



**NSPCC**

# **Achieving emotional wellbeing for looked after children**

A whole system approach

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**EVERY CHILDHOOD IS WORTH FIGHTING FOR**

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All mistakes and omissions remain our own.

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# Executive summary

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Looked after children are approximately four times more likely to have a mental disorder than children living in their birth families. This report explores the causes of poor mental health among looked after children and considers how services in local areas can work together to promote good emotional wellbeing for looked after children. It asks:

*How can we achieve good emotional wellbeing for all children in care?*

*What would a care system that prioritises children's emotional wellbeing look like?*

In partnership with four local authorities in England and Wales, the NSPCC conducted a programme of fieldwork, interviewing looked after children and care leavers, their carers and professionals from health and social care services, to understand their views on how the care system currently supports young people's emotional wellbeing and what changes they would like to see. The NSPCC also commissioned a literature review of evidence on 'what works' in promoting good mental health for looked after children, and worked with the four local authorities and their health partners to consider how to translate messages from research into practice and to design new ideas for supporting the emotional wellbeing of looked after children.

## Priorities for change

The NSPCC's interviews with children and young people revealed that, while some young people had received loving and nurturing care from consistent carers and were very pleased with the quality of support they had received, others had suffered from a lack of attention to their emotional needs. In the worst cases, young people had been let down by a system that did not recognise their behaviour as a sign of distress and failed to provide them with support to develop secure attachments to their carers. As a result they had experienced multiple placement breakdowns.

Analysis by Loughborough University presented in this report suggests that a lack of support for looked after children's emotional wellbeing – and allowing children's placements to break down – could be more expensive than providing specialist support

to prevent placement breakdowns. This analysis shows that:

- One child's unstable and unsupported experience of care cost £22,415 *more* per year (including health, social care and criminal justice costs) than another child's stable and well-supported care journey.
- If a child who experienced nine placements had received a package of specialist support to keep his placement stable, this could have saved an estimated £67,851 over 11 years (approximately a 10 per cent reduction in costs).

Health and social care commissioners should consider how they can make more cost-effective local spending decisions that support improved placement stability and better mental health outcomes for looked after children.

This report highlights that too often the emotional wellbeing and mental health of looked after children is thought of as something that is the responsibility of specialist mental health services alone. This must not be the case; we need a whole system that prioritises the emotional wellbeing of children in care, across social care and health. Based on the fieldwork and research for this project, the NSPCC and its local authority partners identified five priorities for change, which would improve support for the emotional wellbeing of children in care. These are:

- Embed an emphasis on emotional wellbeing throughout the system
- Take a proactive and preventative approach
- Give children and young people voice and influence
- Support and sustaining children's relationships
- Support care leavers' emotional needs

These priorities highlight the importance of local authorities and health services working together to develop appropriate support based on a robust understanding of the emotional and mental health needs of looked after children in their area. Understanding this need is essential, both for individual children and at a population-level, so that

commissioners can ensure that they have sufficient services in place to support children's needs.

Above all, children and young people need consistent relationships with adults who are committed to loving and caring for them. However, some young people will not experience this stability unless the right support is put in place for them and their carers. This requires services that take an individual approach to understanding children's and carers' needs, that give children opportunities to shape their own care, and provide proactive support rather than allowing problems to get worse.

Therapeutic services have an important role to play, and must be made more accessible – but this support must be provided in a range of different ways across social care, health and education. Research shows that the everyday environment that children and young people experience in care is central to their wellbeing. It is critical that we support and empower foster carers and residential care workers to develop strong, trusting relationships with children and young people. A care system that promotes looked after children's emotional wellbeing is one in which young people, carers and professionals (including social workers, health professionals and teachers) are all given the knowledge and skills they need to support children's good mental health and wellbeing. Far from being a specialist task, promoting looked after children's emotional wellbeing is the responsibility of everyone connected with the care system.

Most fundamentally, we must recognise that children and young people have individual experiences and views on good emotional wellbeing. Understanding of these individual needs, views and wishes must be central to how we provide support for children and young people in care. Looked after children and care leavers need an integrated approach to supporting their care, in which professionals actively listen to children and young people, speak the same language and work together flexibly to meet their needs.

## Recommendations for policy and practice

Chapter 5 sets out the NSPCC's vision for a care system that prioritises looked after children's emotional wellbeing. This includes the following recommendations for policy and practice, which suggest actions that can be taken to achieve the five identified priorities.

### Priority one: Embed an emphasis on emotional wellbeing throughout the system

1. Governments must take action to ensure that the mental health and emotional wellbeing of looked after children is a clear priority for our care systems. They should define clear requirements for local authorities' collection of outcome measures to track children's progress.
2. Local authorities and health services should demonstrate the priority placed on looked after children's emotional wellbeing in their local needs assessments and commissioning strategies.
3. Local authorities should have a clear strategy for developing the workforce's understanding of looked after children's emotional wellbeing, ensuring that looked after children receive high quality support from all carers, social workers and other professionals.
4. Local authorities and health agencies should develop joint plans to support the emotional wellbeing of looked after children and facilitate greater integration of social care and mental health services. They should appoint a lead clinician to coordinate support for looked after children's mental health, and ensure routine access to training and clinical consultation for the children's workforce.

## Priority two: Take a proactive and preventative approach

5. To enable access to the right support at the earliest opportunity, the Government in England should introduce the right for all looked after children to have a specialist assessment of their emotional, mental health and other developmental needs by a qualified mental health professional. Their needs should be identified on entry to care and monitored throughout their time in care. The Government in Wales should issue equivalent guidance on the content of mental health assessments as part of the code of practice on part six of the Social Services and Wellbeing (Wales) Act 2014.
6. Looked after children should have the right to the support they need to promote good emotional wellbeing at the earliest opportunity, rather than waiting for a crisis before they can access support. Every looked after child should have a support plan setting out the support that they and their carer will receive, in order to secure good outcomes and keep the placement stable.
7. Social care, health and education should work together to jointly commission a spectrum of integrated services to support looked after children's emotional and mental health needs and build their resilience.
8. Looked after children should be supported to develop their sense of identity. Local authorities should ensure that children are supported to carry out life story work from an early point in their care journey.
9. To end delays in access to mental health support for looked after children who are placed out of area, central governments should set national tariffs for looked after children's mental health assessment and increase the accountability of local providers by requiring that they make a decision within four weeks about the therapeutic services they can offer.

## Priority three: Give children and young people voice and influence

10. Looked after children should be enabled to define what 'good emotional wellbeing' looks like for them. This vision should be the focus of the child's care plan. Local authorities must ensure that children are provided with meaningful mechanisms to feedback on their experiences of care.
11. Local commissioners should ensure that looked after children, care leavers and carers are involved in co-designing their local Children's and Adolescents' Mental Health Services (CAMHS), to develop a service offer that is attractive and accessible to children and young people.
12. Looked after children and care leavers should be viewed as experts on the care system. Local authorities should ensure that they have effective mechanisms for consulting them about service improvement.

## Priority four: Support and sustain children's relationships

13. Local authorities should work to improve the status of foster carers in the children's workforce. Foster carers should be provided with high quality training and support to help them understand and address the emotional needs of looked after children. Local authorities should monitor carers' emotional wellbeing, and promote early intervention to support stable placements.
14. Local authorities must seek to address the structural boundaries between teams that lead to looked after children experiencing unnecessary changes in their key worker. Where changes cannot be avoided, transitions should be flexible so that they do not coincide with other significant changes in an individual child or young person's life.

15. Local authorities and health services must recognise the importance of supporting positive relationships between looked after children and their birth families (where children wish these relationships to continue). Central governments should invest in research and service development to identify effective ways of supporting the relationships between looked after children and their birth families to promote children's emotional wellbeing.

### **Priority five: Support care leavers' emotional needs**

16. As part of their preparation for leaving care, local authorities should work with young people to help them identify and strengthen their support networks, identifying how these can help boost young people's resilience and support good emotional wellbeing during a transition to independence.

17. Young people should not experience a 'cliff edge' in support for their mental health when leaving care; health services should recognise the same corporate parenting responsibilities demonstrated by local authorities. Local authorities and health services must work together to improve this transition and identify support for the mental health and wellbeing of care leavers up to age 25. Central governments should review the resource needed to ensure these arrangements can be put in place.

18. Access to adequate ongoing support is critical to sustaining care leavers' emotional wellbeing after they leave care. Local authorities should work with care leavers to identify their specific requirements and put in place a tailored housing-with-support package that meets their emotional and practical needs.

# Introduction

This project was developed by the NSPCC because a high proportion of looked after children in England and Wales have mental health problems that require professional support – between 45 per cent and 72 per cent of children, according to key pieces of research.<sup>1</sup> However, looked after children's mental health needs are frequently unmet, which increases children's risk of a variety of poor outcomes, including placement instability and poor educational attainment.

Working in partnership with local authorities and their health partners, this project was designed to learn more about 'what works' in meeting the mental health needs of looked after children, and to investigate how we can put this research into practice to transform local services and support for them.

The two central motivating questions in this project were:

*How can we achieve good emotional wellbeing for all looked after children?*

*What would a care system that prioritises children's emotional wellbeing look like?*

Exploring these questions in partnership with four local authorities, the project worked with looked after children, care leavers, carers, social workers, mental health providers and a variety of professionals from a range of services in each local area.

## Our approach

This project involved two main phases of work: 'defining the challenge' and 'designing the solution.'

### Defining the challenge

The first phase of this project included a literature review from the Rees Centre at Oxford University to identify existing evidence of the mental health needs of looked after children, and evidence of how these needs can be met most effectively.

It established a steering group to advise on the project scope and methodology, and commissioned support from the Innovation Unit to help design interview materials and participatory workshops.

The NSPCC recruited four local authorities within the UK to work in partnership with; three in England and one in Wales. These areas represented a variety of social and geographical contexts. They included a London borough, a city council and two county councils with mixed urban and rural populations. In each of these four areas, the NSPCC conducted a detailed programme of fieldwork to learn about looked after children and young people's experiences of care; the nature of current provision of services; and strengths and weaknesses of this provision.

The project's fieldwork included interviews with:

- 42 children in care and care leavers
- 56 foster carers
- 9 residential care workers
- 19 looked after children social workers
- 6 fostering & adoption social workers and managers
- 6 leaving care workers
- 8 Independent Reviewing Officers
- 10 CAMHS professionals
- 4 health professionals
- 7 staff from education services
- 1 children's rights manager
- 2 placement team workers
- 1 Lead Member
- 7 representatives of local voluntary sector organisations

<sup>1</sup> The 45 per cent figure comes from Meltzer et al (2003a) and the 72 per cent figure comes from Sempik et al (2008). In Wales, research by Meltzer et al (2003b) found that 49 per cent of children looked after by local authorities had a mental disorder.



Our interviews with looked after children used visual materials to map their journey through care and represent their emotional wellbeing at different points of their time in care. They also mapped out their social networks to demonstrate the people who were most important to supporting their emotional wellbeing. Interviews with foster carers included exercises to map the stories of the children they were caring for and the support that had been provided during these placements. Please note that while this report will reference these stories, both names and identifying details of children and carers included in this report have been changed to protect their anonymity. Please see the appendix for more information about the children and young people who participated in interviews.

From the fieldwork, and discussions with senior managers, the current provision of services for looked after children in each of the four local authority areas was mapped. These maps described both the types of support services available and the budgets for these services. Workshops with 20–30 professionals and carers in each area were held to discuss the nature of support for the emotional wellbeing of looked after children in their area, as well as the challenges and opportunities to improve this support.

### Designing the solution

In the next phase of work, the NSPCC's analysis of the fieldwork identified a range of challenges to improving support for the emotional wellbeing of looked after children. It also identified five principles of a care system that promoted positive emotional wellbeing, which were agreed by senior managers in each area. These principles are described in detail in Chapter 5 of this report.

In each area, senior managers from children's social care and CAMHS identified the specific focus of improving support for the emotional wellbeing of looked after children in their areas. The topics they identified are described in box A.

#### Box A: Local authorities' priorities for promoting good emotional wellbeing for looked after children

1. Improving the assessment and monitoring of looked after children's emotional wellbeing and mental health.
2. Improving early intervention to support looked after children's emotional wellbeing and mental health.
3. Building children's resilience through a holistic understanding of children's wellbeing.
4. Building the emotional intelligence of the workforce.
5. Improving training and support for carers and other professionals to promote placement stability.
6. Ensuring young people's voices are heard throughout their time in care.
7. Enabling children in care to develop a coherent sense of their identity.
8. Sustaining young people's emotional resilience as they leave care.

In each area, the NSPCC held a 'system design' workshop, which brought together a range of professionals and carers to consider how to redesign support and ways of working to improve support for the emotional wellbeing for looked after children. These workshops were informed by the fieldwork from each area, as well as innovative services identified through an NSPCC 'horizon scan' and evidence from the Rees Centre's 'what works' literature review. Each developed a set of proposals to implement in that area.

## About this report

This report draws together the learning from the fieldwork and system design work in these four local authorities. Combining this with national and academic research, it presents a vision of a care system that promotes the emotional wellbeing of looked after children throughout their time in care and during their transition to independence.

**Chapter 1** presents evidence about the extent of mental health needs among looked after children, along with evidence of the causes of poor mental health.

**Chapter 2** provides a survey of national policy frameworks and a description of the local systems of support in place in England and Wales.

**Chapter 3** describes looked after children and young people's experiences of being in care and the NSPCC's learning from the fieldwork about how well looked after children's emotional wellbeing is currently supported.

**Chapter 4** describes current spending within the care system, and presents Loughborough University's new calculations of the costs of providing therapeutic support to looked after children to support placement stability.

**Chapter 5** presents a vision for a care system that promotes good emotional wellbeing for all looked after children, developed in partnership with four local authorities and their health partners. It details recommendations for change, setting out what is needed to deliver this vision.

# Chapter 1: What emotional wellbeing means for looked after children

Looked after children are four times more likely to have a mental disorder than children in the general population. This poor mental health is caused by the interaction of a variety of factors, including inherited characteristics and children's exposure to maltreatment before they enter care. Consequences of poor mental health for looked after children include a greater risk of instability in care and poor educational outcomes.

This chapter sets out research evidence on these subjects and explores how the term 'emotional wellbeing' is viewed by looked after children themselves. It presents looked after children's and young people's own definitions of their emotional wellbeing, gathered through the NSPCC's fieldwork. These findings highlight the need for an approach to promoting good emotional wellbeing for looked after children that recognises each child's individual circumstances, needs, wishes and feelings.

## Rates of poor mental health among looked after children

Research over the last decade provides compelling evidence that looked after children are at greater risk of experiencing poor mental health than children in the general population.<sup>2</sup> Table 1 compares the prevalence of mental disorders among looked after children and children living in their birth families in England, Scotland and Wales.<sup>3</sup>

Looked after children are just over three times more likely to have a disorder than disadvantaged children and over five times more likely to have a diagnosed mental disorder than non-disadvantaged children. The high rate of behavioural disorders among looked after children is particularly striking, with almost two out of every five children having some kind of diagnosed behavioural disorder. This is a cause for concern as research suggests that

Table 1: Comparison of rates of mental disorder among British children aged 5–17<sup>4</sup>

Category of disorder	Non-disadvantaged children (n = 1,253)	Disadvantaged children (n = 761)	Looked after children (n = 9,677)
Any disorder	8.5%	14.6%	46.4%
Anxiety disorders	3.6%	5.5%	11.1%
Post-traumatic stress disorder	0.1%	0.5%	1.9%
Depression	0.9%	1.2%	3.4%
Behavioural disorders	4.3%	9.7%	38.9%
ADHD	1.1%	1.3%	8.7%
Autistic spectrum disorder	0.3%	0.1%	2.6%
Other neurodevelopmental disorders	3.3%	4.5%	12.8%
Learning disability	1.3%	1.5%	10.7%

2 Tarren-Sweeney and Vetere (2014)

3 In this study, children living in their birth families were divided into two groups: 'disadvantaged' if their parents had never worked or worked in unskilled occupations, and 'non-disadvantaged' if their parents had other types of occupation. These two groups of children were then compared with a representative sample of British looked after children. *ibid*

4 Ford et al (2007), with thanks to Dr Matt Woolgar for his additional analysis.

children with disruptive and hyperactive behaviours are at particularly high risk of placement breakdown, as their carers can struggle to cope.<sup>5</sup>

## Causes of poor mental health

The causes of poor mental health among looked after children are complex and will be different for each child. However, clear messages are emerging from research indicating that looked after children's mental health is the result of the interaction of pre-existing mental health conditions; exposure to maltreatment; the length of exposure to maltreatment; and biological risk and resilience.

### Pre-existing poor mental health

A high proportion of children *already* have mental health difficulties at the point of entry to care. A 2008 study found that 72 per cent of children aged between five and 15 had some kind of emotional or behavioural problem at entry to care.<sup>6</sup> As these difficulties were already present when children entered care, it is likely that they reflect children's prior exposure to adversity.<sup>7</sup> It is, therefore, a mistake to view the care system itself as a primary cause of children's poor emotional wellbeing.<sup>8</sup>

### Exposure to maltreatment within the family

There is strong evidence that child maltreatment is a leading cause of poor mental health in childhood and throughout later life<sup>9</sup>, with more severe maltreatment associated with poorer mental health and higher levels of delinquent behaviour.<sup>10</sup> Researchers have expressed concern that child maltreatment is "a major public-health and social-welfare problem in high-income countries".<sup>11</sup> The term 'child maltreatment' encompasses all forms of abuse and neglect, such as physical abuse, sexual

abuse, psychological or emotional abuse, neglect and intimate partner violence between adults.<sup>12</sup>

Looked after children are far more likely to have experienced maltreatment than children in the general population. Research by the NSPCC found that 5.9 per cent of children in the general UK population aged under 11 had experienced severe maltreatment, rising to 18.6 per cent of children and young people aged 11–17.<sup>13</sup> In comparison, 55 per cent of looked after children in England and 58 per cent of looked after children in Wales entered care in 2014 primarily due to abuse or neglect.<sup>14</sup> Other reasons for children entering care, such as family dysfunction or acute family stress, may also have involved exposure to abuse or neglect (see table 2).

### Length of exposure to maltreatment

Prior exposure to maltreatment is an important dimension of looked after children's elevated risk of poor mental health. However, it is not just the *severity* of maltreatment that children experience that influences their emotional wellbeing, but also the *length of time* spent in an adverse environment. As Selwyn and colleagues observed, "The extent of children's recovery from abuse and neglect is known to be inversely related to the depth and length of their experience of adversity."<sup>15</sup> This combination of the severity and length of exposure to maltreatment is sometimes referred to as the 'dose' of maltreatment.<sup>16</sup>

Children who enter care at an older age (who may have spent longer in an adverse environment) are more likely to have poor emotional wellbeing.<sup>17</sup> A 2008 study found that 18 per cent of children who entered care aged 0–4 had emotional and behavioural difficulties, compared with 68 per cent of children who entered care aged 5–10 and

5 Rock et al (2013)

6 Types of problem were classified as conduct problems; self-harming behaviour; inappropriate sexual behaviour; relationship problems; anxiety or depression; bedwetting; concentration problems and 'other'. See Sempik et al (2008).

7 Sempik et al (2008), p230

8 Hannon et al (2010)

9 Gilbert et al (2009)

10 Radford et al (2011)

11 p68 ibid

12 p69 ibid

13 Radford et al (2011)

14 Department for Education (2014)

15 Selwyn et al (2006), p547

16 Woolgar (2013)

17 Hannon et al (2010)

Table 2: Children starting to be looked after in England and Wales on 31 March 2014

Category of need <sup>18</sup>	Number of children (England) <sup>19</sup>	Percentage of children (England) <sup>20</sup>	Number of children (Wales) <sup>21</sup>	Percentage of children (Wales) <sup>22</sup>
Abuse or neglect	30,430	55	1,170	58
Child's disability	690	2	25	1
Parent's illness or disability	1,040	3	75	4
Family in acute stress	2,940	10	230	11
Family dysfunction	5,710	19	305	15
Socially unacceptable behaviour	1,190	4	105	5
Low income	100	-	-	-
Absent parenting	1,870	6	90	4
Adoption disruption	N/A	N/A	5	0.2
<b>Total</b>	<b>30,430</b>	<b>100</b>	<b>2,005</b>	<b>100</b>

73 per cent of children who were aged 11–15.<sup>23</sup> Another study found that children who entered their foster or adoptive placement by the age of three had lower scores on the Strengths and Difficulties Questionnaire (SDQ), indicating fewer emotional and behavioural difficulties.<sup>24</sup>

### Biological risk and resilience

While exposure to abuse or neglect clearly increases the risk that children will experience poor outcomes, emerging neurobiological research indicates that maltreatment does not affect children in a uniform way.

*Real children are much more than just their brain structure, their physiology, their caregiving history, their attachments or their genetics in isolation.* (Woolgar, 2013)<sup>25</sup>

In practice, the multiple dimensions of 'nature' and 'nurture' interact over time to shape the individual course of each child's development. Dr Matt Woolgar, Consultant Clinical Psychologist at the South London & Maudsley NHS Foundation Trust, has outlined four areas of emerging scientific research that can further understanding of how maltreatment might affect an individual child's development. These are brain development, physiology, genes and differential susceptibility, as presented in box B below.

Reflecting on this research, Woolgar argued that: "The science tells us that biology responds to adversity with diversity in outcomes, and that is why we must privilege individual rather than generic accounts of children's well-being following early maltreatment."<sup>26</sup>

18 Most applicable need code when child started to be looked after.

19 Department for Education (2014)

20 Department for Education (2014)

21 StatsWales (2014)

22 StatsWales (2014)

23 Sempik et al (2008)

24 Biehal et al (2009)

25 Woolgar (2013), p239

26 Woolgar (2013), p249

## Box B: Four factors affecting the mental health of looked after children<sup>27</sup>

*Brain development:* Studies have shown that the brain continues to develop and adapt throughout childhood into the mid-20s. Studies of maltreatment have revealed both structural and functional differences between the brains of those who have experienced maltreatment and those who have not. This research indicates that children's brains adapt in the context of maltreatment to make them better able to identify threats. However, once the child is in a neutral environment they may misinterpret situations as threatening. Changes in the child's brain are possible in response to improved caregiving but opportunities will reduce as the child grows older.

*Physiology:* The stress systems of children who have been abused or neglected may work differently from other children. Prolonged exposure to stress can lead to the child having either chronically elevated or suppressed stress systems. If a child has a chronically elevated stress system, they may appear anxious and fearful; ready to identify and respond to threats. A chronically suppressed stress system can be associated with anti-social and aggressive behaviour.

However, changes in children's stress systems are possible once they move to a safe and nurturing environment.<sup>28</sup>

*Genes:* There is evidence of a genetic contribution to the risk of a variety of mental health problems, such as depression, psychosis and anxiety disorders, as well as drug and alcohol problems. Genes also influence an individual's resilience; their ability to withstand a negative environment. Through 'epigenetic' processes, a child's genes interact with their environment, shaping how the genes are expressed. There is evidence that early maltreatment can 'switch on' genes that are associated with anti-social behaviour.

*Differential susceptibility:* The idea of differential susceptibility helps to explain how some children are genetically more easily influenced by their environments than others. One child may be able to cope with a higher level of maltreatment without experiencing harmful effects than another child. A recent study has had some success in identifying the role of a specific 'differential susceptibility gene' ('CHRNA4') in influencing the extent to which individual children will be adversely affected by a maltreating environment.<sup>29</sup>

## Consequences of poor mental health

The consequences of poor mental health for looked after children are far-reaching. While poor mental health is distressing in itself, it also increases the risk that looked after children will experience a range of poor outcomes.

Children who have poor mental health when they enter care are at greater risk of placement instability. One study from 2006 found that children who had more severe emotional and behavioural problems when they entered care, and had experienced more types of abuse, were more likely to go on to

experience instability and placement breakdowns.<sup>30</sup> Another study found that children's level of emotional and behavioural difficulties at entry to care, measured by the SDQ, could predict their subsequent placement stability over the next eight years.<sup>31</sup> They found that:

*The severity of the children's emotional and behavioural problems [...] appeared to increase the risk of placement disruption.*<sup>32</sup>

Children who were older at the start of their placement were at greater risk of instability, as were children whose carer was rated as 'less accepting'.<sup>33</sup>

27 Woolgar (2013)

28 Dozier et al (2008)

29 Grazioplene et al (2013)

30 Selwyn et al (2006)

31 Biehal et al (2009)

32 ibid

33 ibid

There is also evidence that children's experiences of instability can in turn cause or worsen poor mental health.<sup>34</sup> In the worst cases this can lead to a cycle of worsening mental health and placement breakdown, with escalating costs as children become 'difficult to place'.<sup>35</sup>

Poor mental health is also associated with poor educational attainment and other outcomes for looked after children. One study found that children with higher incidence of emotional and behavioural difficulties also demonstrated poor progress with their education and were expected to leave school without qualifications.<sup>36</sup> Another study found that children who had higher SDQ scores were more likely to have behavioural problems at school, to be truant and to be excluded from school.<sup>37</sup> A third study also found that children with emotional or behavioural difficulties, who also committed offences, were the "least likely to access routine health services or psychotherapeutic support, and the most likely to be excluded from school".<sup>38</sup> A study of care leavers' outcomes found that those who left care with poor mental health were at greater risk of experiencing homelessness and were twice as likely to have poor employment outcomes.<sup>39</sup>

## Defining emotional wellbeing

There is no consensus about how looked after children's wellbeing should be understood and defined. In the fieldwork for this project, the NSPCC used the phrase 'emotional wellbeing' as its meaning is easily understood, it is non-stigmatising and it does not reflect a deficit-model. In comparison, terminology like 'mental health' is often equated with mental illness.

The National Institute for Health and Care Excellence (NICE) has used the term 'mental wellbeing' in its work on children's mental health. Its definition of mental wellbeing is subdivided into three dimensions: emotional wellbeing, psychological wellbeing and social wellbeing – see box C.

### Box C: Children's 'mental wellbeing' as defined by NICE<sup>40</sup>

- Emotional wellbeing (including happiness and confidence, and the opposite of depression/anxiety).
- Psychological wellbeing (including resilience, mastery, confidence, autonomy, attentiveness/involvement and the capacity to manage conflict and to problem solve).
- Social wellbeing (good relationships with others, and the opposite of conduct disorder, delinquency, interpersonal violence and bullying).

The term 'emotional wellbeing' is intended to encompass all three of these dimensions, corresponding with children and young people's understanding of this term. The NSPCC discussed the meaning of both 'good' and 'poor' emotional wellbeing with looked after children and found that they did not distinguish between these different dimensions of wellbeing but found them all to be inextricably linked.

## Young people's definitions of good and poor emotional wellbeing

No account of looked after children's mental health and wellbeing would be complete without asking young people what 'emotional wellbeing' means to them. The following section presents looked after children and young people's own definitions of emotional wellbeing.

