduce geographical inequalities in access to CAMHS and to improve overall quality.

Healthy living centres

The centres are overseen by local partnerships, including health and local authorities and the voluntary and private sectors, and aim to promote health and well-being. They can offer an array of facilities and services, including health services, screening, advice, relaxation and sport, community groups and may be targeted, for example, on minority ethnic groups. Partners involved in health action zones are encouraged to develop proposals for healthy living centres.

Healthy schools programme

The programme is intended to create a healthy ethos in schools and improve children's self-esteem and well-being and is linked to the government framework for personal social and health education in the curriculum.

Drug misuse allocation fund

The drug misuse special allocation fund (Department of Health, 1999d) aims to increase the provision of drug treatment services for young people who misuse drugs and increase prevention services for vulnerable young people in England and Wales. The fund operates in the context of the Government's 10-year drug strategy, which aims to ensure that young people, whatever their culture, gender or race, have access to appropriate substance misuse programmes.

Social exclusion unit

The Government's social exclusion unit has published a national action plan to tackle teenage pregnancy (1999) and reports on neighbourhood renewal, rough sleepers, truancy and 16- to 18-year-olds who are not in education, work or training.

Outcomes of policy and practice

Three recent studies have looked at placement moves of looked-after children (Ward & Skuse, 1999), the outcomes for disabled looked-after children (CDC, NCB and Quality Protects, 1999) and the impact of management action plans (Robbins, 2000).

Placement moves

The Department of Health wants the number of moves experienced by many looked-after children to be reduced and has been looking at why some children are moved several times.

Ward & Skuse (1999) studied the case files of 249 children looked after by six local authorities in England for between 12 and 24 months. The mean age for becoming looked after was seven years; however the most common ages were under one (15 per cent), 14 (8 per cent) and 15 (also 8 per cent). During their first year of being looked after, 44 per cent of the children remained in the same

placement, at least 26 per cent had two placements and 28 per cent had three or more. Temporary or emergency moves to more secure, longer term placements, known as planned transition, were frequently given as reasons not only for first moves but were also common for second and third moves. The 38 children under one year at admission, had, between them, experienced 62 moves by the beginning of April, 1998. Again, 41 were planned transitions with only four moves being placement disruptions. (Placement disruption is a term used when there is a dispute between the looked-after child and the foster carers or residential placement).

These findings reinforce concerns that being looked after can create unpredictability that may hamper attachment in very young children (Zenah & Emde, 1994). Overall, it was found that children who experienced a placement disruption (19 per cent were at the request of the carer while 3 per cent were at request of child) had significantly more placement changes than children who moved for other reasons.

The researchers found no gender differences. However, they found that children who experienced disruptions were significantly older than those who did not. A high proportion of these children had become looked after having been rejected by or estranged from their family.

Children with conduct problems and children who were harming themselves had more placements in their first year. There was, however, no relationship between inappropriate sexual behaviour and the number of placements in the first year. The researchers suggest that local authorities could do more to support children who exhibit behavioural disturbances. It was also found that just over 62 per cent of the 119 children with problem behaviour were not getting help from mental health services.

While being looked after, a small number of young people became involved in criminal activities. This group had more placements in their first year than those who did not offend.

The Ward & Skuse study is longitudinal and data have since been collected on the situation in September 1999 and September 2000.

Outcomes for disabled looked-after children

In September 1999, the Council for Disabled Children, National Children's Bureau and Quality Protects examined 88 randomly selected first-year management action plans for disabled children and families. Their report states that: "In relation to disabled children living away from home, nine authorities were unable to provide reliable baseline information on the numbers of looked-after disabled children". There were different definitions of disability with some authorities only recording disability if the young person was moderately or severely disabled.

Some authorities, such as Bristol, used a matrix to record needs accurately and match them to services. Other authorities, such as North Lincolnshire, reported difficulties in reliably recording the full extent of disabilities and special educational needs. The report notes that there were few references to the special educational needs of looked-after disabled children. There was little evidence of cross-departmental working between SEN staff and social services staff of most of the local authorities. Dorset was unusual in identifying half of its looked-after children as having a statement of special educational needs.

Nearly half the authorities expressed their intention to reduce the use of out-of-borough placements for looked-after children. But two authorities noted that residential education was increasingly used for placement of children with complex needs for whom there was no suitable local provision. There was a lack of clear criteria for determining when to use out-of-borough placements, although a number of respondents referred to inter-agency referral panels. Six authorities were unable to provide baseline data on the number of children looked after in a series of short-term placements.

Many local authorities were attempting to:

- improve the range of respite care services
- expand family-based shared care schemes (and many authorities referred to problems recruiting foster carers)
- address the needs of older children, in particular those with autism, and children with complex medical needs or challenging behaviour
- improve the range of services offered to families from minority ethnic groups.