### Defining good emotional wellbeing

When discussing emotional wellbeing with the NSPCC, young people defined *good* emotional wellbeing according to their feelings; thoughts; behaviours; activities and achievements; relationships; and the importance of safety and stability.

34 Rubin et al (2007)

35 Ward et al (2008), p75

36 Selwyn et al (2006)

37 Biehal et al (2009)

38 Ward et al (2008), p258

39 Dixon et al (2006), p53 and p91

40 Adi et al (2007), p9

Feelings described by young people included upbeat states of mind, such as “happy”, “joyful” and “excited”, as well as more neutral states like “feeling OK” or “stable emotions”. Young people also discussed how good emotional wellbeing meant “feeling good about yourself”. Others referred to qualities like “confidence” and “self-esteem”. Young people also discussed how they would *think* when they had good emotional wellbeing, using terms like “positive thinking” and examples like “Having positive thoughts that I can pass an exam” and “Noticing the positive things instead of the negatives”. Young people also discussed “Being able to deal with your emotions” and “coping strategies”.

Behaviours that young people associated with good emotional wellbeing included “smiling”, “happy expressions”, “laughing” and “looking well”. A teenage girl who lived in a children’s home said “When I’m happy I run around like a lunatic, up and down!” Many descriptions of good wellbeing focused on being active and outward-facing; young people spoke about “having fun”, “going outside” and “getting out of my room”. One young person said that good emotional wellbeing meant “keeping yourself safe”.

Some young people mentioned activities and possessions that supported their emotional wellbeing. These included swimming, bead-making, planning, preparing food, playing computer games with a cousin and using social media like Facebook, Twitter and Skype. A female care leaver who was visually impaired talked about “gadgets like my talking watch and my talking mobile phone”. Young people also spoke about how their achievements gave them good emotional wellbeing, including “not going in the quiet room at school” and “trying to do a level on a game for ages and you finally do it!” A male care leaver who had recently been in trouble for anti-social behaviour discussed the importance of receiving praise: “If that person gets the praise, it feels good.”

Relationships were essential to most young people’s emotional wellbeing. Some explained that if they feel good, they want to “socialise” and “be with mates” or “see my family”. Others talked about the

importance of “having support” and “talking about your problem”. One girl discussed the benefits of counselling: “I think when you let it out...it helps you.” Some young people explained how their relationships with friends, family or carers helped them to move from a state of poor emotional wellbeing to good emotional wellbeing: “Maybe just one of my friends or my sister will ring me and say ‘do you want to go shopping or meet up?’ Then they cheer me up”.

Finally, some young people’s comments focused on the importance of safety and stability to their emotional wellbeing. Some children in care spoke of “feeling secure” and having “a safe environment”, while a male care leaver said that good wellbeing means “having a secure, warm, comfortable place where you can go home and relax”.

### Defining poor emotional wellbeing

Similarly, young people defined *poor* emotional wellbeing according to their feelings; thoughts; behaviours, relationships and experiences of instability. Some found it easier to find words to describe poor emotional wellbeing than good wellbeing. Feelings identified by young people included “sad”, “feeling down”, “depression”, “unloved” “stress”, “angry”, “frustration”, “tearful”, “confused”, “mood swings” and “feeling bad about yourself”.

Thoughts that young people associated with poor emotional wellbeing included “horrific memories” and “weird fears”, such as “fear my family members died or left me”. One care leaver said that for him poor wellbeing was “waking up and thinking ‘oh is it today already?’” Young people also referred to “thinking too much” and “keep looking into the past”.

Behaviours that some young people associated with poor emotional wellbeing included “taking it out on other people”, “violence”, “putting a hole in the window”, “throw stuff about” and “do criminal damage”. Some young also people discussed directing harmful behaviours toward themselves, such as self-harm and suicidal thoughts: “I used to think about hanging myself, jumping off a bridge.”



Other examples included destructive drug and alcohol use: “getting stoned every day” or “getting drunk and ending up in hospital”. Other young people said that they signalled their poor wellbeing through quiet and withdrawn behaviours: “Staying in, slumping around in the same clothes” or “I might just want everyone to go away”. Young people were sometimes only able to express their feelings through harmful or self-isolating behaviours but this was not always well understood by the adults around them.

Relationships with other people were central to young people’s ideas about poor emotional wellbeing. This time, discussion of poor emotional wellbeing often focused on keeping other people at a distance: “keeping things to yourself”, “bottling things up” and “not talking about problems”. One young person said that poor wellbeing was “Pretending you are feeling in a certain way, like happy, content”. Another referred to “putting on a fake face”. If young people did want to confide, poor wellbeing was when “no-one listens”.

Some young people discussed the sadness of separation from loved ones: “My brother and sister were adopted, like three years ago.” However, family relationships were not always seen as a positive thing; one care leaver felt that his difficult relationship with his brother was an ongoing cause of his poor emotional wellbeing. Young people also pointed to the impact of “moving around” and feeling rejected when placements broke down.

## Promoting good emotional wellbeing for looked after children

Ideas of good and poor emotional wellbeing are very different for each child in care. Each looked after child must be recognised as an individual and provided with the consistent relationships and personalised support they need to realise their own definition of good emotional wellbeing.

While each child will require an individual response, research also identifies important themes about what works in promoting good emotional wellbeing for looked after children. The Rees Centre’s literature review for the NSPCC concluded:

*The evidence reviewed supports the position that high-quality caregiving, with added interventions targeted either directly at the child or indirectly (through the carer or those around the child), providing support where necessary, might effect positive change in children’s well-being.<sup>41</sup>*

The authors of this report observed that more research is needed to provide evidence of “what promotes positive outcomes” for looked after children, as the majority of previous research has focused more narrowly on reducing symptoms of poor wellbeing, such as problem behaviour.<sup>42</sup> However, they were clear that much can be done to improve the emotional wellbeing of looked after children. Subsequent chapters of this report look at the evidence about what works to promote good emotional wellbeing for looked after children in more detail.

41 Luke et al (2014), p17

42 p17 ibid

# Chapter 2: Current systems of support for children in care

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A review of national policy frameworks in England, Wales, Scotland and Northern Ireland shows that steps have been taken to support the emotional wellbeing of looked after children across the UK. However, at a local level, there is significant variation in the extent to which work to support the emotional wellbeing of looked after children is seen as a priority. The NSPCC's fieldwork identified a variety of gaps and challenges in local systems of support for looked after children. This chapter identifies some key aspects of local care systems that require more work to ensure that looked after children's emotional and mental health needs are identified and supported.

## National policy frameworks

Responsibility for policy and practice concerning the emotional wellbeing of looked after children is now largely devolved to the four nations of the UK. Each jurisdiction has taken steps to focus on support for looked after children, but further work is needed to ensure that improving the mental health and emotional wellbeing of looked after children becomes a priority in all local areas.

## Legislation and policy in England

In England, new guidance published in March 2015 highlighted the importance of placing an equal emphasis on looked after children's physical and mental health. It set out the responsibilities of local authorities and clinical commissioning groups to ensure that children in care and care leavers do not experience delay or other barriers in accessing services to support their wellbeing. The guidance

also highlighted the role of local areas in planning and commissioning appropriate services effectively, to ensure that children in care can have their physical and mental health needs met.<sup>43</sup> However, it remains the case that emotional wellbeing is not yet a central policy priority for looked after children and further work is needed to ensure that the aims articulated in this guidance are implemented at a local level.

## Legislation and policy in Wales

The *Social Services and Well-being (Wales) Act 2014* lays the foundation for support for looked after children in Wales. Local authorities should "seek to promote the well-being of people who need care and support and carers who need care and support".<sup>44</sup> This includes supporting children's "physical, intellectual, emotional, social and behavioural development".<sup>45</sup> Local authorities looking after children must "safeguard and promote the child's well-being" and facilitate the child's access to services as the child's own parents would.<sup>46</sup> The act contains specific duties to assess whether the child has care and support needs that meet eligibility criteria for services, and meeting the child's eligible needs.<sup>47</sup>

Unlike in England, in Wales there is no requirement to complete a mental health screening tool for looked after children.<sup>48</sup> The draft *Care Planning, Placement and Review (Wales) Regulations 2015*, which are out for consultation at the time of publication, make provision for health assessments on entry to care, including the child's emotional and mental health.

43 Department for Education and Department of Health (2015)

44 Social Services and Well-being (Wales) Act 2014, section 5, p6

45 Social Services and Well-being (Wales) Act 2014, p5 [www.legislation.gov.uk/anaw/2014/4/pdfs/anaw\\_20140004\\_en.pdf](http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf)

46 Social Services and Well-being (Wales) Act 2014, section 78, p65

47 Social Services and Well-being (Wales) Act 2014, section 78, p65–6

48 Department for Education and Department of Health (2015), p17

## Legislation and policy in Scotland

In Scotland, the *Looked After Children (Scotland) Regulations 2009* state that all looked after children should receive a health assessment and that children's carers must be provided with background information about the child's health and development. The action plan, *Looked after children and young people: we can and must do better*, made a commitment that "Each NHS Board will assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments".<sup>49</sup> It also identified the need for care leavers to receive "a range of emotional, practical and financial support" during their transition to independence.<sup>50</sup>

In 2014, the *Guidance on Health Assessments for Looked after Children and Young People in Scotland* recommended that children should be "screened for emotional and mental health difficulties using Goodman's Strengths and Difficulties Questionnaire (SDQ)".<sup>51</sup> The guidance recommends that if children are thought to have 'significant' difficulties, they should be referred to a specialist service for full assessment. This is similar to the approach set out in the statutory guidance for England.

## Legislation and policy in Northern Ireland

*Care Matters in Northern Ireland – A Bridge to a Better Future*<sup>52</sup>, published in 2007 and endorsed by the Northern Ireland Executive in 2009,<sup>53</sup> recognised that looked after children are at risk of poor mental health and need a model of healthcare that prioritises and meets their needs.<sup>54</sup> *Care Matters* estimated that one-third of looked after children in Northern Ireland had low-level mental health needs, while a further third had "high level needs for CAMHS and other services". It expressed concern that provision of CAMHS was not able to meet these needs.

However, as yet no epidemiological research has been published to establish the rate of mental health problems among looked after children in Northern Ireland (previous national surveys of children's mental health have been conducted in England, Scotland and Wales but not Northern Ireland).<sup>55</sup> In 2012, Queen's University received funding from the Office of the First Minister and Deputy First Minister to conduct a study of the health needs of looked after children in Northern Ireland.<sup>56</sup> The Department for Health, Social Services and Public Safety is in the process of developing a strategic statement on looked after children, which will provide an update on developments and recommendations from *Care Matters*.

Therefore, it is clear that while all four nations of the UK have identified issues relating to the mental health and emotional wellbeing of looked after children, further work is needed to ensure that this is consistently identified as a priority for services. Sending this clear signal across health and social care will help to address variations in support for the emotional wellbeing of children in care currently seen at a local level.

## Care systems at a local level in England and Wales

To explore how the emotional wellbeing of looked after children is supported at a local level, the NSPCC undertook a detailed programme of fieldwork in four local authorities (three in England and one in Wales). The following section of this report sets out what was learned about the types of services and support on offer to looked after children in these local areas.

Figure 1 summarises the processes that take place when a child enters care and the challenges involved in understanding and supporting their emotional and mental health needs.

49 The Scottish Executive (2007), p43 Action 15

50 The Scottish Executive (2007), p4

51 The Scottish Government (2014)

52 Department of Health, Social Services and Public Safety (2007)

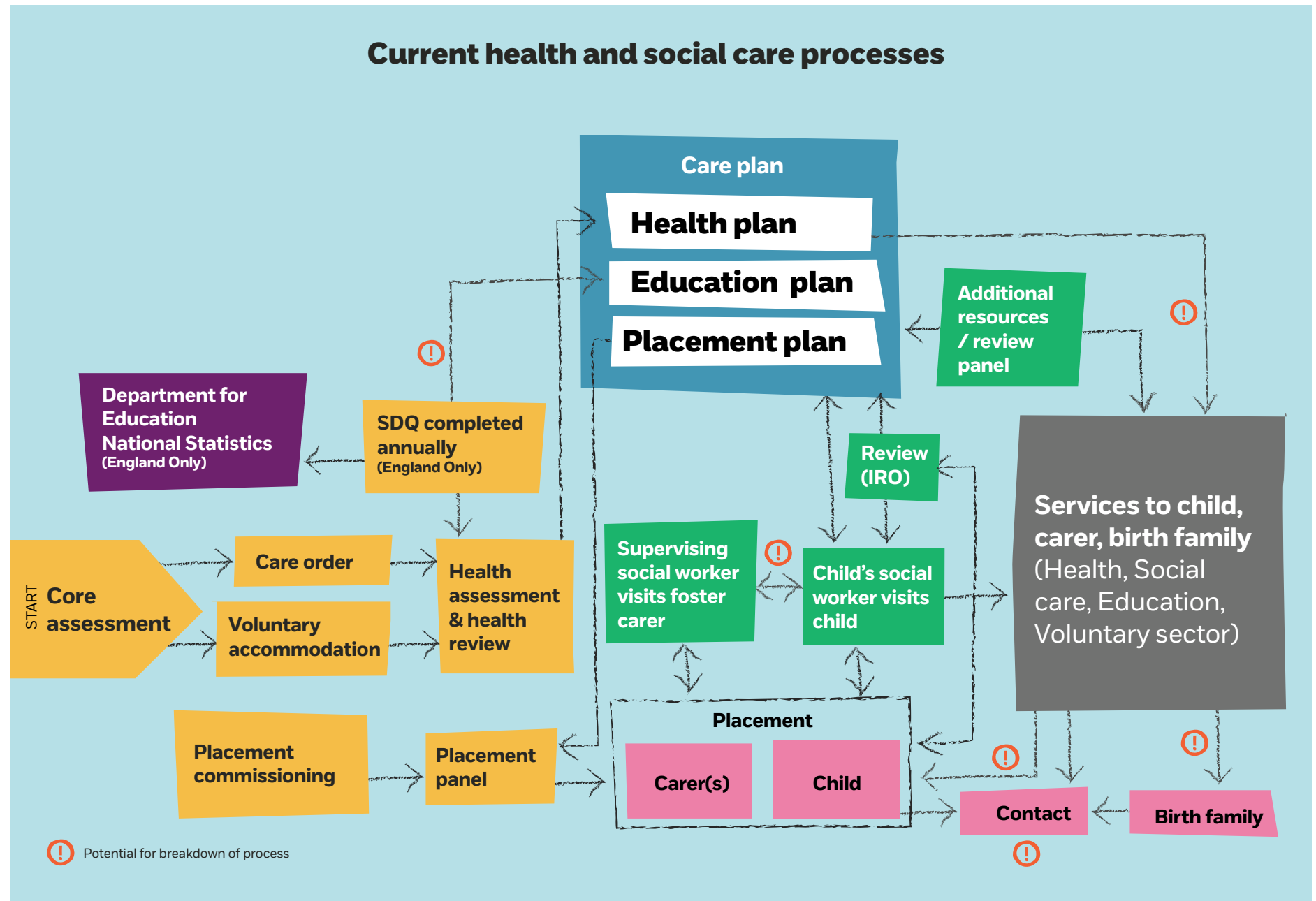
53 [www.northernireland.gov.uk/news/news-dhssps/news-dhssps-17112009-health-minister-welcomes.htm](http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-17112009-health-minister-welcomes.htm)

54 Department of Health, Social Services and Public Safety (2007), p4

55 p31 *ibid*

56 [www.qub.ac.uk/research-centres/InstituteofChildCareResearch/ResearchThemes/ChildreninPublicCareandChildrenAdopted/Currentresearchprojects/#d.en.381426](http://www.qub.ac.uk/research-centres/InstituteofChildCareResearch/ResearchThemes/ChildreninPublicCareandChildrenAdopted/Currentresearchprojects/#d.en.381426)

Figure 1: The current processes at a child's entry to care



In England, local authorities collect information about children's emotional and behavioural health on an annual basis (in the form of the Strengths and Difficulties Questionnaire). However, all too often this information is not collected early enough and is not used to inform decisions about a child's placement or the support that they or their carer will receive. Carers told the NSPCC that while their relationship with looked after children puts them at the centre of the child's support network, they are often not fully involved in planning a child's care or identifying what support they will need.

The fieldwork and wider research carried out for this project clearly identifies the need for social care, health and education services to share responsibility for supporting looked after children's emotional wellbeing. However, in practice their approaches and support are often fragmented. These challenges are explored in more detail below.

### Assessment of health and wellbeing

As figure 1 demonstrates, regulations in England require that each looked after child's care plan should include a health plan, an education plan and a placement plan, and should set out the services and interventions that will be provided for the child, their family and carer. To inform the child's health plan, the child's social worker must ensure that the child receives a health assessment soon after they enter care.<sup>57</sup> Current regulations in Wales<sup>58</sup>, which are soon to be replaced by secondary legislation drawn up under the *Social Services and Wellbeing Act*, also contain duties for local authorities regarding the education and health of looked after children and arrangements for placements.

While this health assessment has a broad remit (and should already focus on the child's mental health, according to guidance in England and Wales), the NSPCC learned from professionals that, in practice, it is often viewed primarily as an assessment of the child's physical health. Children do not receive a routine assessment of their mental health in any of the four areas that partnered on this project, although information about the child's emotional wellbeing might be included in the assessment to a varying extent, and if a Child and Adolescent Mental

Health Service (CAMHS) was already working with a child, they are invited to contribute information.

This relative inattention to children's emotional and mental health needs in initial health assessments is not limited to the four areas in which the NSPCC worked. Analysis of 50 Safeguarding and Looked After Children inspections undertaken in partnership by the Care Quality Commission and Ofsted between January and July 2012 found that four areas were rated outstanding in their delivery of the 'Be Healthy' outcome, 27 were rated good, 12 were rated as adequate and seven were rated as inadequate. Analysis of these 50 inspection reports<sup>59</sup> identified that:

- Children's emotional and mental health needs were not proactively identified or comprehensively assessed in some cases and SDQs were not consistently used to inform assessments of the child's emotional wellbeing;
- Some children, young people and their carers had limited choice and control over where and how their health assessments took place;
- Information sharing and communication between children's social care and looked after children health teams was insufficiently developed in some cases, so that information held by social care or CAMHS was not always shared or used effectively to inform a comprehensive assessment of risk;
- Workforce issues, including the capacity of designated and named health staff and the availability of school nurses and health visitors directly impacted on the quality of health assessments and health outcomes for children at an individual and wider population level.

The inconsistent quality of assessments underpinning care plans for looked after children in Wales was also flagged up by a recent review by the Care and Social Services Inspectorate Wales of safeguarding and care planning arrangements for looked after children.<sup>60</sup> The review also found that the extent to which children and young people are involved in developing their care plan is not always clear.

57 HM Government (2010), p28

58 National Assembly for Wales (2007)

59 Talbot, S (2013, unpublished)

60 Care and Social Services Inspectorate Wales (2015)

It is worth noting that the draft *Care Planning, Placement and Review (Wales) Regulations 2015* out for consultation at the time of publication make renewed provision for health assessments on entry into care to include an assessment of the child's emotional and mental health. It is also notable that the new statutory guidance in England on promoting looked after children's health and wellbeing, which was published after the NSPCC's fieldwork for this project, includes a stronger emphasis on the 'equal importance' of looked after children's physical and mental health.<sup>61</sup>

### Completion of the Strengths and Difficulties Questionnaire

Since 2008, all local authorities in England have been required to ensure that the Strengths and Difficulties Questionnaire (SDQ) is completed for each child by their carer on an annual basis. This data is returned to the Department for Education who publish it annually.<sup>62</sup> There is currently no equivalent requirement in Wales and there was no use of routine mental health screening or

assessment of looked after children in the Welsh local authority partnered with at the time of the NSPCC's fieldwork.

The English statutory guidance is now clear that the SDQ should be used as a mental health screening tool to inform looked after children's health assessments and health plans.<sup>63</sup> However, in practice, use of the SDQ is not consistently embedded in this way. In some local authorities, children's social workers (or an administrator) send out the SDQ to carers, who complete it. The data returned is then entered into a centralised system for reporting purposes but it is not used to inform the child's care planning or to make decisions about the potential need for a further assessment or support. It is unsurprising in this context that the SDQ was often unpopular among carers and social workers, as it did not obviously serve a clear purpose within the system.

It is also notable that the rate of completion of SDQs in English local authorities varies substantially. Table 3 sets out SDQ completion rates for eligible looked after children according to region.

Table 3: Completion rate of Strengths and Difficulties Questionnaires for eligible children by English region (2014)<sup>64</sup>

Region	Rate of completion of SDQs for eligible children
Outer London	83%
North West	75%
Inner London	71%
South West	70%
Yorkshire and the Humber	68%
East of England	66%
North East	65%
East Midlands	63%
South East	62%
West Midlands	59%
<b>England (national)</b>	<b>68%</b>

61 Department for Education and Department of Health, (2015), p10

62 Please see 'Outcomes for children looked after by local authorities', National tables and local tables, SFR49/14 [www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-local-authorities](http://www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-local-authorities)

63 Department for Education and Department of Health (2015), p17

64 'Outcomes for children looked after by local authorities', SFR49/14, Local tables, Table LA7 'Emotional and behavioural health of children looked after continuously for 12 months at 31 March for whom a Strengths and Difficulties Questionnaire (SDQ) was completed, by Local Authority'.

The variation in completion rates for individual local authorities is even starker. In 2014, a quarter of local authorities had a completion rate of 90 per cent or above (nine of these had a completion rate of 100 per cent), while 8 per cent of local authorities (12 areas) had a completion rate of 30 per cent or lower. Three of these areas apparently had a completion rate of zero.<sup>65</sup>

There is no obvious reason why there should be such variation in the completion rate of SDQs; it can only be assumed that this reflects the extent to which this data collection is being prioritised in local areas. Of course, data collection is not an end in its own right; what is important is that looked after children's mental health needs are identified and acted on. However, if this indicated the priority placed on looked after children's emotional wellbeing, then this substantial variation would be a cause for concern.

### Placement matching

Following a decision for a child to enter care, their social worker asks the local authority to identify a placement that 'matches' the child's needs. Professionals report that if a child's emotional and mental health needs have not been identified through their health assessment (including any social, emotional or behavioural difficulties), there will inevitably be a lack of information to inform decisions about the child's placement needs.

The social workers consider the placement options available to the child and identify the most suitable choice. However, professionals also told the NSPCC that, in practice, placement decisions are often very constrained by the availability (or unavailability) of appropriate placements and gatekeeping of resources to reduce the use of external placements that carry a higher cost. There may be rules in place that affect placement decisions, such as a rule that the child's first placement has to be with an in-house local authority foster carer, to reduce the use of higher cost placements. As a result, professionals are sometimes sceptical about the extent to which placement 'matching' to meet the specific needs of an individual child is possible.

### Identifying and accessing support services

As with placement matching, it is unclear how care planning can effectively identify the types of support and intervention a child and their carer might need if their mental health needs have not been assessed at the outset of a placement. Figure 1 highlights the potential disconnect between a child's care plan and the identification of appropriate services and support. In the absence of robust assessments, professionals and carers report that it is difficult to identify the support that might be needed to promote the child's wellbeing, support their carer and maintain the stability of their placement.

As Chapter 3 will demonstrate, this failure to identify children's needs can mean that fragile placements are left unsupported. In some cases, children and carers have to reach crisis point before help can be accessed. In these circumstances, it is down to the resilience of individual carers as to whether placements will continue or break down. As a result, some children are exposed to the damaging impact of serial placement breakdowns.

However, while the process of assessing and planning support for placements can be lacking in robustness, each of the four areas the NSPCC worked with on this project did have a variety of services in place to support the emotional wellbeing of looked after children. These are summarised in box D.

Different approaches are taken to commissioning support for looked after children's mental health in different local authority areas. Two of the areas involved in this project had a specialist CAMHS to support looked after children and their carers, which was funded by the local authority. One of these areas also funded a counselling service to provide additional support for looked after children. The third area funded general CAMHS providers to give support specifically for looked after children and their carers. The fourth funded a service staffed by therapeutically trained social workers to work with looked after children and their carers.

65 'Outcomes for children looked after by local authorities', SFR49/14, Local tables, Table LA7 'Emotional and behavioural health of children looked after continuously for 12 months at 31 March for whom a Strengths and Difficulties Questionnaire (SDQ) was completed, by Local Authority'.

### **Box D: Services in place in four local authority areas to support looked after children's emotional wellbeing**

- Specialist CAMHS for looked after children (2 x local areas)
- General CAMHS for all children in the local authority area (in one area staff from the general CAMHS had protected time for looked after children)
- Therapeutic support service staffed by experienced social workers (1 x local area)
- Counselling service for looked after children (1 x local area)
- Voluntary sector self-harm service (1 x local area)
- Education psychology service (4 x local areas)
- Looked after children health services, for example designated doctors and LAC nurses (4 x local areas)
- Contact centre to support contact with looked after children's birth families (1 x local area)
- Family support workers to support contact with looked after children's birth families (1 x local area)
- Advocacy services (4 x local areas)
- Independent visitor service (4 x local areas)
- Participation services, for example Children in Care Council (4 x local areas)
- Respite care (4 x local areas)
- Voluntary sector service for looked after children offering mentoring and employability support (1 x local area)

All these services suffered from insufficient capacity to meet the need in their area, and in all areas children and young people sometimes experienced long waits to access direct therapeutic services, such as play therapy and counselling. Support for children who had been sexually abused and/or displayed sexually harmful behaviour was not always available, and this support was not always covered by CAMHS. Therefore, there are a variety of reasons why children and their carers may not be able to access the support they need. These issues around access to services and support are explored in more detail in Chapter 3.

#### **Birth family contact and support**

The four local authorities had varying arrangements to support looked after children's contact with their birth families. One local authority mainly supported contact through a contact centre, which seemed to be well resourced. However, some foster carers were concerned that it did not provide a wholly positive environment for families, as it was somewhat sterile and not 'baby friendly'. A CAMHS manager expressed concerns that contact workers

were often the lowest paid and trained, and were not necessarily well equipped to cope with complex family dynamics.

In two local authorities, contact services had previously had more resources but had recently been cut back due to reduced budgets. In one of these areas, responsibility for contact had been delegated to foster carers. Some foster carers felt that this had made the task of caring more complicated because they were increasingly "drawn into the parents' baggage". In the other area, it was the responsibility of looked after children's social workers to facilitate contact, with some additional capacity from family support workers. One social worker expressed the opinion that "as a service we're not able to meet the contact needs of children". Some young people also reported that they had not received enough support to stay in regular contact with their families.

In the fourth local authority, family support workers were tasked with supervising family contact and this could take place at a family support centre or in the community. The service aimed to be as flexible as possible to make contact enjoyable for the child and



their family, and an independent reviewing officer described the family support workers as “a really dedicated team who do amazing work”.