The report draws a number of conclusions. New partnerships are required between health, education and child health services, especially for children with complex health needs or challenging behaviour. Local protocols and assessment arrangements should be developed for disabled children looked after by the local authority or attending residential educational provision, to ensure coherent planning and to facilitate their return to community provision wherever possible. Disabled children, especially those from minority ethnic groups, need more opportunities to take part in leisure activities and play.

Results of second-year management action plans

Tracking Progress in Children's Services: An Evaluation of Local Responses to the Quality Protects Programme Year 2 (Robbins, 2000) summarises evidence collected from all 150 English local authorities on how far each have met management action plan targets. Eight plans stood out as being particularly good: Blackpool, Manchester, Portsmouth, Stockton-on Tees, Suffolk, Tameside, Wandsworth and Westminster, although all 150 were considered of acceptable quality.

All but two councils predicted that they would meet the national target for reducing the number of looked-after children having to move three or more times in one year to 16 per cent of the total they are looking after by this year. (The figure is around 78 per cent for 2000/1.) Factors contributing to success were:

- thorough reviews of provision and analysis of needs
- a wide range of partnerships
- a clear investment strategy
- a flexible approach to commissioning.

Barriers to progress included:

- increasing demand
- problems in recruiting staff
- problems in recruiting and retaining foster carers.

Factors that supported progress in adoption included:

- Best Value and other reviews
- government guidance
- multi-agency co-operation and joint working.

Some authorities were pooling resources and forming consortia to try and recruit staff and foster carers.

The report notes a significant effort being made to improve educational achievements and there was better joint working in some authorities, in areas such as sharing data and developing and planning research. Nationally, 40 per cent of care leavers had gained at least one GCSE or GNVQ at March 1998, although this fell to 30 per cent in 1999/2000. (Recent government statistics show it has since risen to 37 per cent in 2000/1.)

Regarding looked-after children's health, while the report notes improvements against all relevant performance indicators, it shows that significant numbers of looked-after children were not receiving the services they needed. However, the report says that many councils had made developing reliable shared data and meeting health assessments and dental check targets a priority. Mental health was increasingly being recognised as significant, as were teenage pregnancies and the needs of young mothers, by some councils.

Councils identified the progress of their multi-agency local youth offending teams as crucial in reducing offending among looked-after children. The report points to examples of good practice in every region, including mentoring, bail support work, remand carers (instead of custody) and preventive work with under-10s.

When it came to making leisure, sport and cultural activities available to looked-after children, some councils saw the target in very broad terms, covering such activities as community participation, combating social exclusion or parenting initiatives.

The report notes that innovative programmes were being developed to support care leavers up to the age of 21. In order to prevent young people leaving their care too early, good plans and programmes were being created around the country. Strategies for working with younger children and preparing them for independence included:

- developing new posts, teams and resource centres
- using mentoring and specialist voluntary sector services to reach young teenagers
- sharing information between agencies
- specialist provision for disabled children.

Half of the councils appeared to be involving children well in the design, delivery and evaluation of services; indeed, in some councils' plans, children's participation was described as integral to service planning and delivery. Voluntary organisations were often used to conduct research and user surveys and offer outreach and advocacy services. However, the report notes that councils were not so good at involving individual children in decisions about their own care.

4 Key challenges and concerns

There appear to be a number of factors inhibiting further improvements. Two key reports which investigate barriers to improving services are Joseph Rowntree Foundation (Morris, 1999) and Lewis (2000).

Research on barriers

A three-year research project by the National Children's Bureau (Morris, 1999) looked at 10 local authorities, identifying barriers to good health, including mental well-being, in looked-after children.

The report states that mental health care was inadequate. Both staff and young people were concerned about the provision of child and adolescent mental health services. The report says that: "The shortage and difficulties in accessing appropriate mental health services were dominant features of many interviews across both residential and foster care." There was no suitable provision for young people aged 16 to 18 years, with diagnosed mental health problems. Many young people saw services as stigmatising and too rigid, as they only worked with families. Access to play, art and other therapies was difficult and resources limited.

Many foster carers in the study said that a lack of support affected their own mental health.

In the Joseph Rowntree Foundation study, looked-after young people, senior managers and frontline workers were asked what gets in the way of changing things for the better and what helps to bring about change. The main problems uncovered were:

- public attitudes towards children generally and looked-after children in particular can get in the way of listening to children
- the concept of being a good parent is not one that local authorities have generally applied to their relationship with looked-after children
- responses to children's needs are often dominated by a service-led approach and social workers often are not able to fulfil the role that children want from them.

The report recommends:

- listening and involving children and young people
- increasing the number of foster carers and providing them with training and support
- recognising the importance of the relationship between the social worker and the child
- ensuring that looked-after children get more out of the education system.

Language and stigmatisation

Language and stigmatisation are important to many looked-after young people and social services staff. Lindsey (2000) notes that labelling a person as mentally ill "may be adding the stigma of mental health difficulties to the stigma of being in care". However, Lindsey also points out that that

the failure to identify and acknowledge mental health problems results in foster carers not getting support and information and not being prepared for any challenging behaviour and, hence, placements breaking down. Looked-after children may also be relieved to have their mental health problems recognised, as they can then seek help, perhaps improving their relationships and self-esteem and reducing their disturbing behaviour.

A different language problem – but one that may cause confusion – is that different professional groups working with looked-after children often use quite different terminology from each other.

Funding

The Health Act 1999 opened the way for more flexibility in funding arrangements between health and local authorities. Since April 2000, authorities have been able to pool resources or delegate functions across authorities in new partnership arrangements, such as pooled budgets, lead commissioning and integrated provision.

Agencies are now getting more funding for their work with looked-after children and English social services departments spend at least £31m a week on looked-after children. However, this area has been under funded in the past, and children's needs and the major changes required are so great, that more resources will undoubtedly be needed. The aim of this report is not to suggest a figure. However, some of the recommendations will certainly require new resources.

Joint working

Despite innovations such as Health Act 'flexibilities', not all agencies are effectively collaborating. More still needs to be done to break down boundaries between professional groups, including changing perceptions and accepting responsibility. Frontline social workers, for example, think that health professionals and schools are all too keen to shift their role as corporate parents back on to the social services staff (Department of Health, 2000d).

Difficulties also arise over which agency pays for what, over lines of accountability, and because of poor communication between agencies. All of these areas need to be clarified and improved upon.

However, positive moves include management action plans having to show that they are linked into the Connexions services planning structure (Department of Health, 2000b) and Connexions service partnerships having to be informed by existing plans, including children's service plans, school health plans and local teenage pregnancy strategies. The children's national service framework should also help to get agencies working towards common goals.

Recruiting and retaining foster carers

Berridge (1997) points to a general shortage of foster carers making it hard to find appropriate placements for all children, but particularly older children and adolescents (Triseliotis *et al*, 1995 and Waterhouse, 1997) and those from ethnic minorities (Thoburn, 1990 and Caesar *et al*, 1994).

Many authorities are trying to recruit more foster carers. In York, a recruitment campaigning aiming to challenge views about who could and could not be a foster carer and increase numbers by 10 per cent actually achieved a 25 per cent increase. Advertisements were carried on all council vans, distributed through schools, libraries, shopping centres and a cinema advert was shown in total 72 times a day at local cinemas (Department of Health, 2000d).

Recent research has also examined the problem of retention. Looked-after children often exhibit extremely challenging behaviour because of their past experiences. There is a need for foster carers to have training in understanding the mental health problems that may arise for these children and young people. More respite care also needs to be made available. It is a valuable source of rest and support, especially for foster carers offering long-term placements.

The single most common reason given by carers for ceasing to foster was dissatisfaction with services provided for them (Fisher *et al*, 2000). Fisher and his co-authors list attributes and actions that foster carers want from social workers. Staff should:

- be interested in how carers are coping
- be easy to contact and responsive
- be encouraging and prepared to listen
- keep foster carers informed and include them in planning
- deal quickly with payments and complaints
- attend to the child's interests and needs.

The authors suggest that crises may actually be crucial times for establishing good relationships between social workers and foster carers.

The *National Standards for Foster Care* (National Foster Care Association, 1999) outline the training and support foster carers should be receiving in the UK.

Recruiting and retaining social workers

Social work recruitment is in crisis, with a vacancy rate of around 16 per cent in England (in 2000). The knock-on effect for looked-after children is significant, with staff having heavy workloads and much less time to give to individual children and children experiencing upheaval as staff move on.

A number of initiatives are under way to increase the number of social workers and to retain staff. The Government has run a major recruitment advertising campaign. Some authorities have looked at 'growing their own'. Suffolk County Council, Ruskin College, Oxford, and public sector union Unison, for example, have developed a day release diploma in social work for the council's social care staff who want to become qualified social workers. Other authorities are looking at a variety of recruitment and retention packages, including flexible working, training and personal development opportunities and 'golden handcuffs' (annual bonuses for staying).

Making sure policy is understood by frontline workers

Frontline staff need to be kept informed of new local and national policies and guidance and how they affect their day-to-day working. They need to know what their local authority management action plan states they should be attempting to achieve and by what means. Staff working with looked-after children already have heavy workloads and need to be made aware of how extra work or changes will benefit what they are trying to achieve (Department of Health, 2000d). Moreover, they should be made aware of examples of and evidence for current good practice.

Changes needed in child and adolescent mental health services (CAMHS)

Changes are needed in the referral process to CAMHS for looked-after children to improve their access to services. Currently, a looked-after child will be referred by a GP or social worker and is likely to go on a waiting list for a CAMHS appointment in the same way as any other child. However, because many looked-after children go through several placements, they may have moved (possibly more than once) by the time their appointment comes up; they may never even get to know about it.