While the resources to support family contact varied across the four areas, professionals agreed that there was not currently enough focus on supporting children to maintain positive relationships with their birth families. In particular, there was very little therapeutic support available to birth families to help them come to terms with their children being in care. Professionals generally agreed that in a strained system, once a child was in care the birth family could suffer from being a low priority for professionals.

### Monitoring and review processes

In all areas, children received statutory visits from their social workers to monitor their progress, and foster carers received regular visits from their supervising social workers. However, there were clear variations in the frequency of these visits; in some areas, children went for long periods of time without contact from their social worker, while in others they reported that they saw their social worker every week. Children in out-of-area placements were particularly likely to suffer from infrequent contact with their social workers.

Foster carers sometimes reported that they were disappointed by the support provided by their child’s social worker, and in all areas there were some challenges in communication between children’s social workers and foster carers’ supervising social workers. It seemed uncommon for these professionals to make joint visits and, where children had challenging needs, there was often a lack of constructive dialogue between these professionals about how fragile placements could best be supported.

In addition to statutory requirements for independent reviewing officer services, some local authorities had regular panels to provide a forum for reviewing complex cases in order to identify if additional support was needed. One area had a placement stability panel and an integrated resource panel, while another had regular ‘profiling’ meetings where individual cases were discussed.

These were additional processes by which children’s needs could be monitored by senior managers, and social workers could request additional resources. However, as baseline measures of looked after children’s emotional wellbeing were not taken at entry to care, there were no processes in place in any of the four areas for routine monitoring of fluctuations in children’s emotional wellbeing over time.

### Leaving care

In all four areas, professionals recognised that support for the emotional wellbeing of care leavers was insufficient. There was also variations between the areas in the levels of support provided by care leavers’ key workers. In one area, young people received a visit from their social worker every week, while in another area personal advisors reported that their high caseloads meant that their time was dominated by high risk young people. They reported that they had little time to build relationships with other young people for whom they were responsible.

In all areas, care leavers had very little access to support from mental health services and this could mean that young people with quite serious mental health needs sometimes found themselves without support after they turned 18. The impact of this reduction in support for care leavers after they turn 18 will be explored in the next chapter.

### Conclusion

While there are a range of procedures and services in place in local areas to support the emotional wellbeing of looked after children, it is clear that priorities and approaches vary significantly from one area to the next. This variation, along with significant capacity constraints, can directly impact on the emotional wellbeing of looked after children. Understanding the needs, wishes and feelings of looked after children – understanding what emotional wellbeing means to them – is central to addressing this challenge. There is a great deal of progress to be made in improving how looked after children and young people’s individual preferences, needs and priorities are understood from the time that they first enter care.

# Chapter 3: Experiencing the system

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The NSPCC asked looked after children and care leavers about their experiences of being in care and how key life events had affected their emotional wellbeing. They also interviewed young people's carers and other professionals who support them. Interviewees gave their views on how looked after children's emotional wellbeing is currently supported and how support could be improved.

Analysis of these interviews identified five key priorities for a care system that successfully supports the development of positive emotional wellbeing for children and young people in care:

- Embed an emphasis on emotional wellbeing throughout the system
- Take a proactive and preventative approach
- Give children and young people voice and influence
- Support and sustain children's relationships
- Support care leavers' emotional needs

Before we explore these themes, we will look in detail at one young person's story about their experiences of care. Neil's story demonstrates how experiences of both good and poor support impacts on children's emotional wellbeing during their time in care. Neil's story is based on a real case but we have changed names and other identifying details to protect his anonymity – this is also the case for *all* young people's and carers' stories featuring in this report.

## Neil's journey through care

Looked after children and care leavers were asked to plot their journey through care on a timeline and indicate, by drawing a line, when their emotional wellbeing had been good and when it had been poor. The timeline of a young person called Neil, aged 14 at the time of interview, is presented in figure 2.

Neil's story illustrates a number of the themes that emerged through this project. While individual carers and social workers had tried to support him, the system failed to provide him with a stable and secure caregiving relationship until his fourth placement, approximately 18 months after he came into care. Neil's depiction of his wellbeing rose higher each time he felt that his emotional needs were being met, and then plummeted when he felt emotionally rejected. Neil's lowest point was when the people he hoped would become his long-term

carers ended his placement after only six months. The reason for the breakdown of this placement was unclear. Neil told the NSPCC: "I was upset, it was the fact that another person was giving up on me". Neil's keyworker observed: "...that's a bit of a rollercoaster for you mate, isn't it? That's a lot to put up with, all those emotions... you must be exhausted!"

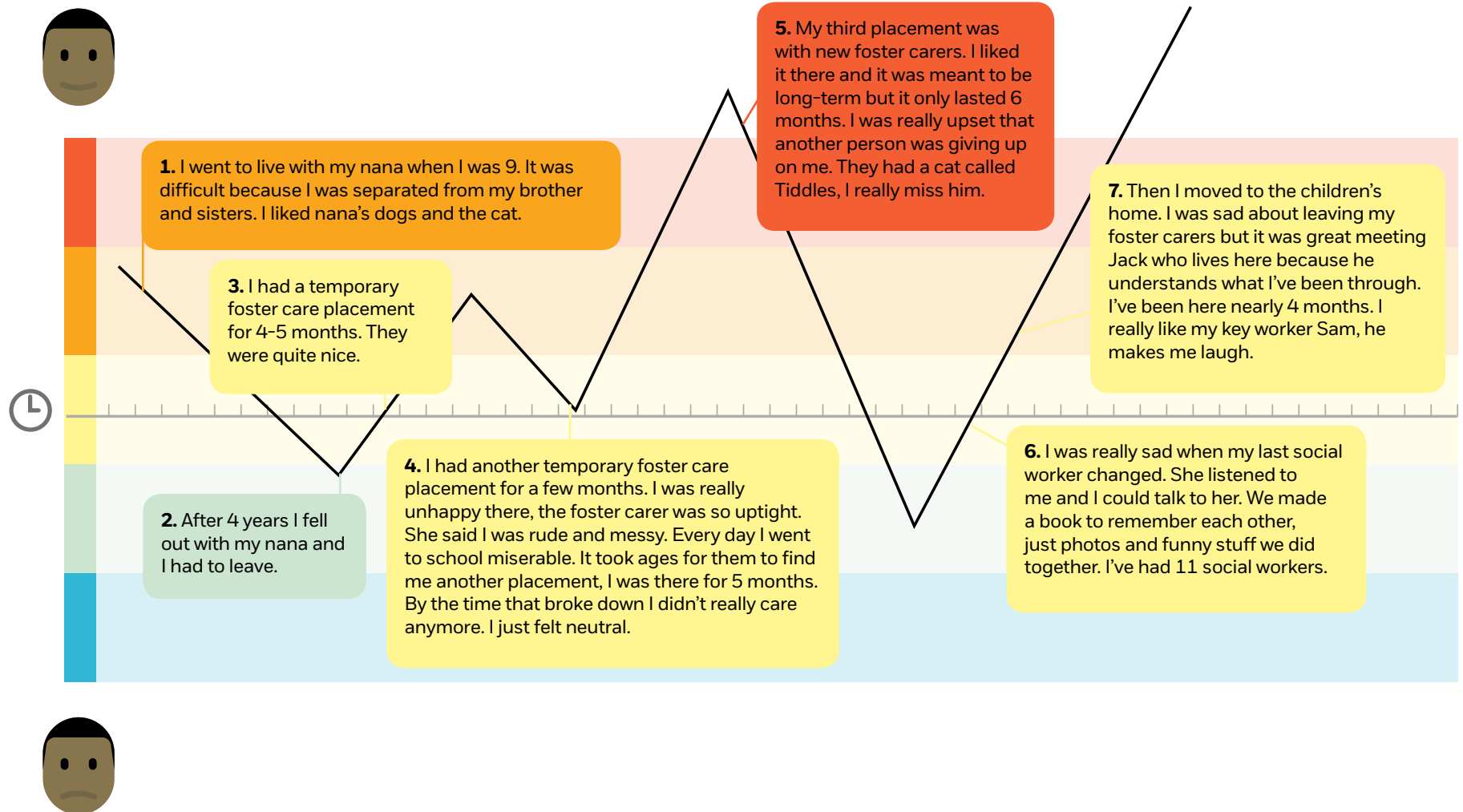
Neil did not only suffer from broken relationships with his carers, he also explained that he had had eleven different social workers since he was nine and his current social worker had only been in his life for a few weeks. He said that the frequent changes in his social worker were "one of the things I could not cope with". Neil completed a social network diagram (see figure 3) to demonstrate which people in his life were most important to him. Two of Neil's previous social workers had been particularly important to him; therefore, he represented them near the centre of his social network diagram, even though they were no longer in contact. He told the NSPCC that these two social workers stood out due to "...the fact that they listened to me. And, without being really horrible. The fact that we had a great relationship with each other. They made things happen for me". When Neil's last social worker explained that she was leaving, she and Neil made a book together: "I did half, she did half and gave it back to me. It had pictures of me and her and things that we did together". It had made a big difference to him that this social worker had considered the emotional impact of their relationship ending, and had acknowledged its significance in this way.

Neil's social network shows that his family continued to be very important to him even though he did not see them very often. He maintained a close relationship with his siblings by speaking to them often on the phone and visiting them as much as he could. His consistent relationship with adults at his school and his school friends had also sustained him during his turbulent months in care.

Now that Neil has found stability and good emotional support in his children's home, he is beginning to flourish. His personal support advisor at school has recently told him "you've got your sparkle back". However, at the time of his interview Neil's future in his independent children's home was uncertain. This was likely to be a high cost placement for the local authority to sustain for the number of years that remained until he would leave care.

Figure 2: Neil's timeline

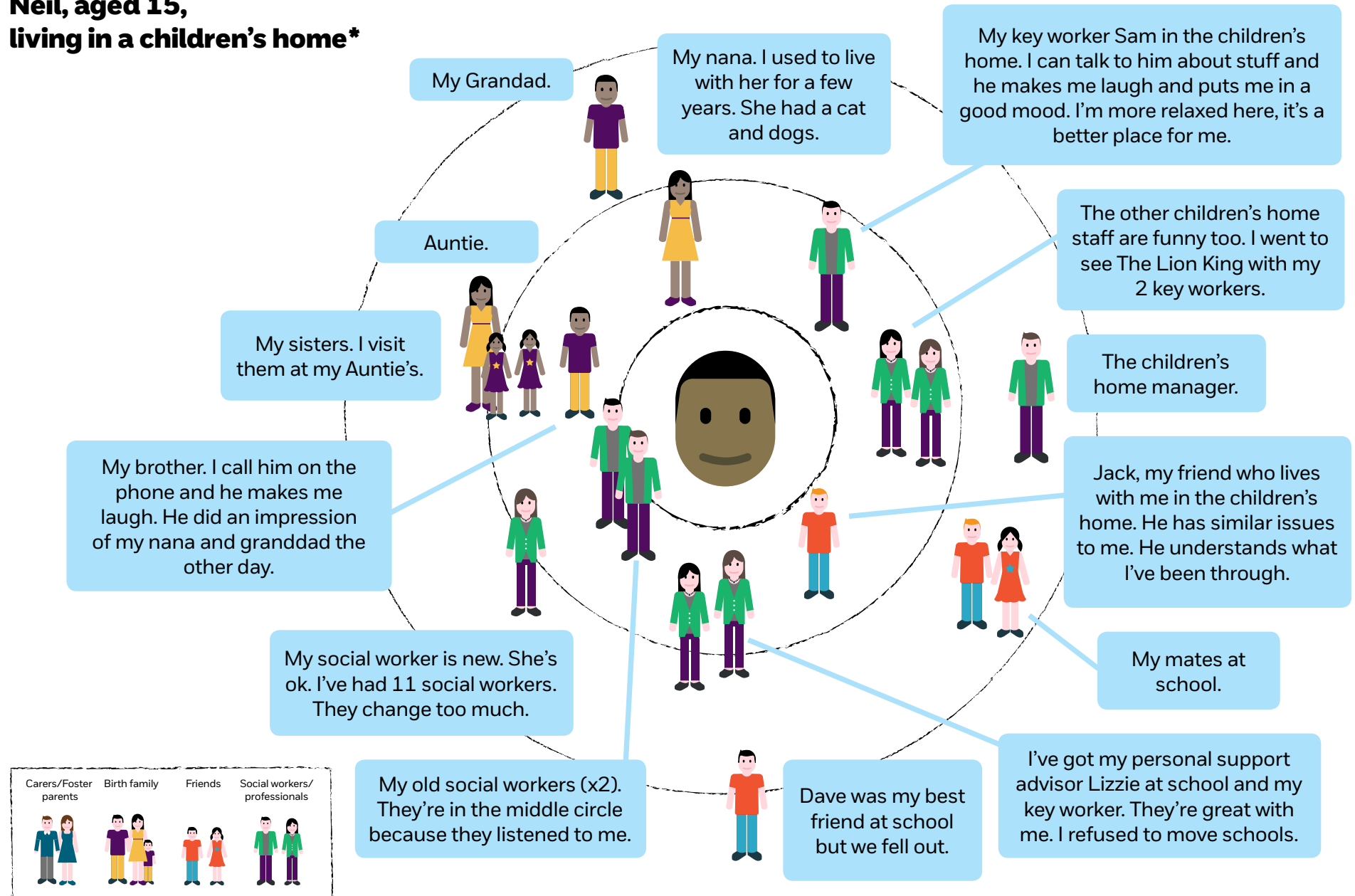
## Neil, aged 14, living in a children's home\*



\* Names and identifying features have been changed to protect identities.

Figure 3: Neil's social network

**Neil, aged 15,  
living in a children's home\***



\* Names and identifying features have been changed to protect identities.

Neil's story highlights the critical importance of strong, stable relationships to the emotional wellbeing and mental health of children in care. Analysis of the interviews with children and young people, backed by wider research, shows that these relationships are central to creating an environment in care that supports the development of positive emotional wellbeing, and allows children and young people to develop their own personal resilience.

Following analysis of fieldwork with young people, foster carers and professionals in four local authority areas, the NSPCC identified five priorities for a system that promotes emotional wellbeing for looked after children.

### **Priority one: Embed an emphasis on emotional wellbeing throughout the system**

While the children, carers and professionals interviewed for this project all agreed on the importance of meeting looked after children's emotional needs, it is clear that there are many practical difficulties in achieving this ambition. Supporting good emotional wellbeing for children in care is not always identified as a key priority for local authorities or health services. Some local authorities do not yet have clear processes in place for making sure that looked after children's emotional and mental health needs are identified and supported. The initial assessment of looked after children's emotional wellbeing and the knowledge of the children's workforce are two key elements highlighted by the NSPCC's fieldwork.

### **Assessment and monitoring of young people's mental health needs**

Each of the local authorities participating in this project had a range of services in place to support young people's emotional wellbeing. However, they did not have clearly defined processes in place for assessing young people's mental health needs and ensuring that they accessed the services they needed. One social worker commented: "We gather information about the child. There is not a mental health assessment", while a looked after children's

nurse commented: "The health assessment is just looking at basics like 'are they registered with the dentist?', 'are they registered with the doctor?'"

There is a requirement for local authorities in England to complete Strengths and Difficulties Questionnaires (SDQs) for looked after children on an annual basis, but there is no equivalent requirement in Wales. There was general agreement that these screening tools are not being used as effectively as they could be. Children's health assessments when they entered care were not routinely informed by SDQs or any other type of mental health screening or assessment.

There were considerable variations between the English local authorities in the extent to which children's SDQ scores were informing care planning. In one area, a social worker described a fairly basic screening system, whereby children who scored above a cut-off point would have an intervention recommended or might be referred to CAMHS. In another local authority, a social worker said that she had "never seen" a completed SDQ. This was because the SDQ was largely being completed as an administrative task without the involvement of children's social workers.

Other doubts were expressed by professionals about the effectiveness of how the SDQ was being used. Concerns included the view that the SDQ was too light-touch as a standalone tool to effectively identify children in need of support and that the arbitrary application of cut-off points might give "a false sense of security" by implying that "there is no need for concern" for children with scores below the cut-off.

There was general agreement across all four local authorities that a lack of attention to assessment in the current system represents a missed opportunity for support and early intervention. One participant referred to "Failure to identify patterns and risk factors". Another highlighted the problem that "a lack of good data means it is hard to track children's progress and you can't look at impact". Participants also suggested that SDQ screening information should be shared more effectively between agencies (for example health services, children's social care and schools).

## Knowledge and skills of the caring workforce

The knowledge and skills needed by carers and professionals to promote young people's emotional wellbeing was a key concern for looked after children. One looked after young person commented:

*Choose the right carers. That's all I can really say. Because some can be good and some can be bad. You've just got to make sure that they're able to cope and support that child in whatever they need.*

Young people were clear that not everybody would make a good foster carer. They wanted young people to have regular opportunities to give feedback on their carers and contribute to their professional reviews: "Carers should be vetted for caring skills, and for how they relate to young people [...] by other young people they have cared for".

One care leaver now in her twenties who had had a very unstable experience of care was clear that how happy she was in a placement was directly related to her relationship with the carers: "I thought they didn't care [in that placement]. It went downhill".

A CAMHS psychologist explained that foster carers had a very broad range of aptitude in relation to their awareness of young people's emotional needs:

*I think the emotional understanding of foster carers varies massively. Some are excellent and are really tuned into those sorts of issues, and I think the opposite of others.*

As a result, a fostering service manager explained the importance of training for foster carers to help them understand the emotional needs of the children they are caring for:

*Whenever it comes to the emotional side, foster carers find that very difficult. [...] I think that's why they've enjoyed the [CAMHS training offered in the past] because it's really focused on the emotional wellbeing of children.*

Looked after children themselves were very clear that carers needed more training in how to communicate with children and young people about their feelings:

*Foster carers and social workers should be given training in understanding children and young people.*

*If you are training to be with kids with emotional issues, and anger issues, you could have parenting classes to help you [...] How to deal with a cheerful kid who is upset.*

*Carers should go on a psychology course to be honest. Because a lot of kids in care wouldn't get noticed... They wouldn't understand their behaviour.*

Foster carers themselves were also enthusiastic about the idea of training that could help them to communicate with and understand the children they were caring for:

*Every time I attend a training course or consultation session I learn something new. It teaches you empathy, and that's the key.'*

However, some carers were concerned that the training they received could be overly theoretical and did not necessarily give them clear ideas of how they could implement what they had learned: "The training we're offered is really good... I've learnt a lot about child development. But it's not always clear what I need to do in practice". Therefore, training opportunities should be complemented by carers having access to ongoing consultation and support.

Many interviewees also emphasised the variation in skills and aptitude for supporting looked after children's emotional wellbeing among social workers. Care leavers commented:

*You can get social workers who will take your feelings and opinions into consideration, but you can also get the ones who say, 'yeah, this is what's happening, this is how it's going to go'. No feeling.*

*It's not always easy to respect or trust someone who is working on your case. They know what happened, in a chronological way, but they don't always take into account how you are feeling. They might not ask you how you feel.*

One care leaver felt very let down that when she had been in a state of acute emotional distress several years earlier, her social worker had not taken any action to support her despite her obvious vulnerability:

*When I was phoning and leaving messages and asking for help, it was obvious I just needed not to be alone. [...] When I cut all my hair off, my social worker should have referred me for counselling.*

Therefore, most young people, foster carers and social workers themselves were clear that social workers also had training and development needs around better understanding of young people's emotional and psychological needs. Foster carers suggested that social workers needed better knowledge of attachment and child development:

*Foster carers have done attachment training – now we think the social workers need the same training.*

*They need to consider the emotional wellbeing of children in care and be aware of the children's emotional needs during transitions.*

A story told by a foster carer called Lisa (see figure 4) highlights the potential impact of social workers having a limited understanding of infants' and young children's attachment needs. In this case, poorly informed advice that the social worker gave to the foster carer and the child's new adoptive parents could potentially have caused this child distress at the time of her transition to her new family, if the advice had been acted on.

This understanding is critical to creating an environment that supports the emotional wellbeing of children and young people in care. However, in addition to gaps in knowledge, one children's participation manager identified that some social workers "don't feel comfortable in talking about mental wellbeing". As a result, they might avoid asking a young person how they were feeling and talking to them about difficult experiences they were going through. One social worker suggested that giving social workers on site access to consultation with "someone with a therapeutic background" could help address this issue.

A care leaver suggested that once professionals were more confident in discussing young people's emotional wellbeing, they should then pass on these skills to the young people themselves:

*It's about creating awareness of emotional wellbeing among young people. People might not realise that abuse can be emotional abuse. All young people should know about emotional wellbeing and mental health and what they mean and recognising symptoms.*

## Priority two: Take a proactive and preventative approach

Participants agreed that an important part of a system that supports the emotional wellbeing of children in care is the need for a more proactive and preventative approach. Children in care need an environment that supports their wellbeing and this support should be provided at an early stage, rather than after a crisis, as too often happens at present. Following the need for assessment of looked after children's emotional and mental health needs, key issues identified included the importance of careful placement matching, the need for proactive life story work and the need to tackle barriers to young people's access to therapeutic services. These were all viewed as key aspects of a proactive and preventative approach to supporting looked after children's emotional wellbeing.

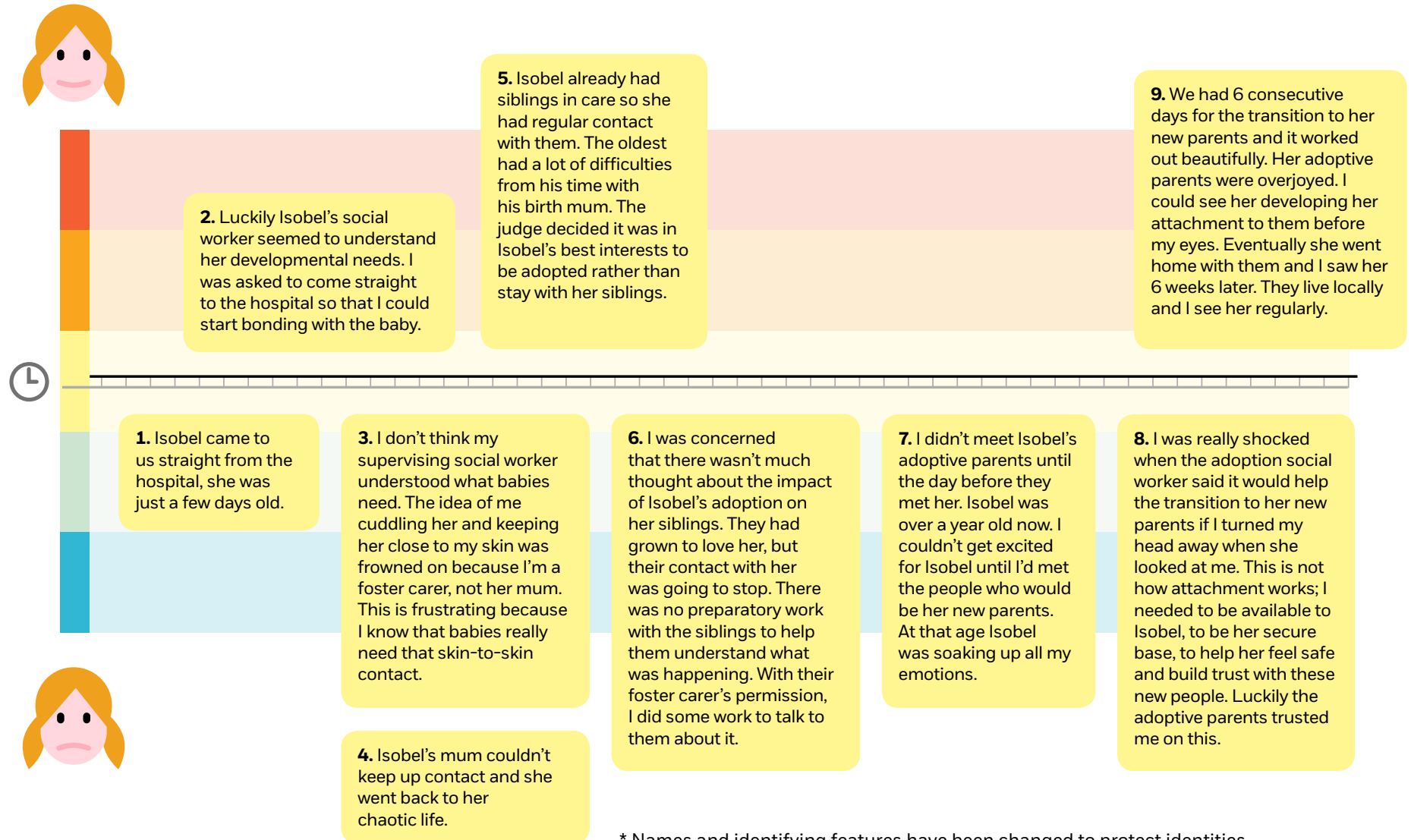
### Placement matching

When a child enters care, one of the most important decisions made is who will care for them. As we have seen, this decision is particularly difficult when professionals have insufficient knowledge of the child, including their emotional and behavioural needs. One independent reviewing officer commented that "Children bounce from placement to placement" and explained that effective matching was "critical" to prevent this.

Despite this, information about children's emotional and mental health needs was not necessarily gathered early enough nor used to inform placement decisions. One placement commissioner

Figure 4: Lisa's timeline

## Lisa, former foster carer for Isobel aged 2\*



\* Names and identifying features have been changed to protect identities.



confirmed that her team did not use information like the SDQ as part of the matching process. In a focus group, a looked after child queried how matching could be effective when social workers did not know the children concerned:

*I don't know how social workers take care, you know, putting kids into placements or residential homes. When they look at them I wonder if they think 'oh they could go with so and so', but they don't actually get to know the child.*

Some of the young people consulted by the NSPCC thought that it would make a big difference if children in care had more choice about their placements. One young person said: "You don't have any input [with moves]. You just get put wherever the social put you really. Wherever there's space". Another young person explained how she had gone into "emergency care", and this had then turned into "long-term care" but this had seemed to happen by default: "It wasn't like my social worker was thinking 'oh she's this kind of person, and she needs this kind of carer'". Another young person simply said: "No one ever asked me". However, one young person described how his social worker had given him the opportunity to meet a number of possible foster carers before he chose which one he wanted to live with:

*With me, I was taken out of my primary school, when I was little, and my social worker drove me round, looking at placements, and it was like 'oh do you like that one?' And it was eventually that I met my mum and dad now and ever since then I've always been there. I got a choice.*

While there were examples of good practice, many professionals felt that resource constraints were limiting the extent to which careful matching was possible. One CAMHS psychologist said: "I think the way things are at the moment, the 'matching process' is a bit of a euphemism. It's more about where there is a bed". One social worker explained that the placement team tended to only offer her two placement options, so "I try to make the child feel involved, but there isn't much choice".