Moreover, medical problems do get missed, not least as children move between foster carers and social workers change. Services need to adapt to prevent looked-after children and young people missing out on suitable mental health services.

5 Key findings

Looked-after children are particularly vulnerable to mental health problems, including severe and enduring disorders, not least because they have suffered abuse or neglect, disadvantage or parental bereavement, disability or serious illness before coming into public care. Once looked after, their access to mental health services is often poor, because of poor communication between health and social care and other agencies, poor health assessments, changing placements or disrupted schooling. Care leavers, too, are vulnerable, with many having serious mental health problems but finding it hard to get appropriate help.

On the positive side, considerable change has taken place in recent years, including Quality Protects, the new children and young people's unit and the forthcoming children's national service framework.

However, while significant progress has been made, there are still large hurdles to be cleared before services can be improved. These include:

- multiple placements
- confusion over different professional terminology
- stigmatisation
- under-resourcing
- difficulties with professionals and agencies collaborating to offer seamless services
- shortages and lack of support and training for foster carers
- shortages and high turnover of social workers
- a lack of proper mental health training for staff in all agencies working with looked-after children
- policies not informing frontline practice
- referrals to CAMHS services.

6 Recommendations

- There is a need for a system of early mental health assessment and intervention for looked-after children and young people, including those who have gone on to be adopted.
- Stability in placements and schooling is a key factor in promoting positive life chances for this population. (Indeed, reducing the number of children who are moved more than three times is one of the ways the performance of social services departments is measured.) Young people who are moved several times, between foster carers and/or residential homes, suffer discontinuity of care, education and treatment for health problems. Long-term stability must be viewed as a high priority.
- There is a need for more research on this population, especially in the following areas:
 - a comprehensive UK-wide study should consider how many looked-after children have mental health problems, what those problems are, how many children have their needs met and how
 - the prevalence of general and specific psychiatric disturbances, the use of mental health services and long-term outcomes, including longitudinal studies
 - specific needs and problems of children from minority ethnic groups and from different faith groups, including the prevalence of psychiatric disorders and different ways of perceiving and dealing with mental health problems
 - specific needs and problems of girls and of boys, including prevalence of psychiatric disorders
 - early intervention, different therapeutic approaches and other treatment options and alternative, non-medical strategies for dealing with mental health problems, including engaging children and foster carers in solutions
 - what prevents some of these vulnerable young people from suffering long-term problems, given that not all looked-after children suffer from mental health problems.
- Common physical and mental health problems are often not identified nor adequately managed. A number of changes are needed including:
 - imminent government guidance for England on health services for looked-after children (forming part of the Quality Protects programme and following on from the consultation paper *Promoting Health in Looked-after Children*) must be integrated straight away into practice upon publication
 - social workers should ensure that all young people are registered with a GP as a matter of urgency when starting a new placement
 - health care records, including genetic and family history, must stay with the children while they are being looked after, even when they move placements
 - health and social services must improve their collaboration, especially on the child's annual medical report.

- Services should be delivered in a sensitive, age-appropriate way that encourages choice and accessibility. Young people also need to be helped to take responsibility for their own health.
- Foster carers need training in and support for dealing with mental health problems that looked-after children and young people may experience.
- Staff in all agencies who work with looked-after children need specialist mental health training, including how to identify problems. At least one worker in each Sure Start and Connexions project should have some form of mental health training.
- Mental health services should offer regular advice and consultation sessions locally, particularly to social workers, teachers, foster carers, parents (as many children will return home) and adoptive parents. These sessions should focus on promoting well-being and not just on detecting ill health.
- Each local authority should have access to two designated doctors and two nurses, experienced in the mental health of looked-after children.
- A comprehensive central CAMHS database should be set up as a matter of urgency, so that it is clear what services are available and where. This needs to be properly resourced, so that it is kept up to date, and widely accessible.
- There should be a comprehensive review of CAMHS, following the lead in Scotland, with a view to ensuring that local services become more needs led.
- More needs to be done locally and nationally to recruit foster carers.
- Regular respite care should be offered to foster carers looking after young people with mental health problems.
- Councillors and senior managers in all services must ensure that staff at all levels are made aware of and act on policy, guidance and evidence-based good practice.
- The barriers and mistrust between health and social services must be addressed as a matter of urgency, both locally and nationally. More emphasis needs to be placed on social services and education services working together to enable young people to remain in education.
- New partnerships and improvements to joint working are also needed for children with complex and multiple needs, such as disabled looked-after children with mental health problems.
- Every school should have a designated looked-after children link teacher. Consideration should be given to recording mental health difficulties in personal education plans.