Professionals also explained that they were expected to try in-house placement options first to reduce cost, which further limited choice. There was general agreement that placement choice was most limited when children had complex needs as "there is a lack of specialist foster care placements". One looked after children's social worker explained: "In difficult complex cases you have to get what you're given but it might not be the best match". Some of the children who were considered hardest to place were young children with challenging behaviour, teenagers with challenging behaviour and those who were self-harming or had high emotional needs. Young people who had 'violent pasts' or were involved with youth justice were also considered hard to place.

Reflecting on the challenges posed by gatekeeping of limited resources, an independent reviewing officer commented: "Sometimes you only get the good provision if the child has been through so many placements before – the children who do end up in the very specialist placements are only there as a last resort – I think that's a short-sighted perspective. Could we invest in children sooner – for a better outcome?" A CAMHS worker expressed concern that "Too many children are put in placements that are likely to fail".

Young people's stories emphasise the substantial impact that good or poor placement matching has on their lives. One care leaver explained that in her second foster care placement: "I didn't know them well enough and I didn't want to know them". However, with her third carers, "They took me in as their own, it felt like I was their own. If I needed that support I could get it from them".

Another care leaver explained she had not been able to accept living in foster care because "Those situations were weird. I had a mum, I knew my sisters". She had broken down a number of foster care placements before she was placed in a children's home: "I think I just preferred it because I had more opportunity to get on with different people. You have more choice, you're not forced to get on with somebody".

## Identity and life story work

Care planning guidance<sup>66</sup> and NICE guidance<sup>67</sup> highlights the importance of enabling looked after children to develop a sense of their identity. However, through this project the NSPCC learned that in practice looked after children often receive very little support to make sense of their early life experiences, reasons for entering care and family relationships:

*We had a child who came to us and he really needed an intervention to help him make sense of why he was there – not just a social worker sitting there and telling him stuff because he wouldn't take it in. (Foster carer)*

Senior social work managers explain that life story work is not always prioritised because “there are no drivers within the system” to ensure it is completed.

Some of the care leavers the NSPCC interviewed were quite unclear about the reasons why they had entered care and were unsure of how many placements they had lived in during their early years in care. One care leaver commented: “There were loads of foster care placements but I don't remember”. A foster carer told the NSPCC about a child she had fostered who “had no idea why she was in care” and was not aware that she had siblings:

*'We didn't have any life story work. We knew a bit about her background [...] She has quite a few siblings but she doesn't know about them. While she was with us there was no contact and no mention of the siblings in any shape or form.'*

Another foster carer spoke of two young siblings whose referral to CAMHS was rejected because no life story work had yet taken place:

*I tried to get the children an emergency CAMHS appointment but it took a year. CAMHS is not prepared to work with the [children] until they've got permanence and have had life story work. (Foster carer)*

One foster carer expressed concern that while she had received some training on completing life story work, there was little ongoing support available:

“There is no standard to work towards or direction about what goes in”. A residential care worker also highlighted the fact that it is not enough to explain a child's life story to them once; this needs to be an ongoing process:

*He has major problems understanding the reasons why he has been taken away from his mum. His social worker comes out and explains it to him over and over again.*

The need for more support for looked after children to make sense of their identities is consistently highlighted by young people and their carers. This was an issue in all of the local authority areas involved in this project.

## Barriers to accessing mental health support for young people and their carers

In the absence of robust processes for assessing looked after children's mental health needs, a great deal of responsibility can be placed on children's carers to notice their needs and advocate for them to receive further support. One social worker explained: “The foster carer has a huge role in identifying the child's needs”. As previous research has suggested, this can present problems if carers do not understand that a child's challenging behaviour is indicative of an underlying emotional or mental health need.<sup>68</sup> Foster carers' individual attitudes to seeking help might also act as a barrier, if they believe depression is ‘natural’ or are reluctant for a child to be ‘labelled’.<sup>69</sup>

Even where carers do proactively identify children's mental health needs and feel positive about accessing support, the NSPCC learned that they frequently experience barriers in accessing services. Some of the barriers experienced by carers were due to the referral requirements of the mental health service, which did not allow carers to make direct referrals. One foster carer who was caring for two young siblings explained that the children's social workers had changed repeatedly while she had been caring for them: “It was 13–14 months before CAMHS got involved. When the children's workers keep changing, referrals to CAMHS are not followed through”. As a result, this carer explained

66 HM Government (March 2010), p140

67 NICE and SCIE (2013), Recommendation 25: Explore personal identity and support ongoing life-story activities, p41

68 Beck (2006)

69 Bonfield et al (2010)

that: “There has been no support with the children’s sexualised behaviour”, and she was left to manage this on her own.

In another case, a foster carer explained that her request for support from CAMHS had been blocked by the child’s social workers:

*I really had to fight to get therapy for [foster daughter], and her social workers didn’t listen. She eventually got it because the referral to CAMHS was made by a doctor.*

Sometimes, overstretched mental health services would not accept referrals for children with lower-level needs, as a designated doctor observed:

*I know that there is a feeling among carers that they will see the more extreme children and that foster carers get left to deal with a lot quite unsupported.*

When foster carers have problems accessing support, this can increase the fragility of children’s placements. One foster carer for a boy whose placement had broken down expressed frustration that CAMHS had not offered him any direct work:

*We tried from day one to get some support for him. He didn’t communicate. We went to CAMHS and they saw us but they didn’t do anything with him. [...] Then when we called notice all the stops were suddenly pulled out.*

This finding is supported by previous research, which found that insufficient professional support can be a risk factor for placements if carers feel isolated and helpless.<sup>70</sup>

Where young people might benefit from direct therapeutic support from a mental health professional, there are many barriers to them accessing services. These include concerns about stigma; failure to identify their needs, waiting lists or restrictive entry requirements and inflexible service delivery that does not meet young people’s needs. These findings reflect themes in previous research.<sup>71</sup>

Both young people and a variety of professionals mentioned the issue of stigma surrounding mental health and mental health services:

*You know there is CAMHS but you only go there if you’re in crisis ... If you’re mental. (Care leaver)*

*The word mental health is like, woah! ‘Are you going to put me in a straitjacket?’ (Care leaver)*

*Some young people distance themselves from counselling. They say ‘CAMHS is for mad people.’ (Residential care manager)*

A CAMHS psychologist argued that more needs to be done to break down barriers around stigma.

However, even when young people were open to accessing support with their mental health, they still experienced challenges. One young woman called Husna told us that while she had exhibited many signs of distress, including shaving off her hair, her key worker did not acknowledge her emotional needs or provide her with further support. This is alarming as it is clear from Husna’s story, told in figure 5, that she was a very vulnerable young woman at this time.

It is clear from Husna’s story that her basic emotional needs were neglected for much of her time in care, due to a lack of sensitive and consistent support from caregivers and other professionals. Husna also was not offered any therapeutic support to help her cope with her distress but she did succeed in accessing some counselling through her college.

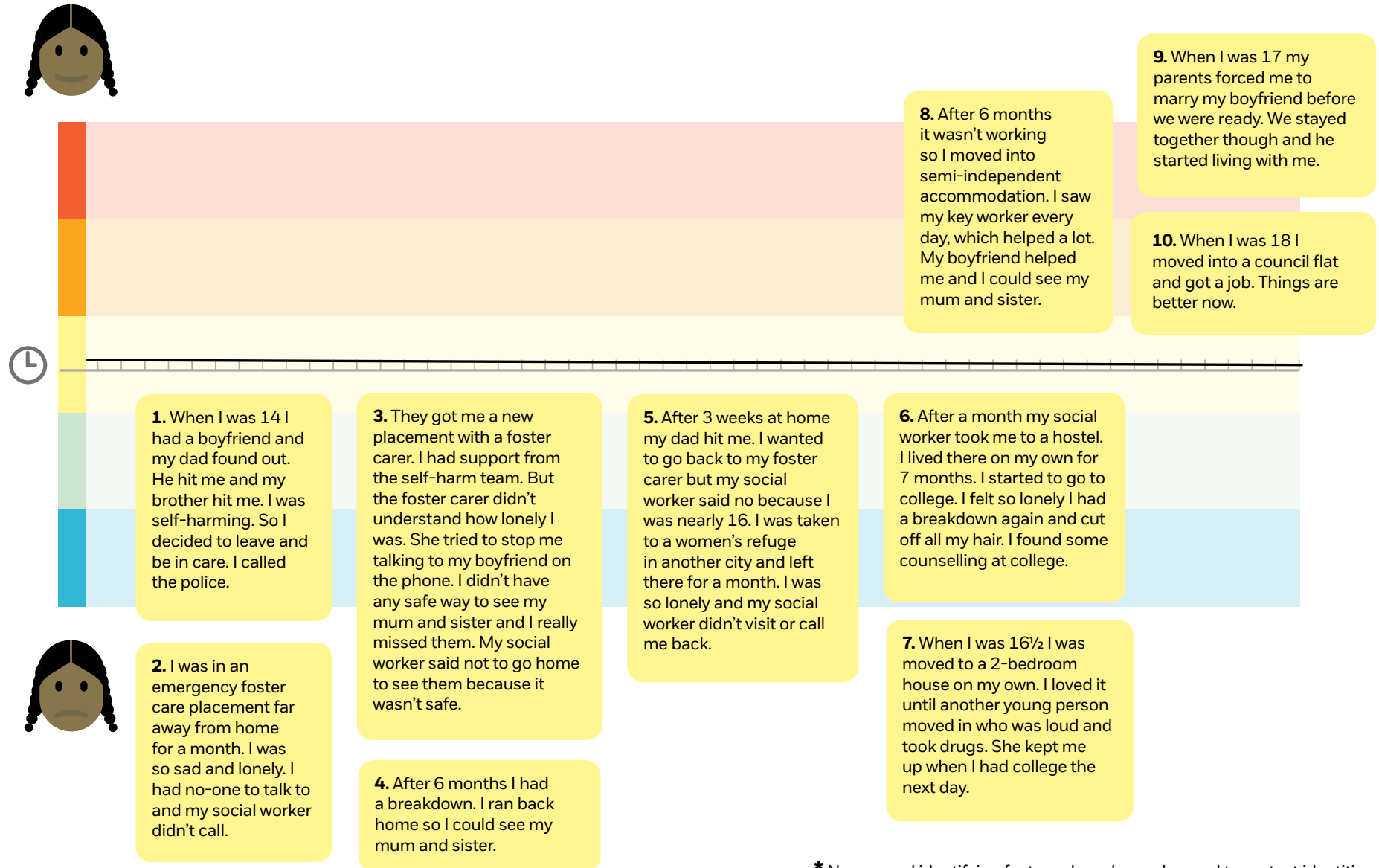
Even where young people were able to communicate their wish for therapeutic support, they still experienced long waiting lists or rigid eligibility criteria, which meant that they were ineligible for any support. One young person in care told the NSPCC: “I didn’t get any [support with my anger]. I was trying to get counselling and I’ve only just got it now. So I’ve been wanting it for the past 4–5 years”. In particular, there was frequent mention of challenges in accessing support from CAMHS for young people who were not in stable placements. As one social worker explained: “CAMHS can refuse to offer direct work to young people who are not in a stable placement”. In England, new statutory guidance is clear that “looked after children should never be refused a service, including for

70 Schofield and Beek (2005)

71 Bonfield et al (2010); Beck (2006); CAMHS Review (2008); Richardson and Lelliott (2003)

Figure 5: Husna's timeline

## Husna, aged 19, living independently\*



\* Names and identifying features have been changed to protect identities.

mental health, on the grounds of their placement being short-term or unplanned”.<sup>72</sup> This needs to be put into practice by local authorities and health services.

One of the CAMHS psychologists interviewed by the NSPCC acknowledged that because their service was so overstretched they were sometimes unable to offer any form of early intervention for looked after young people with lower-level problems:

*What are we going to do with the middle, who are above services threshold but below CAMHS? Sometimes, unfortunately, the implication is ‘come back when you’re worse. When you meet the threshold’.*

This often means that young people have to reach crisis-point before they can access support. One social worker observed: “Cases in crisis tend to take priority. If the placement is stable, there is going to be less priority placed on that child”. Another social worker described the problems faced by an adolescent girl who desperately wanted someone to talk to but did not meet the threshold to receive a service in her area:

*She has always said that she has wanted counselling and help to understand why she feels the way she does now. She hasn’t had that counselling.*

Even when looked after young people were able to access an appointment with CAMHS, there were still concerns that the service could not necessarily engage them effectively. A CAMHS psychiatrist who was new to the service argued that not enough thought was being put into how young people wanted to access mental health services:

*These are the models and we tend to follow traditional models of intervention. The basic model hasn’t changed since Victorian times. We still offer therapy in clinics, suited and booted.*

As a result he was aware that young people could quickly become alienated from mental health services: “They are asked very personal questions and expected to pour their heart out to a stranger”. He argued: “We need to understand how to engage this population better”.

One participation manager told us that clinical settings could themselves be a barrier to young people’s engagement: “The CAMHS buildings are run-down and carry a lot of stigma for young people”. These findings are supported by the recent Vulnerable Groups and Inequalities Task and Finish Group report in England, which noted that “Appointments based in clinic settings are not the most suitable for vulnerable groups and their families”.<sup>73</sup>

Young people who live outside of their local authority area appear to suffer most from a lack of monitoring of their emotional wellbeing, and difficulties in accessing support from services. One social worker admitted that “Children out of area can often become less of a priority. There is a better service for children within the local authority”. This was due to the logistical difficulties involved in visiting young people who lived a long way away. Some professionals expressed concern that “Not enough responsibility is taken for children in out-of-area placements”.

Children cared for in out-of-area placements can also suffer extremely long delays in accessing support from CAMHS. One looked after children’s social worker explained: “If a child is outside [the area] it can be really hard to get CAMHS involvement”. In some cases, looked after young people had been waiting to access CAMHS for over a year. One CAMHS manager explained to us that statutory guidance was clear that young people should not experience delays. However, in practice there were often long negotiations between commissioners and service providers before funding for a young person’s support from their local CAMHS was agreed. As a result of these delays, some young people were kept waiting for a service until a crisis happened. One young girl was refused access to her local CAMHS until she became extremely distressed and harmed herself.

Two of the young people interviewed by the NSPCC had spent the majority of their time in care living in out-of-area placements. Both of these young people had experienced substantial instability, with nine and 15 placements each over the course of their time in care. Both of these young people had experienced challenges in accessing mental health

72 Department for Education and Department of Health (2015), p6

73 Children and Young People’s Mental Health and Wellbeing Taskforce (2015), p4

services. One told us that she had been offered mental health support as a teenager if she travelled back to her local area to access it, but the long journeys were so burdensome she gave up:

*You'd have to go after school so by the time you finish school at 3:30, it takes you an hour to travel to that place. You wouldn't get there til 5 o'clock. Who wants to do that at 5 o'clock?*

The other young person had tried to access mental health support for many years but was only able to finally access it once she moved back into her original local authority area. One of these young people said that her main recommendation for improving the care system was: "More support for out-of-area placements".

It is clear from these interviews that we need to rethink the way we support the emotional wellbeing of children and young people in care. The whole system – social care, health and education – needs to see children's emotional wellbeing as a priority. Carers, and other professionals, need be supported to create an environment that promotes positive emotional wellbeing. 'Mental health' should not be seen as the preserve of CAMHS alone. Where specialist support is needed, children in care should not have to wait until they are in crisis, and efforts must be made to ensure that support is tailored to young people's preferences and needs.

### **Priority three: Give children and young people voice and influence**

Young people told the NSPCC that one of the most important influences on their emotional wellbeing was the extent to which they felt they were listened to by the adults around them. They talked about the importance of carers' and social workers' communication skills, and the need for these adults to understand that some children express themselves through their behaviour. Young people also discussed the importance of making sure that children in care have access to advocacy and opportunities for participation.

#### **Carers' and social workers' communication skills**

Many young people told the NSPCC that they felt let down by professionals who had not taken the time to acknowledge their feelings:

*The advice I would give to workers is...take the time to actually listen instead of ignoring what we say.*

*[I needed] more one-to-ones, catch ups, how are you getting on, people didn't really ask me how I feel. They should know my history, I shouldn't need to explain; there was no communication there.*

Young people expressed frustration that they had had little say in decisions about their care, had not been kept informed, or that plans they had agreed with their social worker were not then carried out. One young person had been given no advance warning of her placement moves, which would just happen out of the blue:

*I never knew when I was going to move – I always thought she was just coming to visit – both times when she came to visit and then told me I was leaving, out of nowhere.*

Another care leaver said he had no say in the placements that were chosen for him: "I was never listened to about placements, there was one placement in a children's home where I kept telling them I would literally rather go anywhere else than there".

A young person called Lindsay told the NSPCC that she had not understood the full implications when she was asked if she would like her carers to adopt her. As her older sister did not wish to be adopted, this meant they were then separated:

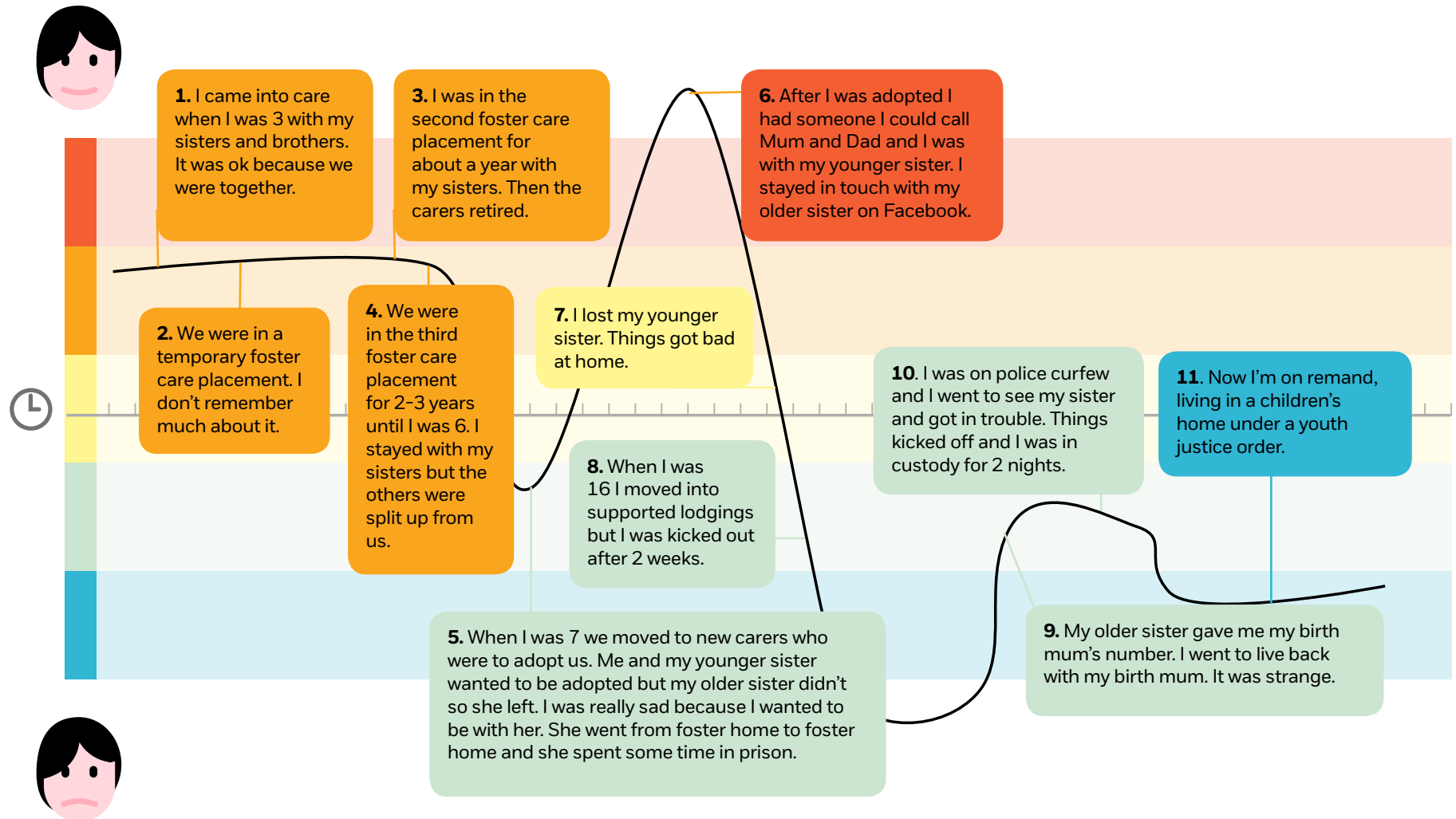
*I can't remember a question...being asked about being split up from my big sister, which was probably the most important thing to me at the time.*

For this young person, separation from her older sister had a very negative impact on her emotional wellbeing and she felt she might have made a different decision if her social worker had properly discussed with her what was most important to her. This young person's journey through care is shown in figure 6.

Another young person who did not feel listened to by his social workers, said the only time he had really felt listened to was when he was allowed to speak in court, to argue that he wanted his care order removed.

Figure 6: Lindsay's timeline

## Lindsay, aged 16, living in a children's home\*



\* Names and identifying features have been changed to protect identities.

## Communication through behaviours

It became very apparent through the NSPCC's interviews that young people do not always communicate in words. Young people explained that they cannot always articulate their feelings, so they might express themselves through aggressive behaviour or by becoming withdrawn. They did not think that this was always well understood by the adults around them.

One young person called Joe, who was aged 16 at the time of his interview, had had an extremely unstable experience of care. When Joe started to become very angry a few years into his next placement, his long-term foster carers had not felt able to understand or cope with his anger so they ended his placement. He then experienced a series of placement breakdowns until he was placed in a children's home that could offer him much more intensive support. This was a real turning point for Joe, who finally felt listened to and supported at this time:

*I had a key worker, a support worker. Every day I had someone there with me, I wasn't on my own. So if I got stressed, they were there to straightaway calm me down. They were always there. I was working 1-1. So if anything occurred where I did get stressed, there was always someone to help calm me down or talk to me.*

At the time of his interview, Joe had been living in a new foster care placement for six months but he had stayed in touch with the key worker from his previous residential home. Joe's social network diagram is set out in figure 7.

Another care leaver had also experienced multiple placement breakdowns, which were related to her behaviour. She reflected:

*Maybe if there was more support for you to express yourself in a different way [I wouldn't have had so many placement breakdowns]. Maybe... people just didn't understand. [...] I just think maybe they could have tried to find out what those behaviours were and how you can overcome it, instead of saying 'No, we're not dealing with this'.*

Other young people highlighted the issue that the needs of quieter young people were often overlooked:

*The people who are left out are the ones who don't make a fuss – they still need to have emotional wellbeing – I kind of felt bad in a way I was getting all the attention just because I was kicking off.*

*Train social workers to listen to the quiet ones.*

A psychiatrist who worked with looked after children supported the young people's view that the care system is poor at noticing young people's less obvious needs:

*The aim is to provide a client-centred practice, but we tend to pay more attention to children who cause more instability in the system [...] As a result, externalising problems, behavioural difficulties and self-harm are more likely to be picked up. These are more likely to be referred to CAMHS. Someone who is depressed, isolated or autistic might not have their needs picked up.*

Previous research suggests that screening tools like the SDQ may be less effective in identifying internalising problems than externalising problems.<sup>74</sup> NICE public health guidance on 'Looked-after children and young people' highlighted this issue, recommending that directors of children's services and commissioners of mental health services should: "Ensure that equal priority is given to identifying the needs of those children or young people who may not attract attention because they express emotional distress through passive, withdrawn or compliant behaviour".<sup>75</sup>

## Advocacy and children's rights

The implications of failing to listen to looked after children can be extremely serious. One young person called Joe, interviewed by the NSPCC, was exposed to abuse by a foster carer over a three-year period because the complaints he made were not listened to and addressed by the other professionals working with him (Joe's story is covered in more detail in Chapter 4). When interviewed, Joe reflected:

*Sometimes people think children in care are different. But that's wrong. Everyone deserves to be listened to. I think...when I was little, they didn't believe me, they believed my carer. They should start paying more attention to what children are saying. And it's not enough just to listen, they need to do something.*

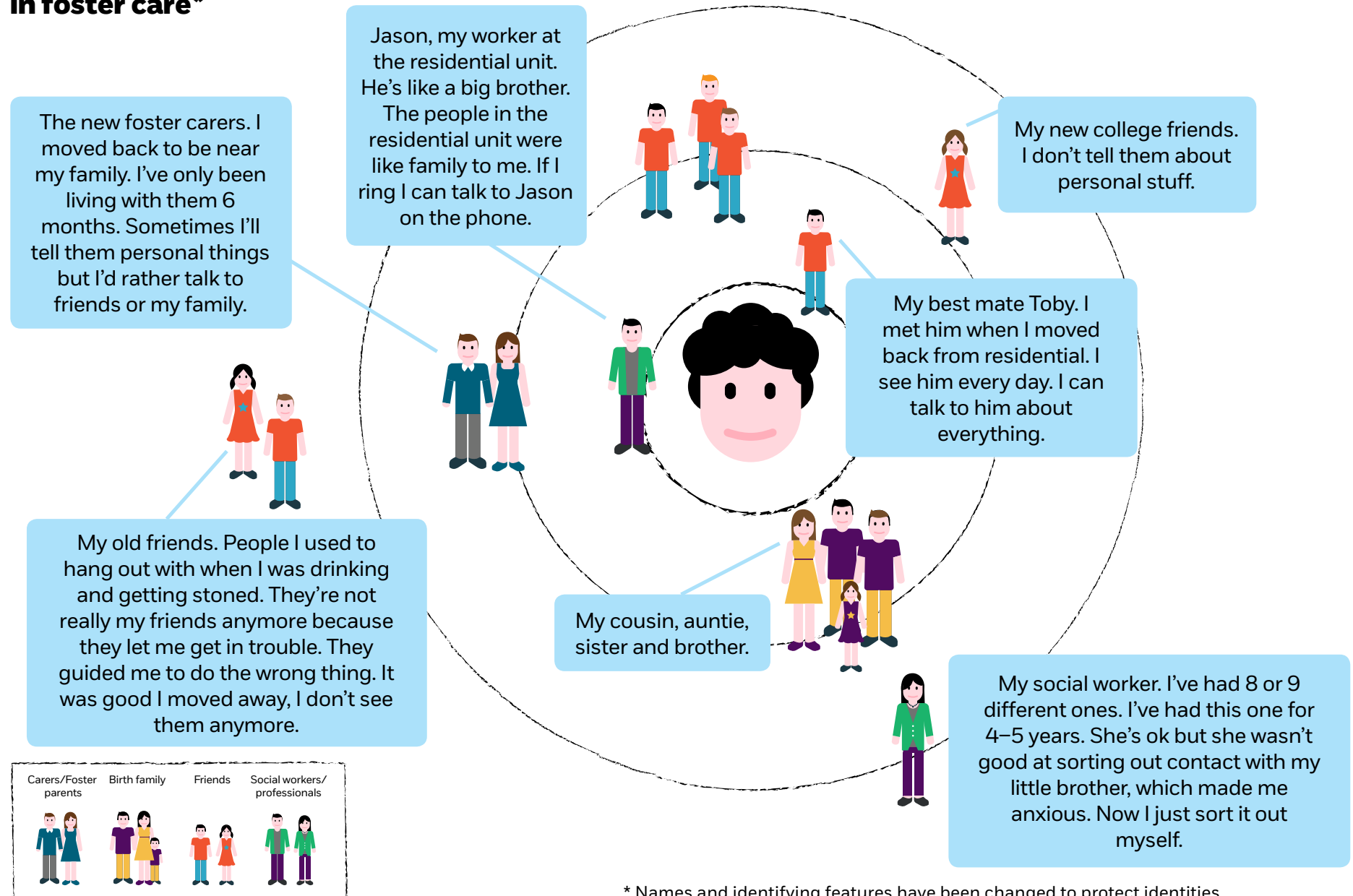
74 Tarren-Sweeney et al (2004); Goodman et al (2000)

75 NICE and SCIE (2013), p25



Figure 7: Joe's social network

**Joe, aged 16,  
in foster care\***



\* Names and identifying features have been changed to protect identities.