Glossary

Affective disorder	Persistent emotional distress and abnormal moods, such as being withdrawn and unhappy, sleeping badly.
Behaviour support plans	Plans developed by local education authorities for children with behavioural problems.
CAMHS	Children and Adolescent Mental Health Services.
Comorbidity	Simultaneous appearance of two or more psychiatric or physical illnesses, for example alcohol dependence and depression.
DSM-IV	Diagnostic Statistics Manual (standard US classification of mental health problems).
Conduct disorder	Syndrome of core symptoms characterised by the persistent failure to control behaviour.
ICD-10	International Classification of Diseases-10 is a standard manual classifying mental illness and behavioural disorders. Published by the World Health Organisation.
LEA	Local education authority.
Looked-after children	Children who are either provided with accommodation by a local authority social services department for a continuous period of more than 24 hours or someone subject to a relevant court order under the Children Act 1989. The court order puts a child in the compulsory care of a named local authority, which then has shared parental responsibility.
MAPs	Local authority management action plans introduced by the Government's Quality Protects programme.
NVQ	National vocational qualification.
PEPs	Personal education plans (produced by each local authority for each looked-after young person): a record of academic achievements and developmental needs.
SEN	Special educational needs.
SEN code of practice	Governs interventions by schools and local education authority support staff for children with special educational needs.
SSD	Social services department.
SSI	Social Services Inspectorate.

Tier 1	Primary mental health services, including those offered by GPs, health visitors, school nurses, teachers, social workers and voluntary organisations.
Tier 2	Services comprising specialist professionals, such as clinical psychologists, nurse specialists, paediatricians and educational psychologists, who tend to work on their own.
Tier 3	More specialised services for severe, complex and persistent disorders. Practitioners tend to work in teams, for example, in a child psychiatry out-patient service, which include psychiatrists and other therapists.
Tier 4	Highly specialised part of child and adolescent mental health services, such as residential in-patient facilities, dealing with very complex needs.

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Appendix 1

Taken from: The Government's Objectives for Children's Social Services (Department of Health, 1999c).

Objective 1 – ensuring stable, secure, safe and effective care for all children

"To ensure that children are securely attached to carers capable of providing safe and effective care for the duration of childhood" by:

- supporting families to help children in need be as successful as possible in their lives
- ensuring more stability for children in the care of local councils
- helping children to find secure homes with adoptive parents
- making sure that where adoption is the right thing, children in care are adopted as quickly as possible
- making sure that where long-term fostering is the right thing, children in care are placed as quickly as possible.

Objective 2 – protecting children from abuse and neglect

"To ensure that children are protected from emotional, physical, sexual abuse and neglect (significant harm)" by:

- bringing down the number of children who die as a result of abuse
- stopping as much child abuse as possible
- making sure that as few children as possible suffer from repeated abuse.

Objective 3 – better life chances for children in need: education, health and social care

"To ensure that children in need gain maximum life chance benefits from educational opportunities, health & social care" by:

- helping children in need to achieve more at school
- helping children in need to grow up fit and healthy
- helping children in need to keep out of trouble with the police
- helping children whose parents are disabled or who have other health problems to enjoy a normal life
- providing good quality care and treatment for children and young people with mental health problems
- helping black and ethnic minority children in need to do as well as possible.

Objective 4 – good life chances for children in care

“To ensure that looked-after children gain maximum life chance benefits from educational opportunities, health care and social care” by:

- helping looked-after children to do as well at school as other children in the area
- making sure that looked-after children grow up fit and well
- bringing down the numbers of looked-after children who get into trouble with the police
- making sure that looked-after black and ethnic minority children are as successful as possible.

Objective 5 – enabling young people leaving care to live successful adult lives

“To ensure that young people leaving care, as they enter adulthood, are not isolated and participate socially and economically as citizens” by:

- making sure that young people who were in care when they were 16 are studying, training or working when they are 19
- making sure that social services departments are still in touch with young people, who were in the care system when they were 16, three years later when they are 19
- making sure that young people leaving care are living in good accommodation at the age of 19.

Objective 6 – meeting the needs of disabled children and their families

“To ensure that children with specific social needs arising out of disability or a health condition are living in families or other appropriate settings in the community where their assessed needs are adequately met and reviewed” by:

- making sure that that local authorities and the health service have a complete picture of the numbers and circumstances of disabled children in their area
- providing more and better family support to help disabled children and their families live ordinary lives
- helping more disabled and non-disabled children use the same play and leisure services
- giving children and parents information about the services which might help them.

Objective 7 – better assessment leading to better services

“To ensure that referral and assessment processes discriminate effectively between different types and levels of need and produce a timely service response” by:

- making sure that social services, health and education agree on how they will assess what help children and families need and how they will respond
- making sure that fewer families have to ask several times before their children get the help they need
- completing the initial assessment within seven working days
- completing the core assessment within 35 working days of the initial assessment
- providing services promptly in response to the assessment.