Where young people did not think their social worker listened to them, some had found that they had been able to make their voice heard through advocacy. One young person told us that advocacy had helped her to find her voice:

*I've worked with advocates [...] I heard about them, that they can say things for you, and they'll sort it out for you, but from then, I just realised, they're just saying what I'm saying, so why can't I say it myself, so that's what I did, I started organising meetings with managers.*

However, some young people were concerned that not enough looked after children are aware that they can access advocacy:

*Foster carers don't mention advocates on purpose, because they know that they are doing wrong, and they don't want to be found out. I think they should do it anonymously, so that a kid is aware or understands.*

Another young person said: "The Children in Care Council tries to make kids aware about advocacy and that, but...they aren't doing a very good job [of publicising it]". One of the young people interviewed, who felt that her foster carer had been manipulative and emotionally abusive toward her, said "I never heard about advocacy services". She expressed concern that looked after children should be informed at an early point about how they can make complaints about their care:

*Before putting them in foster care, they should tell them what they can do if they don't like it, so they don't feel unsafe.*

## Participation

Participation in forums like Children in Care Councils was another important route for young people to have their voices heard. As one young person commented:

*They basically wanted me to go to the Children in Care Council because of everything that I was saying in meetings; they said, 'you should say that at the Children in Care Council'. I think it's good there, you can say exactly what you think should happen, and they do listen.*

Some of the care leavers interviewed by the NSPCC were still involved in participation many years after they left care, as they wanted to help prevent other looked after children from having the negative experiences that they had had. For some it was also a valuable social outlet where they could go and be around other young people who had had similar experiences.

## Priority four: Support and sustain children's relationships

Looked after children and young people, and the adults supporting them, all viewed relationships as being central to young people's experiences of care. In particular, they discussed the importance of stable relationships with foster and residential carers, consistent relationships with social workers and continuing relationships with their family members after they entered care.

### Relationships with carers and placement stability

The professionals consulted in this project were very clear that placement stability was an essential foundation for young people to build relationships, develop resilience and move forward with their lives. Looked after children's social workers told us:

*If you get in early on and provide stability and have a long-term plan, you can make a big difference.*

*Stability tends to be the best kind of therapy the child or young person can have.*

*The therapy is in the relationship between the foster carer and the child.*

However, research by Harriet Ward published in 2009 found that 21 per cent of placement moves are made at the request of carers, indicating that carers' attitudes are an important factor in the stability of placements.<sup>76</sup> There was widespread agreement among professionals participating in this project that placements are particularly at risk of instability when children have challenging behaviours. As a looked after children's social worker commented: "Foster placements can break down if the foster carers can't cope with the children's

behaviour". A previous study, published in 2005, found that carers can become "overwhelmed and exhausted" when caring for children with challenging needs. This can lead to placement breakdown if carers are not well supported.<sup>77</sup>

The foster carers interviewed by the NSPCC were clear that the amount of support available to them was a crucial factor in whether or not they were able to persist with challenging placements. This starts with recognising foster carers' expertise and place within the child's professional network. As one foster carer commented: "Other professionals need to listen to me because I understand the boys' needs". Access to consultation and therapeutic support is also crucial. One foster carer explained that despite her foster son's extremely challenging behaviour, she had been able to persist with the placement because they had been offered intensive support:

*My supervising social worker gave me really good strategies for coping with his behaviour, but it carried on. After six months of this, I had a meltdown. It was such a struggle getting him to school. Often I would have to carry him to the car in his pyjamas. My supervising social worker saw that I was really struggling, and we had some respite care for him, so I could go on a week's holiday. It enabled me to carry on.*

This foster carer's story is described in more detail in Chapter 4, which details the costs of the support she and her foster son Paul received. Another foster carer emphasised the importance of having access to respite care, to enable them to keep caring for a child with foetal alcohol syndrome:

*Our link worker has put regular support in place and that has really helped – we just had to acknowledge the fact that in order to keep going, we needed some time off because caring for him is so exhausting.*

However, some of the foster carers expressed frustration that social workers did not give sufficient weight to their concerns about children, or their opinions on what kinds of additional support the child might need: "Professionals need to have trust that foster carers know the child and know what is best for them". They often described particular challenges in accessing support through the children's social workers, who did not take their concerns seriously: "There is an expectation that

you carry on regardless". This disregard of the challenges experienced by foster carers seemed to be borne out by one interview with a social worker for looked after children:

*Foster carers are paid professionals but they have their own supervising social worker. Why would a professional need a professional to support them? The needs of the foster carers sometimes get put before the needs of the children.*

In the context of support that often felt inadequate, several foster carers told us of their regret that they had asked for a child's placement to be ended. One foster carer had asked for an adolescent girl to be moved after she had physically attacked her. She told the NSPCC:

*Every time she sees us, she comes up to us and gives us a big hug. She says it was the best placement she ever had. I know that since then she has tried to commit suicide on a number of occasions. She's gone to and from different carers.*

Another foster carer called Anne, whose story is set out in figure 8, explained that she had begun to really struggle with caring for the girl she was fostering after her behaviour deteriorated:

*She was extremely rude and wouldn't do anything she was asked. Her behaviour became a battle. She wouldn't get out of bed. At night-times she'd scream the place down.*

When, after a year of the girl's challenging behaviour, this foster carer became very concerned about the impact on her son, she ultimately asked for the girl to be moved. She reflected:

*I wasn't offered respite and I didn't ask for it. In hindsight I think that if I had taken some respite the placement might not have broken down. I needed some time apart to reconnect with my son.*

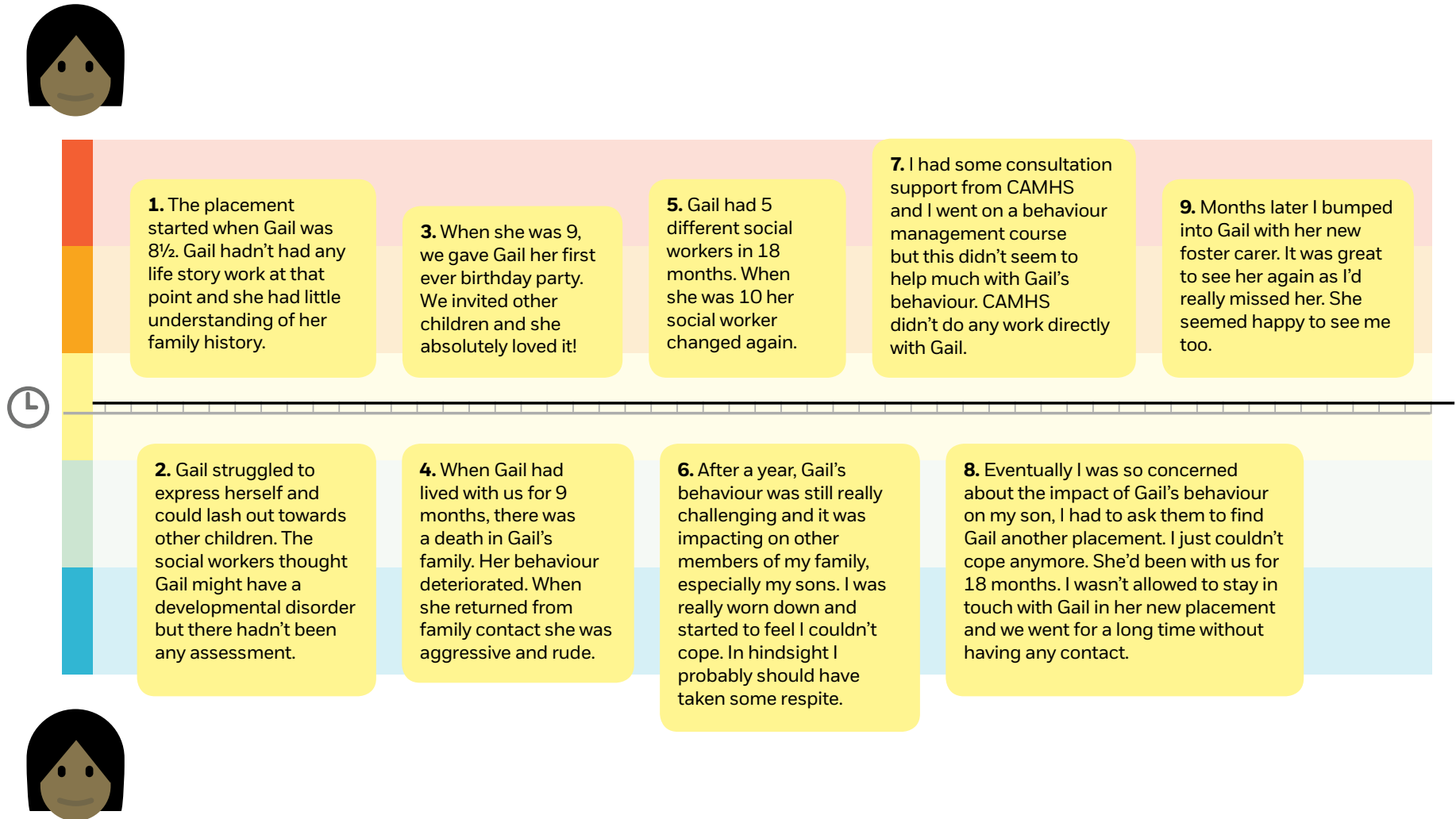
Some foster carers had young people placed with them who were already known to have challenging emotional and behavioural needs. However, they were given very little support to cope with the situation.

Carers emphasised the importance of training, respite care, social worker support and access to clinical consultation from mental health professionals in enabling challenging placements to continue. However, interviews with social care

77 Schofield and Beek (2005)

Figure 8: Anne's timeline

## Anne, former foster carer for Gail aged 11\*



\* Names and identifying features have been changed to protect identities.

professionals highlighted the resourcing challenges involved in supporting stable placements. One IRO commented that “Improving stability is down to budgeting – it doesn’t have to be inevitable. If you had more respite carers, placements might last longer”. Chapter 4 explores issues around the cost-benefit of supporting placement stability in more detail.

All professionals and young people agreed that placement breakdowns could have a very negative impact on young people’s emotional wellbeing. One personal advisor commented:

*Young people don’t know whether they’re coming or going and this has an enormous impact on their emotional wellbeing.*

A young person in care also explained that “Some young people have been through a loss and it’s just important not to give up on them”. Young people’s stories described the damaging cumulative impact that cycles of placement breakdown could have on them. One care leaver, who estimated she had had approximately 15 different placements, thought that her residential carer workers should have shown more persistence:

*Probably the homes themselves should have worked harder with the young people to make sure that it was a success, instead of passing on...I wouldn’t call myself a problem...but allowing the issue to just travel somewhere else. I think they should have worked harder.*

Statistics published by the Department for Education show that 1,480 young people who left care in 2014 (approximately 5 per cent) had experienced 10 or more placements in their care history.<sup>78</sup> As highlighted in Chapter 1, young people who experience instability and poor mental health are at risk of a range of poor outcomes. At present there is insufficient thinking about what can be done to prevent this.

## Relationships with social workers

Young people interviewed by the NSPCC also strongly emphasised the importance of their relationships with their social workers. This could make the difference between feeling genuinely listened to and supported, and feeling abandoned

and ignored. Some young people told stories about relationships with social workers that they had really valued:

*When I was little, I had a social worker, I was about 10, he used to take me from school, and I felt comfortable with him, he spent time building up a relationship with me.*

*I used to see my social worker every week. I loved her, she was amazing! She understood me. She was a young person so it just felt like I could talk to her about things I couldn’t talk to other people about.*

Unfortunately, these relationships had often been severed when young people’s social workers had moved to another job or changed for other reasons. Young people often experienced these changes as a real loss in their life:

*The first social worker I had was friendly and caring; I had a good relationship with her. I was able to be open and had good conversations [...] But she moved on, and the change in social worker was sad for me.*

When young people experienced many changes of social worker, this could have a really detrimental impact. As one young people’s participation manager explained: “Young people tell you that their relationships with adults in positions of trust are really important – consistency is a particular issue. Their social worker is a key contact. When this relationship is suffering, everything else can break down”. Some young people’s comments included:

*I haven’t got used to the social workers because they keep changing.*

*If you’ve moved around a lot that really affects your emotional wellbeing. You don’t have that trust. Also when social workers leave.*

*They [social workers] need to know that I do actually exist!!! And stop changing. And start listening.*

Young people found it particularly upsetting if their social worker left their role without informing them or saying goodbye. One foster carer called Steph explained that she had tried to address this with her children’s social worker because she was concerned about the potential impact on one of the children

she was caring for if his social worker should change suddenly:

*If they turn round and tell him the social worker he's used to is leaving him he will be more than unhappy, he will be devastated.*

Steph's story, told in figure 9, highlights the negative impact of frequent changes of social worker on the two young children she was caring for.

In the worst cases, the transient nature of relationships between young people and their social workers can mean that young people no longer bother to build a relationship because they do not expect their social worker to stay in place for long enough for it to be worthwhile. As one young person commented: "Social workers, to be honest, I don't get on with them, because they've changed constantly throughout my life". However, this was not always the case, as one young person told us:

*I had eight [social workers] in total. It's been around three months for each one. Most of them I didn't get notified that they were moving on. There weren't really any I got on with but I get on with the one I have now. She's just... she's done a lot.*

As this shows, when young people felt that their social worker genuinely cared about them, this could make a huge difference to their life.

### Relationships with family members

Young people and professionals were also clear that in most cases regular, well-supported contact with birth families was essential to young people's emotional wellbeing, their understanding of their identity and their support networks after they left care. However, in some cases family contact could be very detrimental to young people's emotional wellbeing.

Some young people told the NSPCC about the huge importance of regular contact with their birth family to their emotional wellbeing. One young person said:

*Contact is a big issue. Listen to what the child wants, and look into it if it's a severe case and don't promise things what [stet] you can't do.*

Two young people told us about the sadness caused by infrequent contact with their siblings while they were in care:

*It's a bit nerve-racking for me because obviously contact is my main thing with family. So if she doesn't sort it out, I don't know when I'm going to see my little brother.*

*I only saw my older sister once a year from the age of 7. For only an hour. Huh! I only saw her for 7 hours in 7 years.*

One young person in care named Joy told us about her frustrations about how it had taken a year for social workers to give her a phone number for her younger siblings. Joy's social network diagram, figure 10, represents how she felt quite distanced from her siblings at the time of her interview, due to the long period of time without being in contact.

Another young person, Alfie, who was living in a young offenders' institution at the time of interview, emphasised how his father had provided a consistent source of support for him throughout his 17 different placements with foster carers and many different social workers. Alfie's social network diagram is represented in figure 11. As this shows, Alfie's outer circle was well populated with some family members, friends and his youth offending team worker, but only his father and his sister were located within his inner circle. Alfie's social worker was at the very outer edge of his drawing because "I can't trust my social worker [...] but he'll do things for me".

Members of their extended family were also very important to some young people. A young boy interviewed by the NSPCC said how much he would like to be able to spend more time with his grandfather "because I really get along with him".

In some cases, infrequent contact with birth family members had been a major cause of young people's placements breaking down. As one social worker commented: "Some children abscond regularly because they want to see family members". This was the case for Josh, whose story is told in figure 12.

Lack of family contact also caused problems for Husna, whose story was told earlier in this chapter. She explained that she had returned home because she had grown desperate to see her mother and sister. She had then experienced further abuse from her father: "I needed safe contact with my birth family, away from my dad".

Figure 9: Steph's timeline

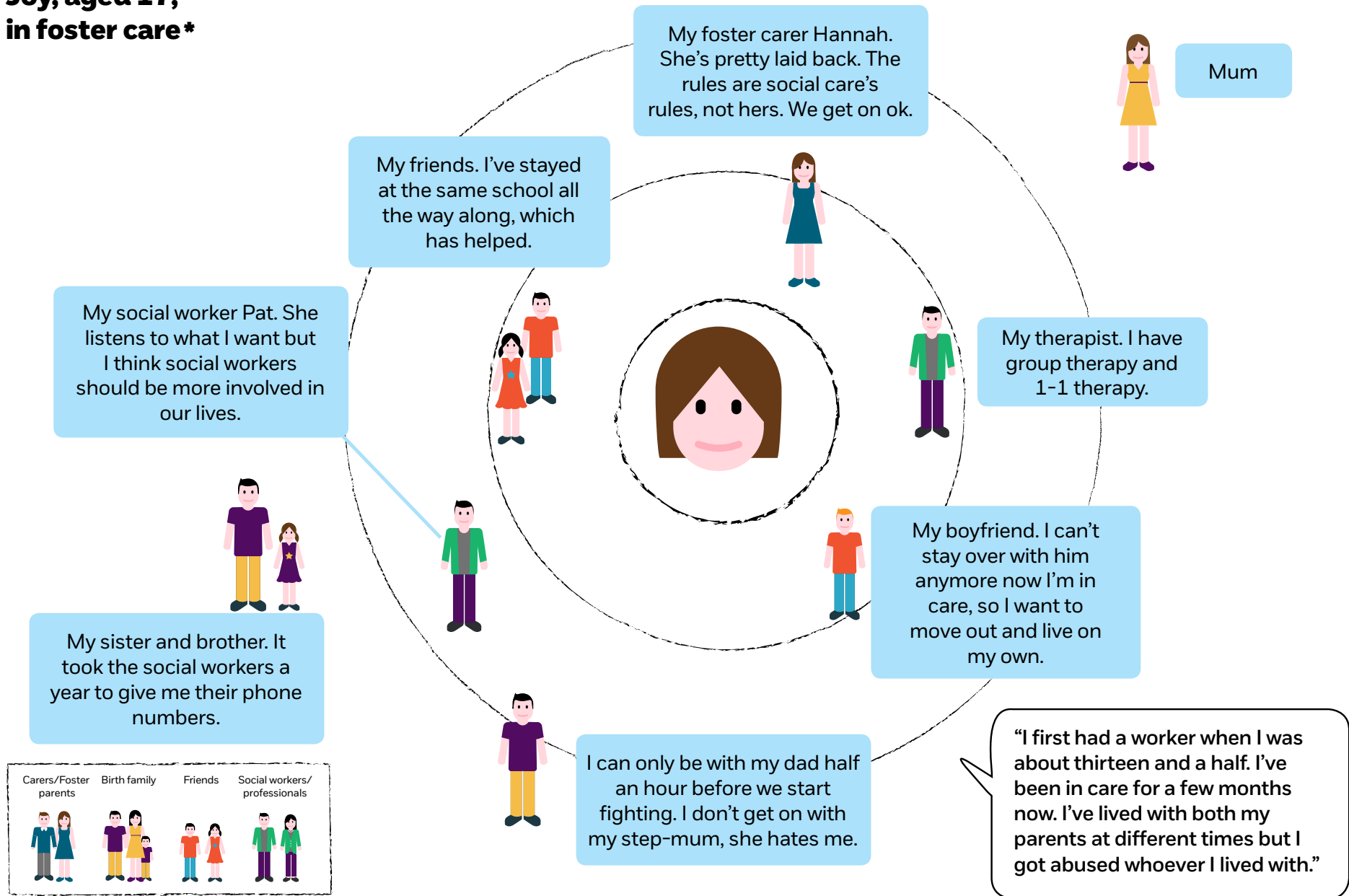
## Steph, foster carer for Millie aged 6 and Tom aged 8\*



\* Names and identifying features have been changed to protect identities.

Figure 10: Joy's social network

**Joy, aged 17,  
in foster care\***

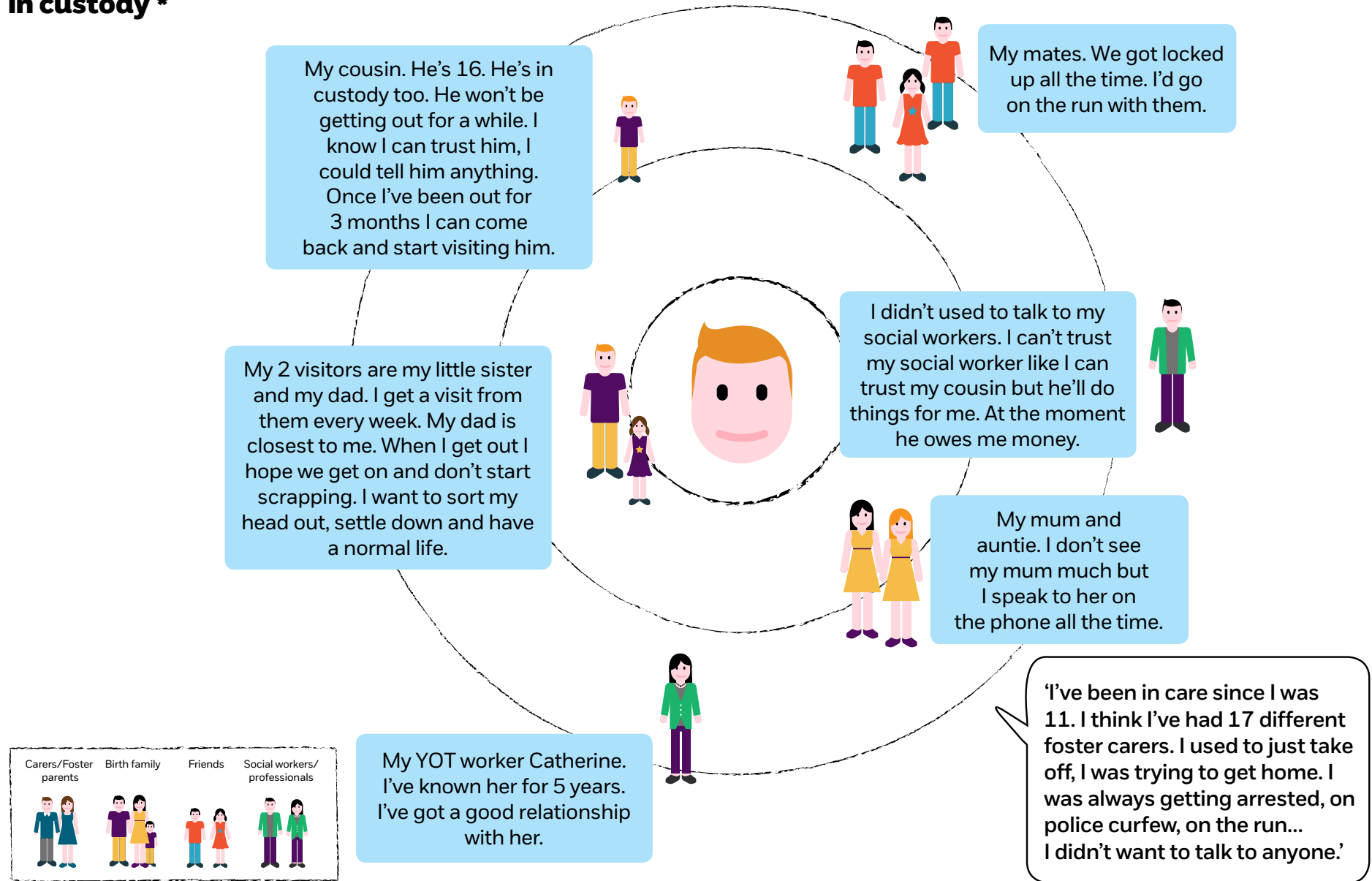


\* Names and identifying features have been changed to protect identities.



Figure 11: Alfie's social network

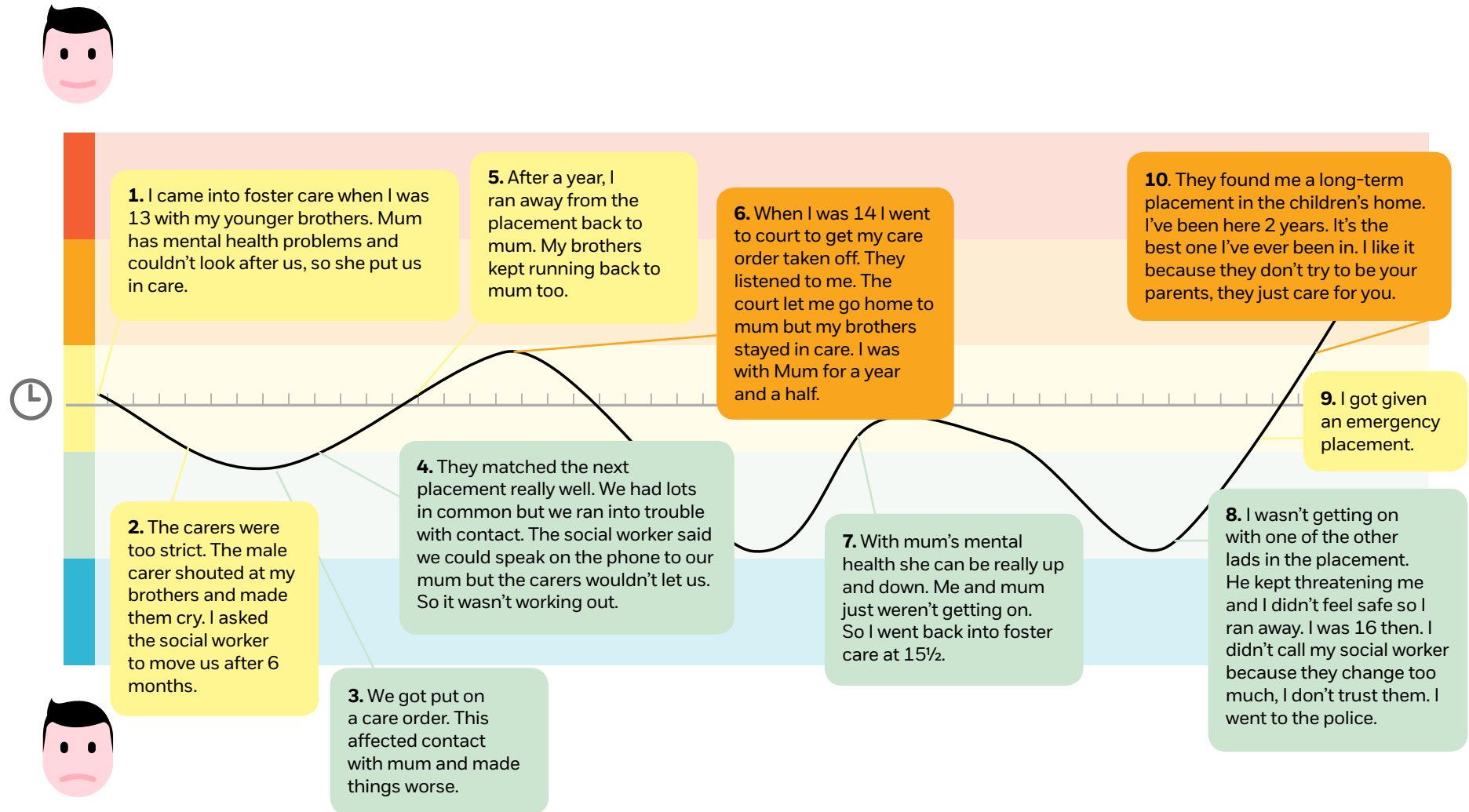
**Alfie, aged 15,  
in custody \***



\* Names and identifying features have been changed to protect identities.

Figure 12: Josh's timeline

## Josh, aged 18, living in a children's home\*



\* Names and identifying features have been changed to protect identities.

Young people also described some really positive examples of the support they had received with family relationships. One young person who had recently come into care following a family bereavement had lost contact with his mother and extended family. His social worker organised a family group conference, which enabled him to get in touch with his mother, aunt and cousins:

*They helped me to connect with my mum and talk to my mum again. She is in her country and has children so it is hard for her to come here. [...] They also did a family conference and my Aunt and the family came round, to decide if we were going to stay in our family or stay in care. It was good because it felt like we had more support. Now if we have any holidays we can just go visit because it feels like we are connected.*

The support he received to make renewed contact with his mother and extended family had been a very positive experience for this young person.

### Getting contact right

While birth family relationships were very important to many young people, their foster carers and social workers were also clear about the very negative impact that poorly supported or monitored contact could have on children. As one foster carer commented:

*All kinds of family contact needs careful planning, including routine contact, final contact and siblings moving on.*

One foster carer explained that her foster son was sometimes “really upset” after contact because his mother had said inappropriate things to him and “the contact supervisor didn’t stop the conversation or stop the contact”. This situation improved when the boy’s contact began to be supervised at a contact centre where it was monitored more professionally.

One social worker expressed concern that: “Some parents sabotage what the children have. The birth family can try to break up the foster home”. She explained that it could be difficult to change contact arrangements as these were decided by the court. Another social worker explained:

*The influence of the birth family was so strong, the children didn’t come out of their rooms and mix*

*with their carers. The young person challenged the carer and hit her, and then the placement broke down. Sometimes you have to weigh up the impact of contact in the long term.*

A CAMHS manager also expressed concern that: “With contact we get it wrong a lot of the time. Children can be re-abused through contact with birth parents”. Therefore, while family contact is very important for many children and young people, it is essential that it is appropriately supervised, and that carers and other professionals continue to monitor its impact on children.

### Therapeutic work with birth families

One issue that was not discussed very frequently in the fieldwork was the possibility of involving children’s birth families in therapeutic work. A CAMHS manager in one of the local authorities explained:

*Birth parents’ emotional and mental health needs are often significant but frequently are not addressed by adult mental health services. This is because they either do not meet the criteria for adult services, the parents themselves do not recognise their needs as benefitting from counselling or therapy, or the emotional mental health needs are so tightly tied in to their role as parents and their battle with the local authority in relation to the care of their children that adult mental health services do not see this as their job.*

However, a CAMHS psychologist argued that without any kind of therapeutic interventions involving birth families, there was little chance of healing these troubled relationships and enabling looked after children to have positive relationships with their birth families. She argued that ideally there would be “a CAMHS service that could provide a flexible approach to working with birth parents”. However, unfortunately there was currently little capacity in that CAMHS to carry out this kind of important work with families.

### Returning home

The most common outcome for a looked after child is to return home to their birth family.<sup>79</sup> However, there is currently little support from mental health services to help children and parents to heal their relationships. Professionals from one local authority

79 Hyde-Dryden et al (2015)

argued that: “After a child enters care, birth families should receive ongoing support to enable that relationship to be a positive one for that child, who may later return home”.

One young person interviewed by the NSPCC had recently returned home to her birth family. She explained that some things had changed for the better: “My mum is now nicer”. However, her father’s behaviour had changed very little. She explained that her parents had been asked to attend a parenting course, but had only attended one session. With this limited engagement, it is unsurprising that the problems that led to her entering care had not gone away. This young person felt very responsible for her time in care, as it was she who had brought the problems she was experiencing to the attention of professionals. Therefore, at the time of interview she was experiencing feelings of guilt as well as alienation from her extended family: “It just destroyed my relationship with my dad. It made a bad impression of me with my other family members”. While she was receiving counselling, very little work had been done with her parents to help address their difficult family dynamics.

## Priority five: Support care leavers’ emotional needs

The period of time around when young people leave care can also be a particularly challenging time for their emotional wellbeing. Those who participated in interviews and workshops pointed out that care leavers frequently experience many transitions in a short period of time, including leaving their placement (and carer), a change of key worker and, in some cases, moving to a new geographical area to live in new accommodation. Therefore, leaving care can be a particularly stressful time.

### Preparation for leaving care

Poor preparation for leaving care is associated with poor outcomes.<sup>80</sup> Those interviewed by the NSPCC pointed out that while these many transitions and the new responsibilities associated with them are wholly predictable, young people sometimes still receive very little preparation. One care leaver told us:

*I think I was completely unprepared – the process between 16–18 of moving me into semi-independence didn’t prepare me for independence, job seeking, all the benefits you are entitled to, none of that was ever explained. I remember getting into a real panic after a month of not paying my water bills.*

Another care leaver, who had begun to live independently at 16, told us:

*I don’t think they did much to prepare me for independent living when I left the [children’s] home. I didn’t hear from any of them again as soon as I left. I don’t think that’s good. Some people might have needed a bit of transition or support. [...] Even though I managed to be fine with it, other people wouldn’t have been.*

Leaving care social workers explained that young people’s foster carers did not always help to prepare them for independence. As one social worker explained, “Some foster carers are very good at trying to prepare them and others are still providing the level of care they gave when they were nine”. Participants in one of the local authority mapping workshops confirmed this view:

*There is a culture of ‘do for’ in many of our foster homes which actually, over the long term, is disabling for many of the young people – some foster carers forget that they need to teach the children they care for life skills.*

### The emotional impact of leaving care

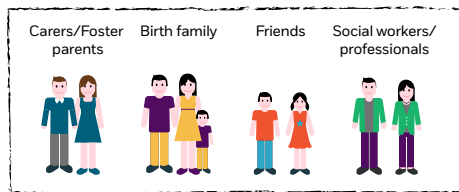
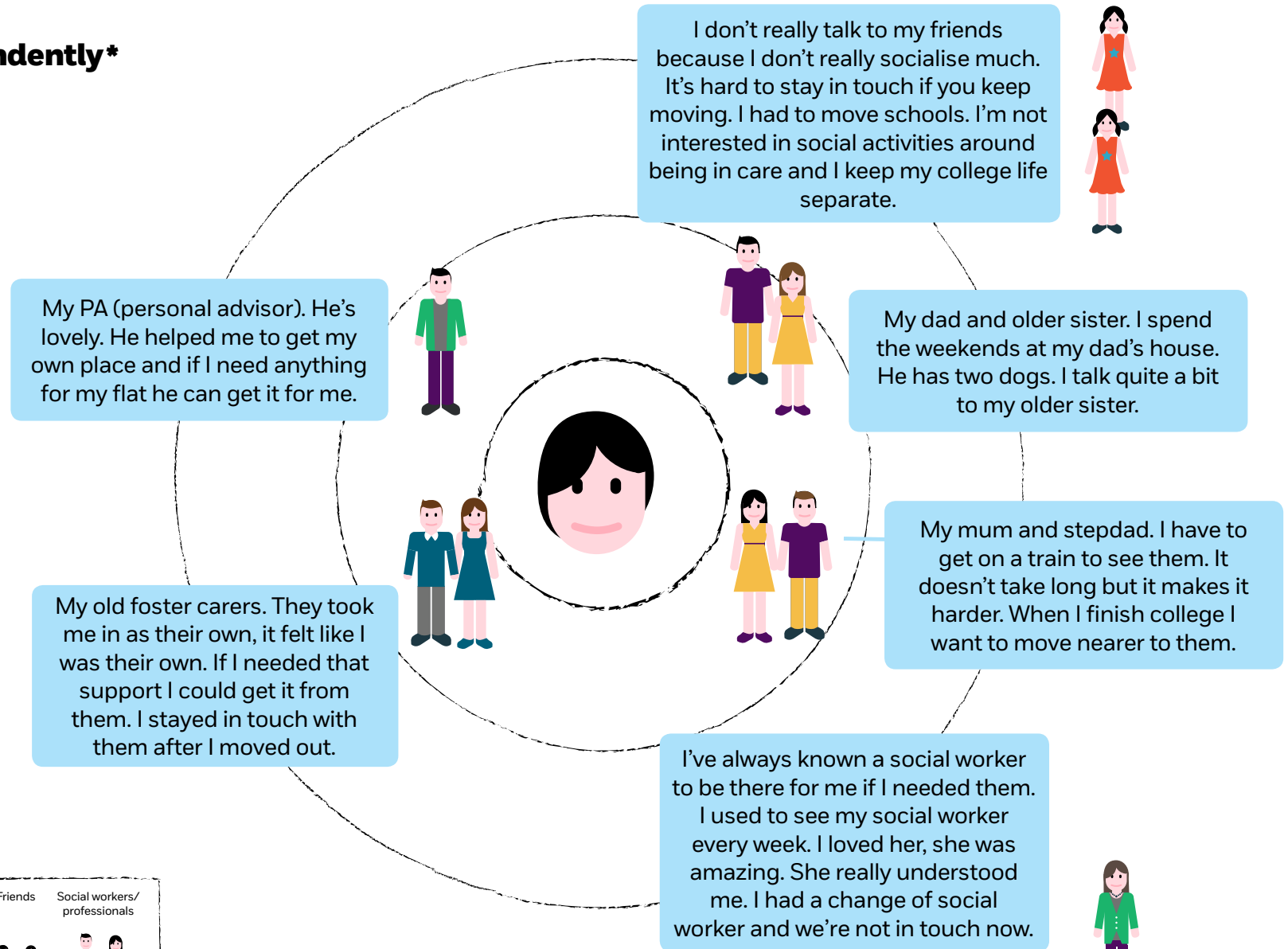
Many of the young people interviewed by the NSPCC found the experience of leaving care and living alone for the first time daunting and socially isolating.

One care leaver called Jill explained how instability while she was in care, followed by moving to a new area after she left care, had weakened her social networks. She had become distanced from her friendship groups and could not see her family as often as she would like to. Jill’s social network diagram is presented in figure 13.

Another young person called Kelly (see figure 15) explained that: “I used to enjoy having a drink with my mates ... seeing them”. However, since she had left care she had been moved to supported lodgings

Figure 13: Jill's social network

**Jill, aged 18,  
living independently\***



\* Names and identifying features have been changed to protect identities.

in a new area, which had fractured her social networks: “I’ve only lived around here for about six months so I don’t know that many people”.

Several of the young people had also felt under pressure to move out of their placements before they felt ready. One care leaver told the NSPCC: “When I moved out at 18 I still felt like I needed support”. Another said that when he had moved into semi-supported accommodation at 16 things had quickly spiralled out of control; he had become dependent on drugs and alcohol and “there was no positive” about the situation. Luckily he had subsequently been allowed to move back into a foster care placement with a carer he already knew.

Scott, a care leaver who was aged 18 at the time of his interview, explained how living in supported lodgings at the age of 15, before he was ready for this level of independence, had contributed to a downward spiral in his emotional wellbeing. After spending time in a young offenders’ institution, Scott spent a short period of time in a children’s home and then moved into semi-independent accommodation where he received a much more intensive package of support than he had had previously. Scott’s story is told in figure 14.

The NSPCC also interviewed two young people who were approaching independence but were still living in their placements. One, who was still living in his children’s home, told us:

*I thought it was really exciting, you know, viewing flats, but I’m scared because I’m going to be on my own, and I don’t like being on my own. I want to be independent, but I don’t want to be lonely.*

Another young person said: “One thing I’d like to change about the care system is that people shouldn’t be kicked out at 18”.

### Limited professional support

Professionals were often concerned about the limitations in the support that they were able to offer to care leavers. One foster carer highlighted the problem that care leavers are sometimes “shifted across teams”, and see their social worker replaced by a personal adviser before they are ready for that transition. Several of the personal advisers interviewed in one local authority area

expressed frustration that they were not able to build the supportive relationships that they would like to with care leavers because their time was too stretched across their large caseloads. One personal adviser said:

*These days there is very little time at all to build relationships. I do still desperately want to build in that time to have a cup of tea with the young person but often it is just unrealistic. These young people need continuity of relationships, not the disjointed, stop and start support, which is all we can provide. We would love to be able to do more.*

Another personal adviser discussed a vulnerable care leaver on his caseload:

*He needs stability – someone who can build up that trust – so that he will actually value and appreciate their advice [...] The perfect service would be somebody qualified, like a counsellor, who could actively pursue him to engage, and follow up with him. He could build a relationship with that person.*

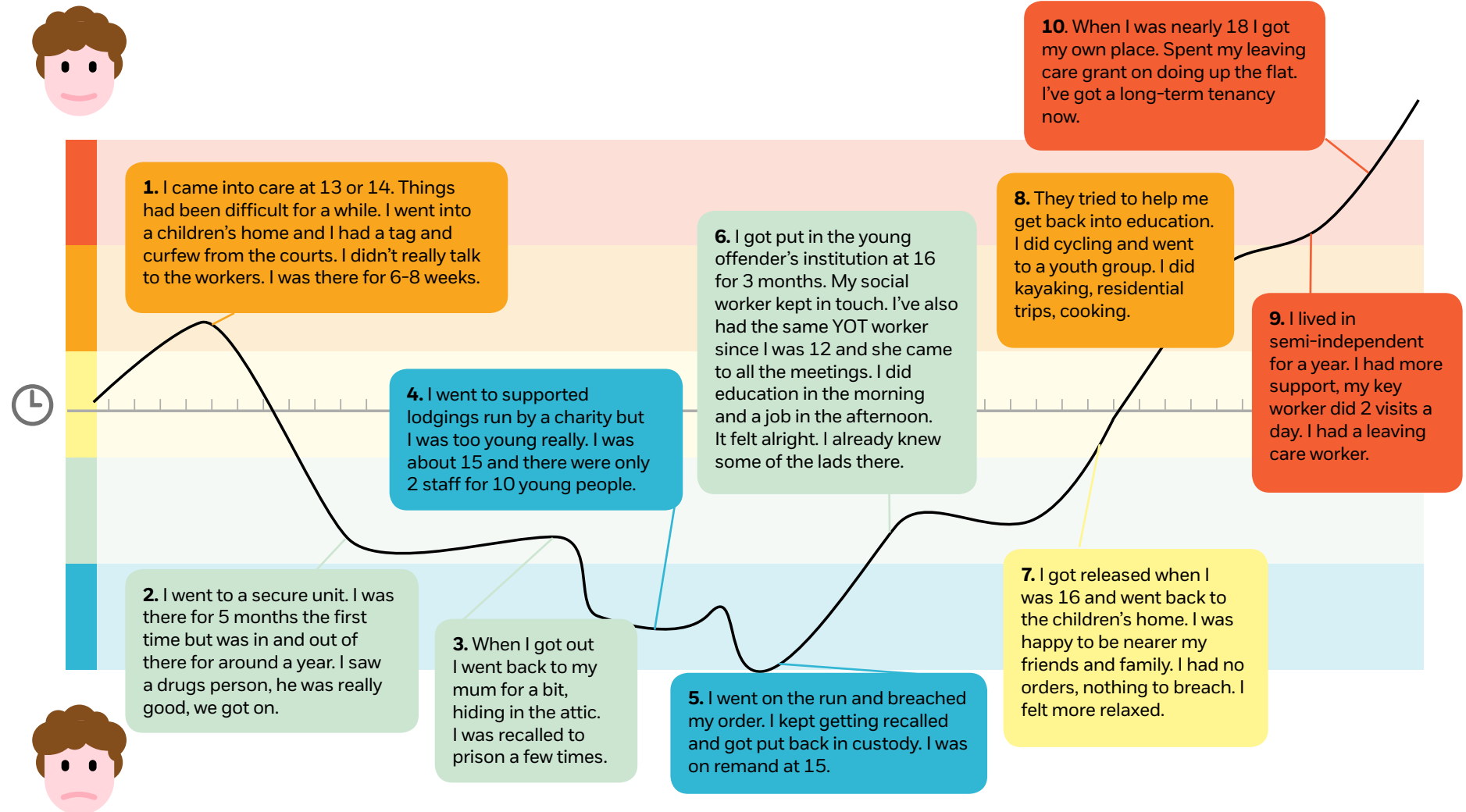
This personal adviser told the NSPCC that because they could not offer young people the consistent support that they needed, their work “does end up being crisis-led because young people turn up at the office with issues that need immediate attention: no money, rent arrears, police involvement”. Also, young people in this area had learnt that if they did not “comply” they “get more attention”, so there were disincentives to following their personal advisers’ advice.

However, this was not the case for every young person. In one of the other local authority areas, a care leaver described their positive relationship with their personal adviser:

*I see my personal adviser every week. He is one of those who would always be there if I needed him.*

The level of resourcing for leaving care services clearly affects how well supported care leavers felt. For some, leaving care can be a very lonely time. One care leaver aged 17 told us: “I don’t really have many people in my life”. Another young person who now lived independently said: “I worry about everything, all the time. Sometimes I think I’ll just run away from it all”.

Figure 14: Scott's timeline

**Scott, aged 18, living independently\***

\* Names and identifying features have been changed to protect identities.

## Birth family relationships after leaving care

As support from carers and care professionals decreased around the time of leaving care, young people's birth family relationships often became their predominant sources of emotional support. Therefore, a manager from one local authority's leaving care service argued:

*We should be looking to involve families in children's lives in a meaningful way. What role will families play when the young person leaves care?*

Some of the young people had been disappointed that they were not able to rely on birth family members to the extent that they would have liked after leaving care.

Kelly, a care leaver aged 17, was very disappointed that her mother did not show any interest in staying in touch with her: "I don't speak to my mum – she never makes an effort. I'd love contact with her". Kelly had experienced periods of homelessness after leaving care and of all the young people interviewed by the NSPCC, her social network was the most limited – she included only five people on her diagram and one of those (her supported lodgings carer) she had known for only a few weeks. Kelly's relationship with her father and younger sister were very important to her. Kelly's social network is presented in figure 15.

## Mental health services for care leavers

At the same time that support from carers and social workers reduces, care leavers can also find that they are no longer eligible for support from mental health services. As one leaving care service manager commented: "It would need to be a very strong assessment for adult mental health services to even take a look at it". This is very unfortunate timing for the withdrawal of services as research has shown that many care leavers report a deterioration in their wellbeing in the year after they leave care.<sup>81</sup> One of the care leavers emphasised the irony of mental health support being withdrawn from care leavers in early adulthood; when you are younger

and have easier access to CAMHS "you might not want it, you might not see the benefit of it...You speak to a lot of [care leavers] who say they wanted it when they're older, not when they're young and could have been hanging out with their friends". Another care leaver pointed out that:

*A lot of care leavers are young parents – we have to battle with that as well - and so a lot of people do fall into that hole of depression.*

One personal advisor described how the withdrawal of CAMHS from one young person after she turned 18 had very serious consequences: "The frequency of self-harming went up hugely, she contemplated self-harming her face, and she was using cannabis and cocaine".

Even while care leavers were still eligible for support from CAMHS before they turned 18, this did not always mean that they could make use of this support. One social worker from a local authority care leavers' service told the NSPCC:

*What tends to cause problems [with accessing CAMHS] is if they have got a very chaotic lifestyle sometimes, not that they don't want to do it, but if there's everything else going on.*

This problem could be made worse by the inflexibility of services. As a personal advisor described:

*It's three strikes and you're out. Quite a harsh system where they are on the book. [...] We're in a situation where no one wants to take responsibility.*

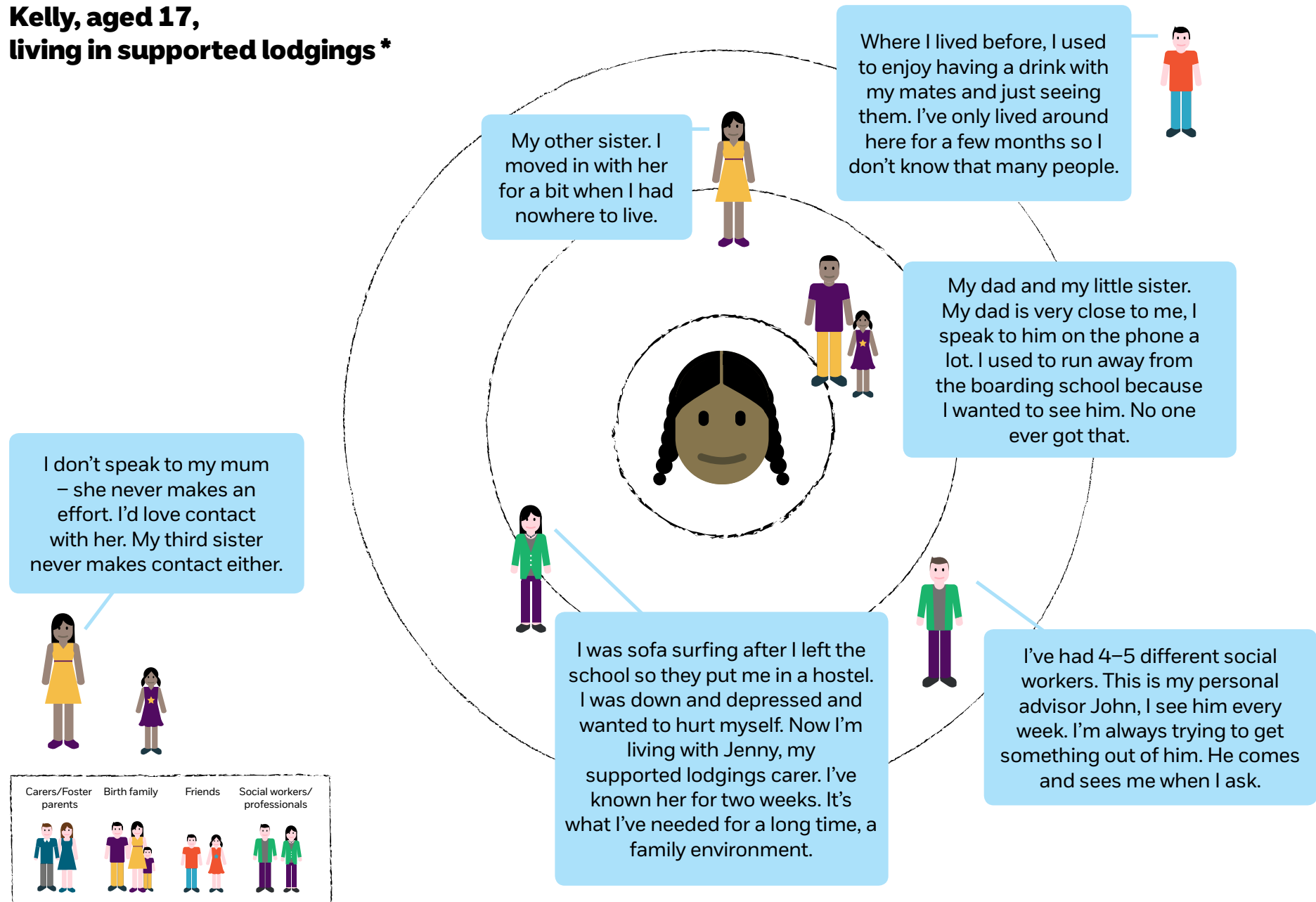
To help address this situation, one looked after children's social worker suggested that it would be helpful "if supported accommodation had staff who are experts in mental health so that you have access to that support". However, this is not currently the case. All of the four local authorities participating in this project identified mental health services for care leavers as a key gap in support.

81 Dixon et al (2006)



Figure 15: Kelly's social network

**Kelly, aged 17,  
living in supported lodgings\***



\* Names and identifying features have been changed to protect identities.

## Employment and resilience

While young people identified many risk factors for poor emotional wellbeing and mental health after they left care, they also identified some important sources of resilience. In addition to relationships with friends and family, and stable accommodation, some care leavers emphasised the difference that employment had made to their emotional wellbeing. One care leaver reported that his job “makes me feel secure and happier – it’s good to know I am paying all of my own bills”. Another young person said:

*Now that I am working here, I feel a lot better, I’m not self-harming anymore. People know me here. They help me out.*

A number of the young people NSPCC interviewed had benefited from apprenticeship schemes provided by their council or support from a personal advisor who had helped them to get a job. Previous research has identified a close relationship between care leavers’ emotional wellbeing and their successful engagement in education, employment and training.<sup>82</sup>

## Conclusion

The experiences described in this chapter identify a number of key areas where looked after children and the adults who care for them thought that the care system could better support young people’s emotional wellbeing. Particularly important themes include the need for better assessment to identify young people’s emotional and mental health needs; better training for carers, social workers and other professionals to equip them to meet young people’s emotional needs; a stronger emphasis on early intervention to ensure that children’s emotional wellbeing is well supported from the outset; support for young people to make their voices heard; and increased focus on supporting and sustaining children’s relationships with carers, professionals and family members. Young people were clear that they still need emotional support and support from mental health services after they leave care.

Chapter looks in more detail at how children are supported in their placements to have their emotional and mental health needs met, and models the potential cost implications of providing this support.

# Chapter 4: Spending within the care system

With Helen Trivedi

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Spending on looked after children represents a significant proportion of local authorities' budgets. In 2014, the National Audit office estimated that local authorities in England spend £3.4 billion on care.<sup>83</sup> This figure increases further when health service and voluntary sector spending is also included.

How this resource is used at a local level varies significantly. Figures 16 and 17 demonstrate how spending varies between the four local authorities who participated in this project. As this report has shown, social care support, as well as specialist mental health services, plays a critical role in improving the emotional wellbeing of looked after children. Alongside investment in specific therapeutic services, figures 16 and 17 provide a description of spending across a range of different services and support in the four local authority areas.

The difference in spending patterns between these four areas demonstrates that local authorities and their health partners are making choices about how their resources are best spent. Of course there are significant resource constraints faced by local authorities and their partners in shaping their local services. However, improving support for the emotional wellbeing of children in care may not necessarily require investing new money. Instead, it may mean using resources in a different way.