Objective 8 – actively involving users and carers

“To actively involve users and carers in planning services and in tailoring individual packages of care, and to ensure effective mechanisms are in place to handle complaints” by:

- actively involving children and families in planning and reviewing the services they use and in the decisions which affect them
- ensuring that children in care have trusted people to whom they can speak and who will speak on their behalf
- showing that children and families are becoming more satisfied with services.

Objective 9 – using regulation to protect children

“To ensure through regulatory powers and duties that children in regulated services are protected from harm and poor care standards” by:

- making sure that all staff and workers stick to the rules which protect children and which set standards of care.

Objective 10 – making sure that child care workers are fit for the job

“To ensure that social care workers are appropriately skilled, trained and qualified and promote the uptake of training at all levels” by:

- making sure that all residential child care workers are qualified to at least National Vocational Qualification (NVQ) level 3 by March 2002
- helping child care social workers achieve the new, post-qualifying award in child care.

Objective 11 – making best use of resources: choice, effectiveness and value for money

“To maximise the benefit to service users from the resources available, and to demonstrate the effectiveness and value for money of the care and support provided, and allow for choice and different responses for different needs and circumstances” by:

- making sure that every penny spent on children’s services is used to maximum effect
- meeting the needs of children and families from black and ethnic minority communities.

Appendix 2

Government initiatives

Government programmes and documents launched in the past from 1997 to 2001 which have had an impact on the mental health and well-being of looked-after children are:

Programme/document	Launched	Sponsoring or lead government department or unit
Sure Start	1997	Department of Health (DoH)
Health improvement programmes	1997	DoH
Healthy schools programme	1997	Department for Education and Employment (DfEE); renamed the Department for Education and Skills (DfES)
Health action zones	1998	DoH
Education action zones	1998	DfEE
Quality Protects	1998	DoH
National priorities guidance	1998	DoH
CAMHS innovation mental health grant	1998	DoH
<i>Teenage Pregnancy</i> report	1999	Social exclusion unit
Drug misuse special allocation fund	1999	DoH
Crime reduction strategy	1999	Home Office
Youth justice reform programme	1999	Home Office
<i>Promoting Health for Looked-after Children</i> (consultation document)	1999 (guidance imminent)	DoH
Guidance on the education of looked-after children and young people	2000	DfEE and DoH
Children's fund	2000	Children and young people's unit
<i>Adoption: A New Approach</i> white paper	2000	DoH
Connexions service	2001	DfES
<i>Valuing People: A New Strategy for Learning Disability for the 21st Century</i> white paper	2001	DoH
National service framework for children	Forthcoming (announced 2001)	DoH
Children (Leaving Care) Act 2000		DoH

Appendix 3

Current initiatives to improve the mental health of looked-after children

There are a number of initiatives under way that show how mainstream services can improve the mental health of looked-after children. They provide examples of how policy can be put into practice and of how barriers to improvement can be broken down. The Department of Health, for example, is funding a number of projects that offer examples of joint working between health and social services.

The following is a snapshot of what is occurring in England. The majority of the projects included below provide good examples of joint working; others provide support to specifically prevent placement breakdowns or provide education on mental health issues through mainstream schools.

Some examples of projects providing specific interventions were highlighted in *The Mental Health Needs of Looked-after Children* (Richardson & Joughin, 2000).

1 CAMHS innovation mental health grant – originally CAMHS mental illness specific grant (MISG)

Twenty-four local authority projects, including the Southampton behaviour resource service (outlined below), were set up in England in 1998/1999 with a three-year Department of Health grant (Department of Health 1999a). All of the projects are partnerships between health authorities, health trusts and local authority social services departments, as well as, in many cases, education departments and the voluntary sector.

The Department of Health has announced a further two years of tapered funding for the projects after March 2002. Twelve of the projects are specifically about looked-after children. Two projects, in Devon and Lewisham, are working with young people involved in offending and/or substance misuse.

The Young Minds charity has worked with the Department of Health to evaluate the projects and an overview report is expected at the end of the year. See www.youngminds.org.uk or contact the Department of Health at cathy.james@doh.gsi.gov.uk

Behaviour resource service: Southampton's multi-agency integrated treatment service for young people with complex difficulties

The behaviour resource service is a tier 4 service working with the most disturbed and disadvantaged young people in the city of Southampton.

Half the project is funded by Department of Health CAMHS innovation grant for the first three years.

Referrals are selected by a multi-agency panel on the basis of functional impairment, symptom severity and complexity; half are looked-after children. There is a short-stay residential unit (four beds, one for emergencies) staffed by residential social workers, RMNs and a multi-disciplinary community team. The service offers intensive management based on a multi-systemic model of care, providing interventions in partnership with local CAHMS/social services and specialist education services.

The behaviour resource service is a partnership between social services, the local education authority and health, jointly planned, staffed, funded and managed by all three.

Southampton also has a looked-after service, which is less intensive than the behaviour resource service; many of its clients have previously attended the latter. Direct work, carer support and consultation to residential units are provided.