Research has highlighted the interaction between looked after children's emotional and behavioural difficulties and the stability of their placements. Children who enter care with more mental health difficulties are at greater risk of placement breakdown<sup>84</sup> and children who have externalising difficulties (such as challenging behaviours) are at particularly high risk.<sup>85</sup> There is also evidence that

children who experience placement instability have more difficulty in accessing support services.<sup>86</sup> In a previous study, Ward, Holmes and Soper found that:

*When costs were calculated over a period in care or accommodation, there appeared to be an inverse relationship between the costs of provision and children and young people's opportunities for improving their life chances and developing or sustaining stable relationships with adults and peers.<sup>87</sup>*

This was because young people with "extensive and entrenched needs" often did not receive well-supported, intensive placements until "they had run the gamut of other, cheaper options".<sup>88</sup> These young people's unstable experiences of care exacerbated their difficulties, so that over time their care increased in cost while their wellbeing simultaneously worsened. Ward, Holmes and Soper have argued for a "comprehensive systems approach" to analyse how the cost of supporting looked after children is spread across agencies.<sup>89</sup>

To further investigate the relationship between placement stability, the provision of support services to looked after children and overall expenditure, this chapter explores the cost of two individual children's journeys through care in England and compares their costs. Helen Trivedi and her colleagues at the Centre for Child and Family Research (CCFR) at Loughborough University carried out the cost estimates for this chapter using their methodology that has underpinned the development of their Cost Calculator for Children's Services.<sup>90</sup> Loughborough University developed this methodology with the involvement of a Welsh local authority and it is also applicable to Wales but the specific analysis prepared for this chapter relates to England.

83 Audit Commission (2014)

84 Biehal et al (2009); Selwyn et al (2006)

85 Rock et al (2013)

86 Richardson and Lelliott (2003)

87 Ward et al (2008), p258

88 p258 ibid

89 p265 ibid

90 [www.lboro.ac.uk/research/ccfr/research/exploring/project---the-cost-calculator-for-childrens-services.html](http://www.lboro.ac.uk/research/ccfr/research/exploring/project---the-cost-calculator-for-childrens-services.html)

Figure 16: Expenditure on placements and mental health services in four local authority areas

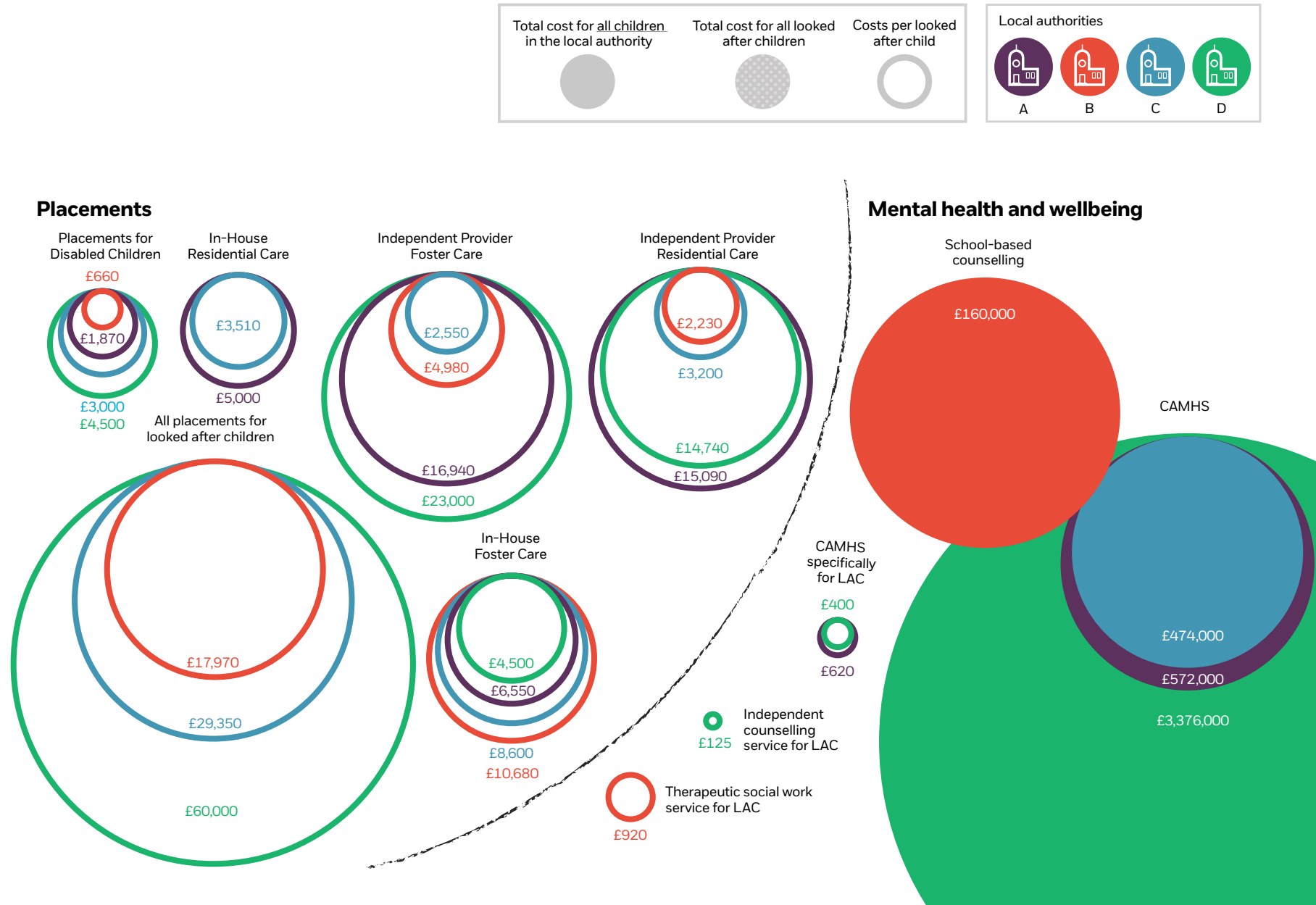
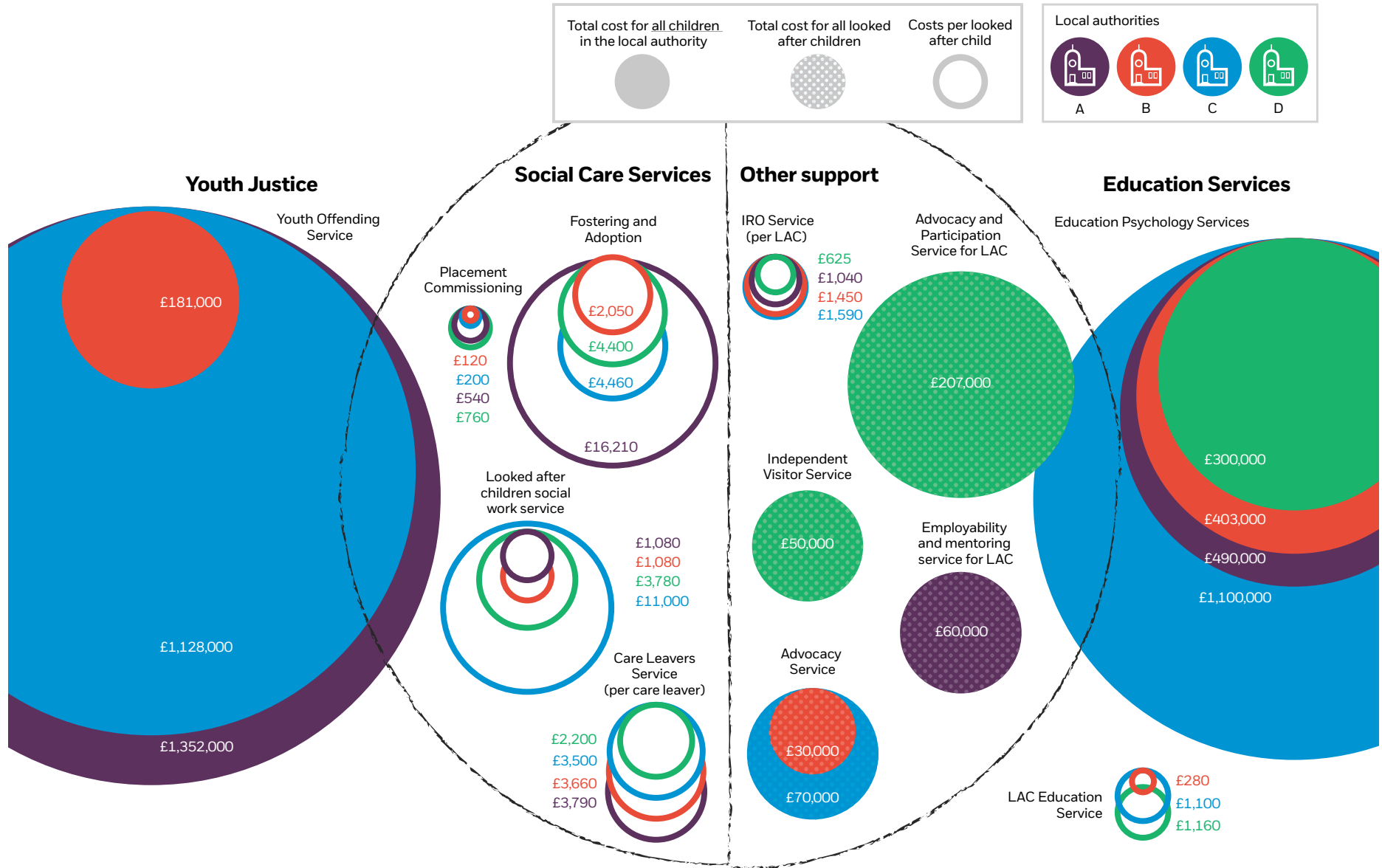


Figure 17: Expenditure on placements and mental health services in four local authority areas



## Costing children's care journeys

Figures 18 and 19 tell the stories of "Paul" and "Joe", two young people in care in England, as told to the NSPCC during the fieldwork for this project. In Paul's case, after some initial difficulty accessing support, he and his foster carer both received help to meet his emotional and behavioural needs and keep his placement stable. However, in Joe's case, following an experience of abuse in foster care, his emotional and mental health needs remained unsupported and he did not receive adequate support until he had experienced multiple placement breakdowns.

Working with the NSPCC, Loughborough University has calculated the cost of each of these placements, enabling a comparison of the cost of supporting a stable placement with the cost incurred by placement breakdown.

### Paul's story

Paul's carer Sue initially experienced considerable delay in accessing support from mental health services to help her understand and meet Paul's needs. However, Paul and Sue did receive support from CAMHS relatively quickly after their GP made a referral. The support CAMHS gave to Paul and Sue included long-term support (for a period of over two years). This included two different types of therapeutic support to help Sue understand how she could meet Paul's emotional needs and help Paul process his difficult feelings. The local authority also gave Sue training to help her manage his behaviour and a package of respite care for five weeks a year to prevent her from becoming exhausted.

Using the Cost Calculator for Children's Services conceptual framework and underpinning methodology, Loughborough University estimates that **across almost eight years (from 2007 to 2015) Paul's care and support cost £371,336; approximately £47,914 each year.**

Published data shows that a child in local authority foster care with few additional needs costs a local authority an estimated £46,509 each year.<sup>91</sup> Therefore, on average, maintaining Paul in his

stable local authority foster care placement cost an additional £1,405 each year.

### Joe's story

Following Joe's experiences of abuse he was distressed and his carers struggled to understand and cope with his anger. Through no fault of Joe's, the lack of support for both Joe and his carers ultimately led to his placement breaking down.

When Joe entered care he first lived in a short-term agency foster placement and then moved to a second agency foster placement. Following abuse in his second placement, Joe was moved to a third agency foster placement where he was happy and had a good relationship with his carers. When Joe became very angry and aggressive after three years in this placement he was referred to CAMHS. However, CAMHS did not give Joe or his carers any support to understand and manage his angry feelings. After a further year this placement broke down, which was very distressing for Joe.

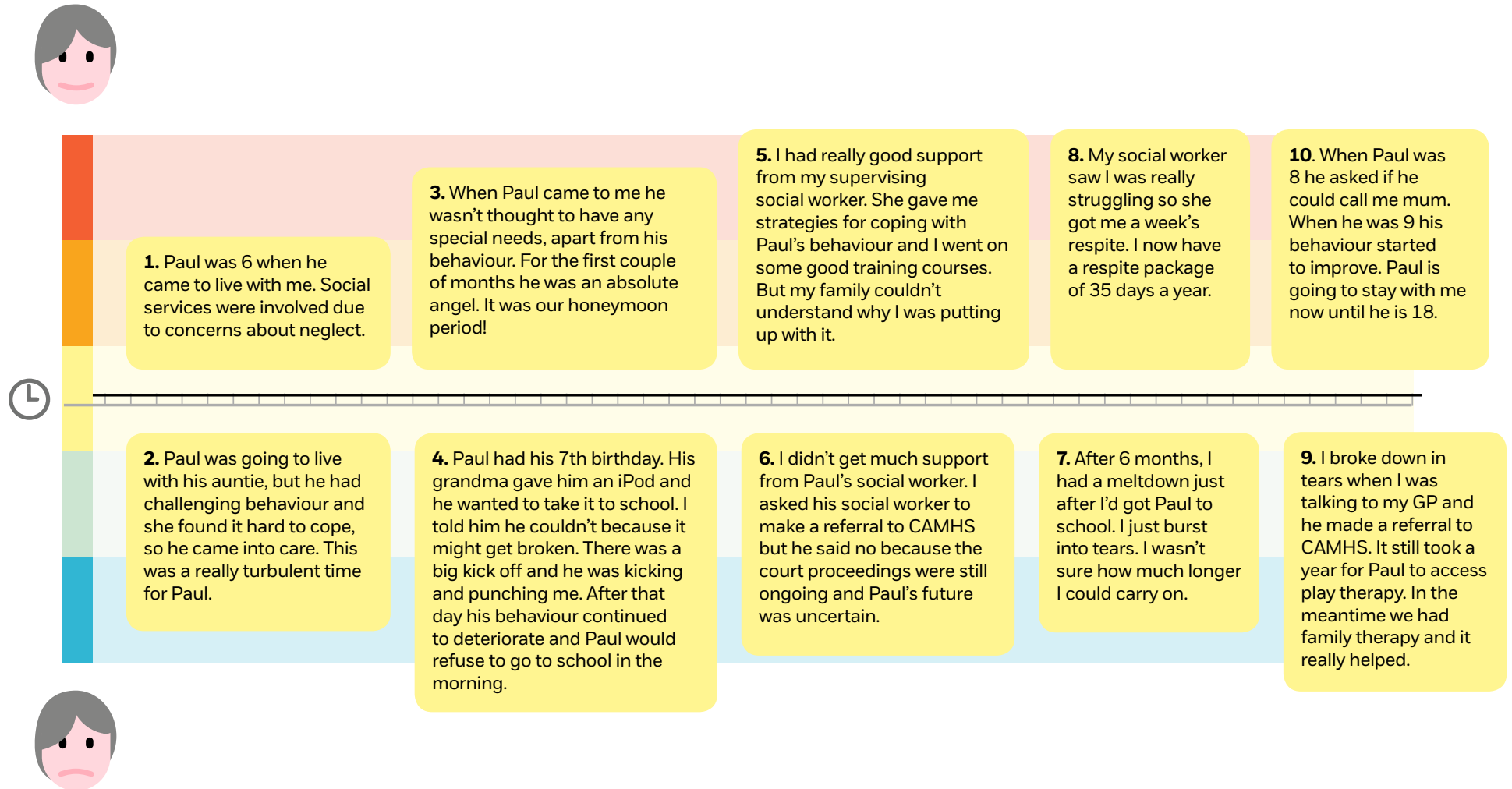
Joe went on to experience multiple placements in agency foster care, followed by a placement in residential care where he got in trouble with the police. During his 18 months in residential care, Joe's emotional needs were met by his relationship with his key worker and he felt much more stable. He then chose to move back into local authority foster care to be nearer his family and he started to access counselling.

Using the Cost Calculator for Children's Services conceptual framework and underpinning methodology, Loughborough University estimates that **over almost 11 years (from 2003 to 2014), the total cost of Joe's care and support was £738,460; approximately £70,329.51 per year.** This figure includes all of Joe's social care, health and criminal justice costs.

When the average yearly costs of Paul's stable placement (over a duration of almost eight years) are compared with the average yearly cost of Joe's unstable care (over just under 11 years), Paul's care cost an average of **£22,415 less per year.**

91 Curtis (ed) (2014)

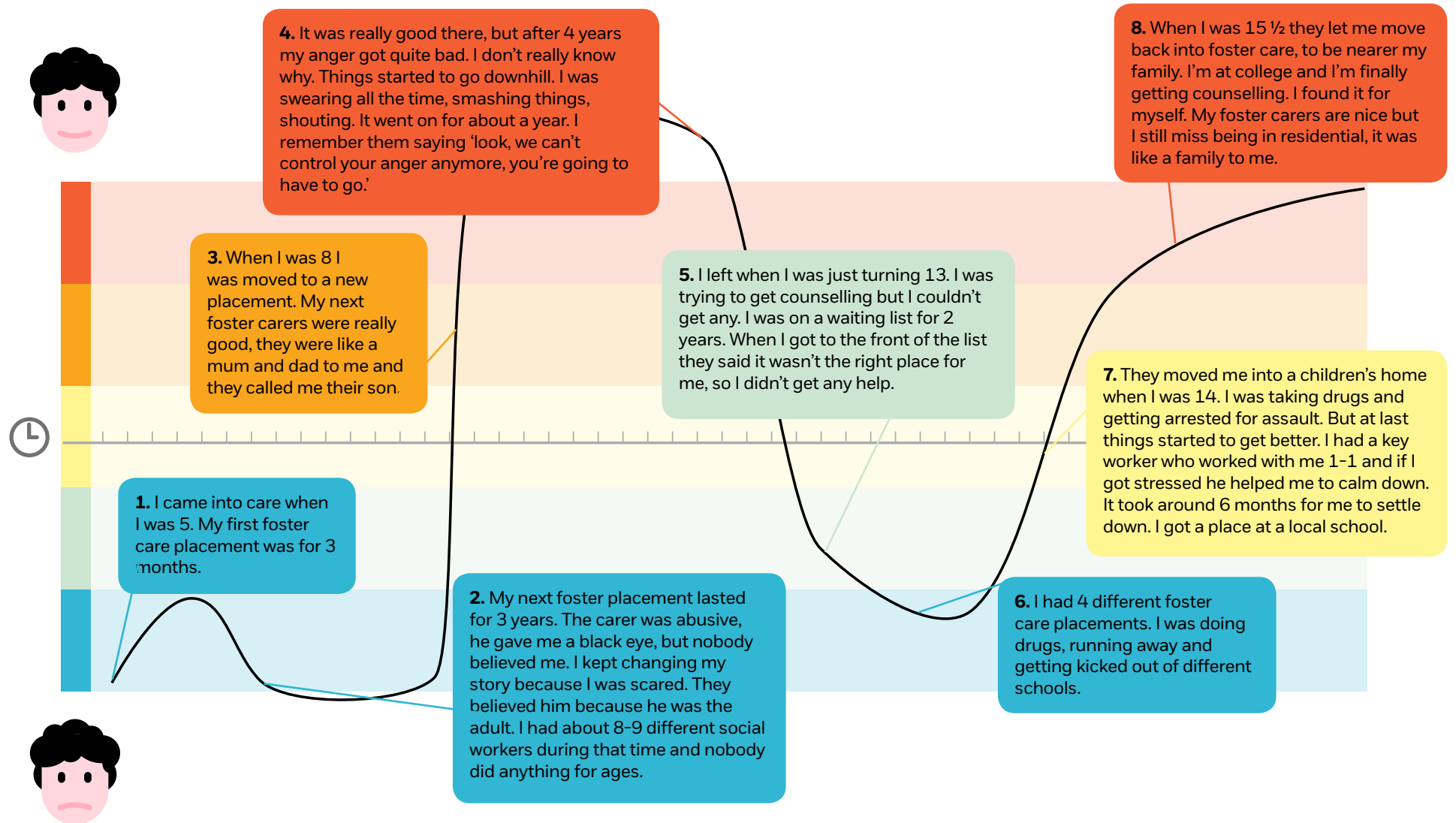
Figure 18: Paul's timeline

**Sue, foster carer for Paul aged 12\***

\* Names and identifying features have been changed to protect identities.

Figure 19: Joe's timeline

## Joe, aged 16, living in foster care\*



\* Names and identifying features have been changed to protect identities.



## The cost of improved support for Joe

What might have happened if Joe and his carers had received support earlier to maintain their relationship and keep his placement stable? How might Joe's local authority have potentially avoided the distress Joe experienced due to his placement disruptions, as well as the associated increased expenditure?<sup>92</sup>

To help explore these questions, Loughborough University estimated the cost of two hypothetical support packages from CAMHS; a 'medium' support package lasting for six months and a 'high' support package lasting for 12 months. They devised these packages based on published estimates of health and social care costs.<sup>93</sup> Each of these packages might involve a CAMHS worker supporting a child's carer to help them understand and meet the child's needs (a 'consultation' approach) or carrying out direct work with a child. These are both common models of CAMHS support for looked after children and the cost of an hour's contact time is the same whether it is with a child, their carer or both together. Details of the content and costs of these packages of support are set out in table 4.

If Joe and his carers had received a high support package (lasting 12 months) at the outset of his third placement, this would have cost **£4,610.76** in 2007 costs. In this scenario, Joe's third foster care placement did not break down and he did not have any subsequent placements including the 18 months he spent in residential care.

Using the Cost Calculator for Children's Services conceptual framework and underpinning

methodology, Loughborough University estimates that the total costs incurred for this hypothetical stable care journey (including health and social care costs) would have been **£670,609 over almost eleven years, or £63,867.55 each year.**

This version of Joe's care journey, with a support package from CAMHS to keep his placement stable, is **£67,851 lower than the actual cost of his care over 11 years.** This equates to an annual saving of £6,462, which is approximately a 10 per cent reduction in costs.

## The cost of placement instability in England

Using existing research and published data on the cost of children's social care services, health services and other local services,<sup>94</sup> it is possible to estimate the costs that might be avoided by providing support packages from CAMHS to maintain the stability of looked after children's placements.

As the research discussed above shows, the stability of looked after children's placements is often related to their level of emotional and behavioural difficulties. To explore the cost of placement instability and how this might be related to the support children receive, Loughborough University estimated the potential impact of providing improved therapeutic support to looked after children who experience multiple placement moves – for example, three or more placements in a 12-month period. Data shows that the proportion of looked after children in England who experience

Table 4: Details of hypothetical mental health service packages

Medium support package	High support package
Referral by the child's social worker	Referral by the child's social worker
Referral reviewed at CAMHS	Referral reviewed at CAMHS
Screening assessment	Screening assessment
6 months' support: weekly sessions with the young person and/or the carer(s)	12 months' support: weekly sessions with the young person and/or the carer(s)
	Review session every two months
<b>£3,160 (2014 costs)</b>	<b>£6,168 (2014 costs)</b>

92 A 'cost avoided' is a change in the projected or predicted expenditure. A 'cost saving' is a reduction of current or actual expenditure. Based on McDermid and Holmes (2013).

93 Curtis (ed) (2014), Schema 12.7

94 Curtis (ed) (2014)

three or more moves within a year has remained relatively stable for the past five years, at 11 per cent of the care population.<sup>95</sup>

In 2003, Meltzer et al established that 45 per cent of looked after children aged five to 17 years old are likely to have a diagnosable mental disorder.<sup>96</sup> Meltzer et al also found that of this 45 per cent who had a diagnosed need, 44 per cent of children were already accessing specialist services.<sup>97</sup> This leaves 56 per cent of looked after children with a diagnosable mental disorder who were not receiving support. According to data published by the Department of Education, in 2012 there were 5,950 five to 17 year olds who experienced three or more placement moves.<sup>98</sup> Based on Meltzer et al's research, it is estimated that 2,768 of these children (45 per cent) have a diagnosable mental disorder. Of these, it is estimated that 1,499 children (56 per cent) are not receiving therapeutic support from CAMHS.

If a looked after child or young person with emotional or behavioural problems does not receive adequate support then their mental health may deteriorate further, which may put the stability of their placement at risk. As we have seen in the example of Paul's case study and Ward et al's previous research,<sup>99</sup> this will lead to some children needing increasingly specialist placements.

Loughborough University has used these assumptions to estimate the costs of three different hypothetical care journeys of children experiencing three or more placements in a year. In all three journeys, the year has been divided into three equal placements. These are presented in table 5. The scenarios for 'Journey 2' and 'Journey 3' involve progressively more expensive placements.

Assuming that the distribution of local authority foster care, agency and residential care placements in this example reflects the wider care population, this equates to 875, 418 and 206 children who experience journeys 1, 2 and 3 respectively (and are likely to have a mental disorder and are not receiving therapeutic support).

Research shows that 25 per cent of CAMHS cases last for more than 12 months, 17 per cent last between six and 12 months, 19 per cent for three to six months, 21 per cent for one to three months, and 19 per cent for less than one month.<sup>100</sup> On this basis, Loughborough University's estimations assume that 25 per cent of looked after children experiencing multiple placements, who were not already receiving support, would require the high needs support package and 75 per cent would require the medium need package of support (as previously set out in table 4).

Table 5: Three example placement journeys for children in England requiring mental health support who experience three or more placements in a year

Placement journey	Estimated number of children	Annual cost of journey per child (£)	Annual cost per child in stable placement (£)	Total difference between stable and unstable costs (£)
<i>Journey 1</i> : 3 x local authority foster care placements	875	48,061	46,509	1,358,478
<i>Journey 2</i> : 1 x local authority foster care placement, 2 x agency foster care placements	418	59,748	46,509	5,534,740
<i>Journey 3</i> : 2 x agency foster care placements, 1 x residential care	206	89,989	64,039	5,349,208
<b>Total</b>	<b>1,499</b>	-	-	<b>12,242,426</b>

95 Department for Education (2014)  
 96 Meltzer et al (2003a), p20  
 97 Meltzer et al (2003a), p67  
 98 Department for Education (2013)  
 99 Ward et al (2008)  
 100 Curtis (ed) (2014), Schema 12.7

Research indicates that looked after children are likely to have higher levels of mental health need than the general population of children and young people.<sup>101</sup> Therefore, the use of a medium support package of six months, and a high support package of 12 months' mental health services (as shown in table 4) is likely to provide a conservative estimate of the cost of mental health support for an individual child. Furthermore, Loughborough University estimations assume that children experiencing three or more placements have a *maximum* of three placements when, inevitably, some children will have experienced more placement moves than this in one year. Therefore, the annual cost of placement breakdown in this estimation is likely to be an underestimate.