Both services have input from community paediatricians (for other health needs, including sexual health). There are also two education specialists for looked-after children: a behaviour resource service teacher and an educational psychologist.

Each school in Southampton now has a designated teacher with lead responsibility for looked-after children.

The findings suggest that a one-team approach is more effective than disjointed services.

Brighton and Hove attachment project

A multi-agency team offers an intensive assessment and treatment facility for children with attachment difficulties, who are in or awaiting permanent placement with adoptive parents or long-term foster carers. The team also offers consultation to other professionals on care planning.

Cheshire

A multi-agency project, Just, in Ellesmere Port, works with 11- to 16-year-olds who are looked after or at risk of becoming looked after, to support their education and care placements. The team consists of a youth worker, a senior teacher, a social worker, a psychologist and a clerical officer. It also offers support and consultation to carers and professionals. There is also a multi-agency project in Crewe focusing on young people at risk of becoming looked after.

Dorset: Connections project

The aim is to increase looked-after children's access to therapeutic services, particularly in the case of children who have been abused. The project's co-ordinator organises therapeutic sessions and also funds sports and leisure activities. Support and consultation is offered to carers and professionals, along with a library information service.

Essex: looked-after children's clinical support team

This project is a partnership between social services and the local health authority and trusts and has links with a local in-patient unit and a social services secure unit. (It works with the local

CAMHS in order to ensure that children have continuing support following intensive help from the project.) It targets looked-after children who have significant mental health problems and who are at risk of placement breakdown, providing a multi-disciplinary response and seeking to improve the confidence and competence of foster carers and residential staff. The team consists of social workers, clinical nurse specialists, a psychologist and has input from a psychiatrist.

Liverpool: Rosta project

This project works with looked after 13- to 16-year-olds with serious psychological and emotional needs, particularly those at risk because of self-harm and substance misuse, as well as carers and sometimes birth families. The project comprises a multi-disciplinary team, including a therapeutic foster care service. It also aims to keep young people in their community and reduce the use of out-of-area placements.

Northampton: Delta project

A partnership between social services, education and health services provides an intensive three-month assessment and treatment programme, including education, therapy and 24-hour care on a one-to-one basis, for young people in residential care exhibiting extreme behaviour. The team consists of a project leader, residential social workers, a clinical psychologist and specialist teaching staff. The project aims to support young people in their existing placements or to help move them on to appropriate placements and to reduce the use of out-of-area placements.

Sheffield: Sheffield support service for looked-after children

A multi-disciplinary team provides assessment and a range of therapies for children and young people in residential and foster care, as well as specialist educational input. The team also provides consultation, support and training to carers and professionals working with looked-after children. It is a partnership between social services, education and health services and the NSPCC.

Southwark: the Care Link project

This project assesses usually black or ethnic minority 6- to 18-year-olds, who have been looked after for more than three months and who have emotional or behavioural difficulties that threaten to disrupt their school or care placement, and offers short term therapy. Care Link has also helped young people to make a film about their experiences of being looked after.

Staffordshire: Sustain project

A project aiming to reduce placement changes, to enhance the skills and knowledge of carers and to provide consultation to professionals, Sustain uses a systemic family therapy approach with children and their carers where there is a high risk of a placement breaking down. Referrals come from foster carers, children and young people and residential workers.

West Berkshire: Connect project

A multi-disciplinary team with links to mainstream CAMHS offers assessment and therapeutic input to looked-after children and their carers in both foster and residential settings.

West Sussex: foster care project

This project provides assessment and therapeutic input to children looked-after in long-term placements, particularly where there are attachment difficulties. It also offers training, consultation and support to foster carers.

2 Beacons

The NHS beacons programme comes under the auspices of the Modernisation Agency, set up to modernise services in line with the 10-year NHS Plan and to develop NHS leaders and managers.

Each year the programme identifies high quality services. Beacon services' good practice is then shared with others in a number of ways, for example, via the Department of Health beacons website (www.modernnhs.nhs.uk). Two of the three CAMHS beacons announced in 2001 focused on looked-after children. One is Southampton's behaviour resource service.

Joint strategy on mental health services for children and families in Leicester, Leicestershire and Rutland

Partner agencies agree services on a three-year basis. A young people's team offers a designated mental health service to looked-after children in Leicester, Leicestershire and Rutland, as well as working with local youth offending teams and hostels for families, made homeless through domestic violence. A jointly funded psychology post has been set up to work with young people in residential care. A mental health team for looked-after (and adopted) young people provides mental health assessments, a range of interventions, consultation to other agencies, liaison and joint work and training. Supported by the CAMHS modernisation fund, it comprises two primary mental health workers for looked-after children and two for youth offending teams, two psychologists, one child psychiatrist and one family support worker for the homeless.

3 Other research projects

National Children's Bureau – two projects

a) Taking Care of Education project (2000-2003), Gatsby Charitable Foundation

This project aims to support three local authorities by bringing together current knowledge, resources and ways of working that improve the educational achievements of looked-after children.

Through an evaluation report, the project aims to highlight what, from a range of approaches, works well in a sample of local authorities to improve the education of looked-after children; to identify any changes in the well-being of a sample of young people and in their attitudes to education; to ascertain the views of young people on their experiences of being looked after and education; to highlight any educational achievements and other 'social inclusion' outcomes and identify any associated factors; to identify costs of developmental programmes and highlight barriers to implementation.

b) Promoting positive mental health for children in public care (2000-2003), The Diana, Princess of Wales Memorial Fund

The project hopes to help develop child-friendly assessment processes for identifying the mental health needs of individual care leavers, as well as carrying out mental health promotion work with care leavers. Working initially with a small number of local authorities, the project is consulting looked-after young people and recent care leavers about the support and services they want for their mental health and well-being. The findings will be given to service providers, who will also be helped in developing services to meet the needs uncovered. Training is also to be given to those working with or supporting looked-after young people.

The King's Fund

King's Fund research has shown that young people who leave local authority care are at increased risk of mental health problems and that traditional services let them down. The organisation is funding a £70,000 project in Lewisham, south-east London, to bring mental health services to care leavers. A specialist outreach worker (a community psychiatric nurse or social worker) will hold regular drop-in sessions at a venue used by young care leavers. The project also aims to train past care leavers to act as mentors or advocates for others leaving the system. The project is a partnership between Lewisham council, the South London and Maudsley NHS Trust, the Children's Society rights and participation project and the voluntary organisation, First Key.

The Who Cares? Trust charity's CareZone

CareZone is a range of child-centred information and communication technologies (ICT) services, such as secure, online links with other looked-after children, information on health and well-being and education resources. The services will be accessible via the web, personal computers, mobile phones, digital TV and games consoles. It aims to be a 'virtual world' for the looked-after child, accessible anywhere, any time. For more information, contact carezone@thewhocarestrust.org.uk.

Leicestershire evaluation projects

Two evaluation projects, funded by Leicester and Leicestershire local authorities and Leicestershire health authority, are under way. One is assessing the health profile and service needs of looked-after children in the area. The other is an evaluation of the Leicester, Leicestershire and Rutland, young people's team (see above). This involves interviewing children, their carers and other staff before and after the intervention to find out the impact a designated team can have and the extent to which it can support Quality Protects objectives (such as meeting the mental health needs of looked-after young people, developing measurable outcomes and evidence-based service provision).

4 Other initiatives

Many other initiatives are under way around the country. The following are interesting projects which have yet to be evaluated.

Joint working

In Cambridge, a multi-disciplinary team (psychiatry, clinical psychology, social work, primary mental health workers and counsellors) has been formed from the general CAMHS service to work specifically with families referred by social services, bypassing the general CAMHS waiting list. They offer a consultation to the referring social worker, refer to child psychotherapy, family therapy or in-patient teams or work directly with some cases (18 out of 28 families according to the first audit).

In Sheffield, a residential workers forum was set up to allow residential social workers and staff from the local in-patient tier 4 service for adolescents to talk, because of tensions between the services. (A training-needs analysis had shown that social services wanted more contact with the tier 4 service, while the latter had had problems with social services not being able to accommodate their children and young people over the weekend.)

Placements

The Peper Harow Foundation has a number of projects working primarily with looked-after children. One is the Midlands children's project in Northampton offering outreach and sessional support, short-term residential care and educational support to young people and their parents and carers to prevent placement breakdowns. Another is the Shropshire and Telford and Wrekin children's project providing day-support programmes to young people who are having problems at school and in their placements.

In Buckinghamshire, a health, social services and education project provides a rapid response, using systemic-brief-solution focused interventions over eight weeks, to looked-after children at risk of placement breakdown and to families where there is a risk of family breakdown.

Therapeutic social work team

In Leeds, a therapeutic social work team, based in CAMHS tiers 3 and 4 teams, co-ordinates the therapy, training and consultation for looked-after children, usually in the community. Referrals for therapeutic services are made by the allocated area social worker and considered at a monthly multi-disciplinary panel, where they can then be sent either to one of the CAMHS teams or back to the therapeutic social work team. The team aims to make contact and begin the process of intervention within 28 days of the referral going to the panel. A range of therapeutic interventions are offered, such as direct work, group work (cognitive, psychoanalytic, and systemic), individual work and systemic family therapy.

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The Mental Health Foundation is the UK's leading charity working for the needs of people with mental health problems and those with learning disabilities. We aim to improve people's lives, reduce stigma surrounding the issues and to promote understanding. We fund research and help develop community services. We provide information for the general public and health and social care professionals. We aim to maximise expertise and resources by creating partnerships between ourselves and others including service users, Government, health and social services.

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