Based on this data for children in England who have three or more placements in a year, who are likely to have a mental disorder and are not receiving therapeutic services (1,499 children), an estimated **additional £12.2 million** is being spent nationally on placement moves and maintaining these children in their subsequent placements. By comparison, the cost of providing packages of therapeutic support to these children and their carers is estimated to be **£5.8 million**. Therefore, the potential national cost avoided by providing therapeutic support to these children could equal **£6.4 million each year**, if children with unmet mental health needs had these met and as a result stayed in a stable placement.

### Breaking even

This work demonstrates that placement instability potentially has a higher cost than providing therapeutic support to enable a child to remain stable in their placement. The provision of support to children who have a diagnosable mental disorder therefore becomes cost neutral if it results in a reduction in the number of placement changes that are experienced by these children.

To estimate the point at which the cost of additional therapeutic support breaks even with the cost avoided by reducing placement instability, we need to know the proportion of children who would have to remain in their first placement to balance these costs.<sup>102</sup> Loughborough University

estimated that 48 per cent of the children who experience three or more placements, and have an untreated mental disorder, would need to remain in a stable placement to balance with the cost of their treatment. This equates to a total of only 12 per cent of the total population of looked after 5–17-year-olds who experience three or more placements in a year.

These estimations show that it takes a relatively small number of children to benefit from support and not experience placement breakdown for the cost of mental health services to be a cost-neutral investment. Furthermore, the current estimations are limited to the small proportion of children who experience multiple placement moves; more costs might be avoided by proportionate investment in supporting stability more widely.

As figure 16 at the outset of this chapter shows, current patterns of spending are not fixed and alternative decisions can be made about the allocation of resources. These cost estimations suggest that providing improved support for looked after children's emotional health and wellbeing could avoid costs overall. Local authorities should analyse their own budgets and explore the extent to which they can rebalance their spending to support a more proactive and preventative approach to supporting looked after children's emotional wellbeing.

### Conclusion

The analysis presented in this chapter shows that one child's unstable and unsupported experience of care cost £22,415 *more* per year (including health, social care and criminal justice costs) than another child's stable and well-supported care. Cost estimations of three unstable care journey scenarios also showed that the provision of improved therapeutic support for looked after children who currently experience unstable care could be cost-neutral if it led to approximately half of the children who received this support remaining in a stable placement. These examples should lead health and social care commissioners to consider how they can make more cost-effective local spending decisions that support improved placement stability.

101 McDermid et al (forthcoming)

102 These would be children currently experiencing three or more placements in a year, with a diagnosable mental health disorder and estimated not to be receiving mental health support.

# Chapter 5: Reshaping systems around looked after children's emotional needs

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*What would a care system that prioritises children's emotional wellbeing look like?*

To answer this question, and respond to the challenges identified in this report, the NSPCC held a series of system design workshops in partnership with four local authorities in the UK. At these workshops, professionals from mental health, social care and education examined how the care system could be redesigned to better promote the mental health and emotional wellbeing of looked after children.

This chapter sets out the conclusions of that work, along with recommendations drawn from the fieldwork, participatory workshops, research literature and policy analysis. Recommendations are organised into the principles of a care system that promotes good mental health as identified in Chapter 3.

The recommendations set out in this chapter are aimed primarily at local authority and health service commissioners and practitioners. It also contains recommendations for central government policy makers, which aim to strengthen the policy and legislative framework to ensure that support for the mental health of children in care is improved. The recommendations are based on analysis of work that has predominantly taken place in England and Wales. However, the principles that they describe are more widely applicable, and should also be considered by policymakers and practitioners in Scotland and Northern Ireland.

Case studies are included throughout the chapter to provide inspiration. While their inclusion is not necessarily an endorsement of effectiveness, each provides a clear example of innovative work taking place to support the emotional wellbeing of looked after children.

## **Embed an emphasis on emotional wellbeing throughout the system**

The aim of improving looked after children's emotional wellbeing should be viewed as a driving ambition for those in national and local leadership roles, and all professionals working with looked after children. This has the potential to drive changes in culture, practice and service provision throughout the system. As Chapter 2 shows, all four nations of the UK have made some progress in identifying the emotional wellbeing of looked after children as a priority of national policy. However, more needs to be done to embed this emphasis on children's emotional wellbeing at a local level.

## **Make looked after children's emotional wellbeing a strategic priority**

The NSPCC's analysis of published strategies for all local authorities in England (including their Joint Strategic Needs Assessments, Health and Wellbeing Strategies, Children and Young People's Plans and other published strategies) has found that three quarters of local authorities (76 per cent) have explicitly identified looked after children's mental health as an issue to be addressed. A quarter of local authorities (24% make very limited mention of looked after children's mental health or no mention at all. It is notable from this analysis that only a minority of areas use data gathered from looked after children's Strengths and Difficulties Questionnaires to inform their analysis of need. This indicates a lack of strategic planning in some areas to ensure looked after children's mental health needs are being met.

Local authority and health commissioners should ensure that looked after children's emotional wellbeing is clearly identified as a strategic priority for their area. Actions should include:

- Ensuring that robust data on looked after children's mental health is gathered and analysed at an individual and population level to inform strategic planning.
- Ensuring that Joint Strategic Needs Assessments (or equivalent planning documents) accurately reflect looked after children's mental health needs.
- Developing a local strategy about how the emotional wellbeing of looked after children will be assessed, monitored and supported, and ensuring that a spectrum of evidence-based services are commissioned to respond to looked after children's mental health needs.
- In England, local areas' Transformation Plans for Children and Young People's Mental Health and Wellbeing<sup>103</sup> – which are to be drawn up by Clinical Commissioning Groups in partnership with local authorities – should demonstrate how local services will support the emotional wellbeing and mental health of looked after children.

Figure 20 sets the information that commissioners should consider in planning their services to support the emotional wellbeing of looked after children.

### **Make looked after children's emotional wellbeing a key outcome measure for services**

Effective care systems should be able to measure their success in achieving good emotional wellbeing for looked after children. This should be a key outcome measure for children's social care and local authorities should track how looked after children's emotional wellbeing changes over time.

To support local authorities with this task, central Governments should improve their guidance on the collection and analysis of outcome data. Local areas should use robust outcome measures to track looked after children's wellbeing at an individual and population level, and should analyse changes in wellbeing over time. This will require a more sophisticated use of outcome data by local authorities and central Government than is currently the case in England. Screening tools like the SDQ should be complemented by subjective measures of wellbeing or resilience, to enable young people to give their own opinion on how they feel and the progress they are making toward their goals.

Mental health and wellbeing outcome measures are not yet used on a routine basis in the Welsh care system. Therefore, the Welsh Government should establish a requirement for local authorities to gather robust outcome measures to monitor the emotional wellbeing and mental health of looked after children. Changes in looked after children's wellbeing should then feature as a key outcome measure in the annual reports anticipated in the *Regulation and Inspection of Social Care (Wales) Bill*.

All agencies, including health, social care and education, should seek to use consistent measures of young people's wellbeing so that they are working toward shared outcomes. Analysis of changes in looked after children's wellbeing over time can then show whether services are working effectively in partnership to improve children and young people's wellbeing.

The NSPCC has taken this approach to the evaluation of its 'Face to Face' service, which measures changes in young people's wellbeing over time using a tool called the Outcome Rating Scale (ORS). The ORS, which is also used for outcome monitoring in Children and Young People's Improving Access to Psychological Therapies<sup>104</sup>, is designed to capture young people's own perspectives on their wellbeing in a robust and quantifiable way – see case study 1 on page 72.

103 Department of Health and NHS England (2015), p18

104 Child Outcomes Research Consortium 'Child rated measures' [www.corc.uk.net/resources/measures/child/](http://www.corc.uk.net/resources/measures/child/)

Figure 20



## Case study 1: The NSPCC's Face to Face service<sup>105</sup>

The NSPCC's Face to Face service supports children and young people in care or on the edge of care who are aged between 5 and 18 years. The service was designed to respond to research that showed that looked after children would most like to access confidential face-to-face support from someone who would "listen and not judge". They wanted a service that would result in tangible changes but would not feel "too heavy".

The Face to Face service offers children and young people up to eight sessions of support using a solution-focused approach. Young people are able to choose the location of the work and also how frequently they wish their sessions to take place. The young person chooses the focus of the work by identifying their "best hopes" (for example this might be wanting to have more friends at school or to improve their relationship with their foster carer). They then work toward their identified aim, with the support of a trained NSPCC practitioner, who helps them to identify their coping skills and strategies. It is up to the young person to decide when they feel they have made enough progress toward their "best hopes" and are ready to end the work.

Evaluation of the Face to Face service used a measure called the Outcome Rating Scale (ORS)<sup>106</sup>. This is a four-item measure designed to track wellbeing outcomes for children and young people.

It provides clinically validated scores that indicate clinical distress. It assesses four dimensions:

- Individual: personal or symptomatic distress or wellbeing
- Interpersonal: the quality of the person's relationships
- Social: the person's view of satisfaction with work/school and relationships outside of the home
- Overall: a big picture or general sense of wellbeing.

Children and young people took part in the service evaluation by completing the ORS at every session. Young people also completed the ORS three months after they last accessed the service.

The NSPCC's evaluation of Face to Face found that 58 per cent of children and young people had a clinical level of distress when they first accessed the service. However, at their last session only 15 per cent of the same children were still experiencing clinical levels of distress. Over two thirds of children and young people reported that Face to Face had helped a lot in addressing the immediate concern that had been impacting on their emotional wellbeing.

## Build the emotional intelligence of the workforce

The social care and health professionals who participated in this project were very clear that the work of supporting looked after children's emotional wellbeing requires an emotionally intelligent workforce. We need to develop a system in which looked after children's emotional wellbeing, mental health and resilience is not seen as the responsibility of specialist services, but is viewed as

everybody's responsibility. As the recent Vulnerable Groups and Inequalities Task and Finish group in England argued:

*Frontline staff working with vulnerable young people should be trained in mental health, e.g. encouraged to use MindEd, and in basic therapeutic techniques, and encouraged to develop confidence around mental health, so that they are able to prevent excess referrals to specialist mental health services.<sup>107</sup>*

105 Fernandes (2015)

106 There is an equivalent scale for children aged 6–12 years called the Child Outcome Rating Scale (CORS).

107 Children and Young People's Mental Health and Wellbeing Taskforce (2015), p13

All carers and professionals who work with looked after children and young people – including social workers, personal advisors, IROs, health professionals and teachers – should have access to core training to give them the confidence they need to:

- Understand the impact of abuse, neglect and trauma on the behavior and development of looked after children
- Identify and understand signs and symptoms of poor emotional wellbeing in infants, children and young people
- Talk to children and young people about their emotional wellbeing
- Take an individual approach with each child to meet their specific needs
- Share information about looked after children's emotional wellbeing appropriately with other members of the child's professional network (which might include the child's GP, teacher, school nurse, social worker, foster carer or CAMHS worker)
- Identify *what they can do* to help an infant, child or young person have positive emotional wellbeing
- Identify when they may need to access a more specialist service to assess a child's needs or provide specialist support.

Carers and frontline workers throughout the care system should be supported to develop these skills and knowledge. As Chapter 3 shows, young people benefit from relationships with people who acknowledge their distress, express concern about their feelings and ensure that they are listened to. These are all things that carers and professionals at every level of the system can offer. By providing core training that is shared across professional boundaries, local areas can facilitate effective joint working between people who “speak the same language”.

Further recommendations for the content of core training are provided in guidance by NICE

and SCIE.<sup>108</sup> A literature review by the Rees Centre<sup>109</sup> also identified important messages to inform commissioners' thinking about training programmes for their local workforce:

- Training programmes targeted at carers are a promising method for improving looked after children's wellbeing.
- Foster carer training programmes work well when they offer a structured programme of core components, some flexibility to meet individual needs, a multi-disciplinary approach and provide follow-up support once the intervention has ended.
- Local authorities and foster care providers must choose evidence-based training programmes. Not all training programmes are equally effective and some do not demonstrate any positive effect on children's outcomes. Among foster carer training programmes, Fostering Changes currently has the most promising evidence, with indications that it may help prevent escalation in children's needs.<sup>110</sup> Other promising interventions include Attachment and Biobehavioural Catch-up (ABC); Fostering/Nurturing Attachments; and Keeping Foster Parents Trained and Supported (KEEP).<sup>111</sup>
- Team work is essential to support looked after children effectively, and joint training between carers and social workers could facilitate joint working.
- More attention should be given to developing mixed approaches that target both the child and the system around them (for example their carer, social worker and school).

Case study 2 provides an example of an innovative training programme that is aimed at children's social care professionals to enhance their awareness and understanding of care leavers' emotional needs. This project has also identified that looked after children and care leavers are themselves well placed to train carers and social workers in effective communications skills, and they should be given a role in providing this training (see case study 10 on page 91).

108 NICE and SCIE (2013), Recommendation 50: Develop a national core training module, p63

109 Luke et al (2014)

110 Briskman et al (2012)

111 Luke et al (2014)



## Case study 2: Understanding the emotional needs of care leavers: The Tavistock and Portman NHS Foundation Trust

This training was developed by the Tavistock and Portman NHS Trust with the assistance of Sheila Simpson, Team Manager of the Royal Borough of Kensington and Chelsea's Care Leavers service. It is an open access course, which is delivered at the Tavistock Centre in London.

The aims of the course are to enable participants to develop their understanding of the emotional needs of care leavers; through understanding the impact of early experience, adolescence as a developmental stage; and the use of work discussion groups to critically reflect on and improve their professional practice.

The course is taught by a consultant social worker and adult psychotherapist from the Tavistock Clinic; a social worker experienced in delivering local authority care services and multi-disciplinary

staff from the Tavistock Clinic who have expertise in working with care leavers.

The course involves a weekly training session for 12 weeks, assigned reading between sessions and a written assignment.

The course explores the effects of pre-care, in-care and post-care experiences on the emotional and psychological development of care leavers. It covers topics including an overview of good and poor practice with care leavers; attachment theory and its implications for practice; understanding of adolescence as a developmental stage; loss and separation; identity and belonging; managing the emotional impact of working with care leavers; and care leavers' perspectives.

## Closer integration between children's social care and mental health services

Developing a knowledgeable, emotionally intelligent workforce will go some way to promoting the emotional wellbeing of looked after children. However, the experiences described in Chapter 3 also demonstrate how looked after children and their carers can suffer from a lack of joined-up working between children's social care and local mental health services. Children's social care services and mental health services can sometimes seem to be working at cross purposes. Tensions can arise when CAMHS will not accept a child's referral when they are not in a stable placement, but social workers cannot see how the child can find stability without therapeutic support. Well-intentioned requirements put in place by CAMHS that a child must have a permanence plan or must have received life story work before they can access a service can become barriers to children and their carers accessing therapeutic support, leaving fragile placements unsupported.

Social care professionals report that they value access to clinical consultation from mental health workers who can help them think through children's behaviours and emotional needs and consider how these needs can best be met. It is also important that CAMHS clinicians understand the constraints that social workers are working within. Therefore, local services should aim for a degree of integration between children's social care and local mental health services to improve communication and shared expertise. In line with the recommendations of the recent Vulnerable Groups and Inequalities Task and Finish group, mental health services in each area should identify a lead clinician for looked after children who will coordinate support and services for looked after children, and oversee the training and development of the wider children's workforce.

Case study 3 describes a model implemented by Cambridgeshire County Council, which involves employing clinicians within looked after children's social work units. This approach is not the only means of achieving closer service integration; the Oxfordshire Attach Team model described in case study 12 also achieves this in a different way.

### Case study 3: Cambridgeshire County Council's 'Social Work: Working for Families' model

Cambridgeshire established its 'Social Work: Working for Families' model in 2012, setting up 47 Social Work Units across four service functions: Access; Children in Need; Disabled Children; and the Looked After Children service. Within the 10 looked after children units, two units are focused on very young children with a plan for adoption or family reunification, and eight units are for children and young people for whom the permanence plan is to remain in care. The units are supported by an Integrated Access team, part of a multi-agency safeguarding hub (MASH) that manages the 'front door', two traditional teams for disabled children and their families requiring support, and an 18–25 service for care leavers.

The unit structure includes a consultant social worker, two social workers, a unit coordinator and 0.5 full time equivalent of a clinician (for example, clinical psychologist or family therapist), who are largely employed by the NHS but have their role funded by the local authority.

Cambridgeshire County Council report that this model has:

- Improved the identification of young people's mental health needs

- Given foster carers quicker access to clinical consultation
- Provided looked after children's social workers with greater access to clinical expertise and consultation through a joint-working approach
- Given looked after children's social workers greater support from the consultant social worker in their team, who oversees their cases and provides regular supervision
- Freed up social workers' time for direct work as administrative tasks are taken on by the Unit Coordinator
- Enabled professional networks to 'speak the same language'; clinicians in the social work units can communicate effectively with the local CAMHS when referrals need to be made

Cambridgeshire County Council has reported that, as a result of these changes, social workers have more capacity to work with children's birth families, ensuring that their views are heard. As a result, children's birth families are often more willing to cooperate with children's social care and "give children permission to be looked after", which facilitates children finding stability with their carers.

### Summary of Recommendations: Embed an emphasis on emotional wellbeing throughout the system

1. Governments must take action to ensure that the mental health and emotional wellbeing of looked after children is a clear priority for our care systems. They should define clear requirements for local authorities' collection of outcome measures to track children's progress.
2. Local authorities and health services should demonstrate the priority placed on looked after children's emotional wellbeing in their local needs assessments and commissioning strategies.
3. Local authorities should have a clear strategy for developing the workforce's understanding of looked after children's emotional wellbeing, ensuring that looked after children receive high-quality support from all carers, social workers and other professionals.
4. Local authorities and health agencies should develop joint plans to support the emotional wellbeing of looked after children and facilitate greater integration of social care and mental health services. They should appoint a lead clinician to coordinate support for looked after children's mental health and ensure routine access to training and clinical consultation for the children's workforce.

## Take a proactive and preventative approach

Chapter 3 demonstrated how looked after children's emotional and mental health needs are often overlooked for far too long. Support is too often provided during or after a crisis rather than at the earliest possible opportunity. This can have devastating consequences for children and young people. Senior managers in local authorities agree that a care system that prioritises the emotional wellbeing of looked after children needs to take a more proactive and preventative approach to meeting children's emotional needs.

### Assess children's emotional wellbeing and mental health as early as possible

Early assessment is the critical first step toward a proactive and preventative approach to supporting looked after children's wellbeing. Chapters 2 and 3 highlighted how some local authorities do not have processes in place to enable the routine assessment of looked after children's emotional and mental health needs when they enter care. Professionals and carers told us that this lack of early assessment is a missed opportunity:

*Let's not wait till problems occur, let's be proactive.*  
(Foster carer)

*It's alright keeping them safe but actually every child should go through the CAMHS system and be assessed. The social workers should follow through with CAMHS recommendations.*  
(Foster carer)

*Really the anticipation ought to be that there is going to be a need for a mental health response, and so the question becomes what is the best response in this case rather than should there be one at all.* (Designated doctor)

Young people also called for more help to access the support they need:

*Children need to be aware of what services are there to help them – someone who will assess your needs and tell you what's there to meet your needs.* (Care leaver)

Research shows that approximately half of looked after children are likely to have a diagnosable mental disorder and a further quarter may have difficulties approaching this threshold.<sup>112</sup> A child entering care is “more likely than not” to have some form of difficulties that require support.<sup>113</sup> A preventative system should provide all looked after children with a robust assessment of their emotional wellbeing and mental health needs by a suitably qualified mental health professional at entry to care, and subsequently as frequently as this is required. This will require professionals to gather historical information about the child from case files and other services, to provide a rounded picture of the child's development. Tarren-Sweeney has highlighted the importance of such assessments providing a comprehensive understanding of children's “felt experience”, relationships and “systemic and care-related influences” on their life, as opposed to a “narrow” focus on symptoms and disorders.<sup>114</sup>

Each child will respond to early adversity in their own unique way; therefore, individual assessments are needed to understand what support they may require.<sup>115</sup> Research also highlights that “the reliability of assessments depends on who is completing the instrument; in what context; and the skills of the person interpreting them”.<sup>116</sup> Therefore, professionals who complete screening tools on children's behalf, or interpret completed measures, will require training to ensure that they undertake this correctly.

112 Tarren-Sweeney and Vetere (2014)

113 Tarren-Sweeney (2010)

114 Tarren-Sweeney (2010)

115 Luke et al (2014), p20

116 Luke et al (2014), p12

The starting point is to ensure that screening tools and self-report measures of children's wellbeing are used effectively on entry to care (in England, the SDQ already has to be completed for every child aged 4–16 who has been in care for 12 months). Screening tools and self-report measures should be completed in time for a child's first health assessment, and be repeated regularly thereafter to inform their statutory reviews. The Rees Centre considered a variety of assessment tools in their literature review, including the Child Behaviour Checklist (CBCL), Children's Global Assessment Scale (CGAS) and the DAWBA.<sup>117</sup> The authors suggested that assessments should also include a measure that assesses the relationship between the child and their caregiver, rather than just looking at the child's needs in isolation.<sup>118</sup> Children and Young People's IAPT (Improving Access to Psychological Therapies) also has a variety of useful child-rated outcome measures.<sup>119</sup>

However, the use of screening tools alone will be insufficient. The study described in case study 4 found that discussion with the carer and observation of the interaction between the child and the carer enabled more effective identification of the child's therapeutic needs than the application of a screening tool alone.<sup>120</sup> Therefore, specialist assessments should also include discussion with the child and their carer (and, where possible, other significant adults, such as the child's birth family and teachers) to allow them to contribute their views and knowledge to the assessment.

The *Social Services and Wellbeing Act* in Wales has already enshrined the need to assess looked after children's mental health and this will come into force in 2016. The Government in England should also require local authorities to provide a specialist mental health assessment as part of a child's initial health assessment. To support this process, national governments should issue guidance on the content of this assessment process and how it should inform care planning.

The NSPCC Face to Face service (described in case study 1 on page 72) found that young people often value the opportunity to report their own perspective on their wellbeing. Therefore, it could be useful to use a tool like the Outcome Rating Scale (described above) alongside the SDQ and other tools, to ensure that the young person's perspective is included in assessment and monitoring. Case studies 4 and 5 on the following pages describe work by two local authorities to screen looked after children's mental health and improve access to support services.

### Improved placement matching based on children's emotional wellbeing and mental health needs

When the emotional wellbeing and mental health needs of looked after children are better understood, a more robust process of placement matching can take place, informed by an understanding of their individual needs. Professionals working on this project emphasised that placement matching should be undertaken with as much care for children who are to remain in foster care long-term as for those who are to be adopted. Local authorities should have processes in place to ensure that short-term placements do not become long-term placements by default. This may mean that a child has a temporary placement while a suitable long-term placement is being found.

Looked after children and young people described their desire to be more involved in placement matching decisions. One young person suggested:

*Say if you were given a leaflet of all personalities and interests [of the foster carers]. They would know what you enjoy as well. So they give it to social services and they can match your personality. Then you can get one that suits you.*

Placement choice can be constrained by the number of placements available in a given area. However, it must be our ambition to give all young people a choice of the type of placement they would like to have and this should be reflected in local authorities' sufficiency strategies.

117 Luke et al (2014), p12

118 Luke et al (2014), p16

119 [www.corc.uk.net/resources/measures/child/](http://www.corc.uk.net/resources/measures/child/)

120 Hardy and Murphy (2014)

#### Case study 4: Social-emotional screening of children aged 0–4: Carelink, Southwark CAMHS<sup>121</sup>

Between September 2010 and November 2011, the specialist CAMHS for looked after children in Southwark, called Carelink, piloted a social-emotional screening service for children aged 0–4. This pilot service screened the emotional and social development and mental health needs of children aged 0–4 years who entered care in Southwark. Children’s carers would receive a brief intervention if this was needed (there was only the capacity and funding to offer brief work at this time).

The Carelink service was notified of children who entered care aged 0–4 who were waiting for their initial health assessment. The child’s network was informed about the screening service. The child’s initial health assessment was used as a first point of contact with the child, their carer and in some cases their birth family, usually about a month after they entered care. This gave the research worker and CAMHS clinician the opportunity to observe the child in an unfamiliar environment (for example the doctor’s surgery).

Two standardised questionnaires were used that were appropriate to the children’s age: Ages and Stages: Social and Emotional (ASQ-SE); and the Greenspan Social and Emotional Growth Chart. These questionnaires were incorporated into a conversation with carers. These discussions were important as information emerged that carers did not necessarily share through the questionnaires.

After the initial health assessment, the Carelink staff visited the child and their carer in the home, to complete the Parent Caregiver Involvement Scale, which explored the relationship between the child and carer. This provided an opportunity to observe the child and carer’s interaction in the home environment.

The CAMHS clinical specialist then drew on these observations and background information, and wrote a screening summary for the child, which had recommendations for the child’s social and emotional development. This report was shared with the child’s professional network and was produced in time for the child’s Looked After Child review meeting.

Findings from the pilot:

- 55 per cent of children aged over three months scored below the standardised clinical cut-off point in the ASQ-SE screening questionnaire. This finding was considered to be possibly related to the high prevalence of undemanding, passive and withdrawn behaviors in the infants/children. However, 66 per cent of the same group of children were recommended an intervention because further information had emerged through conversation with the carer and observation of the child’s interactions with their carer, which identified further concerns.
- Interventions that were offered focused on the carer-infant/child attachment and giving the carer guidance on how they could build a relationship with that child and meet their developmental needs. Carers’ responses to these interventions were positive (they gave a mean score of 4.6 out of 5).
- In the year prior to this study, concerns were identified about the social-emotional development of children aged 0–4 in only 10 per cent of cases. In the year that screening took place, 67 per cent of the children screened had concerns identified and were thought to need intervention from CAMHS.

121 Hardy and Murphy (2014)

### Case study 5: First Step, Tavistock and Portman NHS Foundation Trust, Haringey

First Step has provided psychological health screening and assessment for all children and young people looked after by Haringey council since 2012. The aims of the service are to embed a focus on emotional wellbeing within the care system, to ensure that all children who are looked after have their psychological and emotional needs considered and responded to, and to facilitate referral to the relevant service when further assessment or treatment is indicated.

First Step is a small multi-disciplinary team of experienced clinicians including clinical psychology, social work, family therapy and child psychotherapy. The team works closely with colleagues in social care, usually the child's social worker and foster carer and the supervising social worker. Rather than relying on referrals, the service screens the psychological health needs of the entire looked-after population.

The Strengths and Difficulties Questionnaire (SDQ) is used as the initial screening tool for all children and young people in care of the London Borough of Haringey. Each year, the SDQ is sent to carers of children and young people who are already in care. For each child who enters care, the SDQ is sent to the carer in the first weeks of placement.

For children who are not being seen by CAMHS, First Step provides an Extended Screening, if the SDQ indicates problems or potential difficulties, or if the social worker is concerned about their psychological wellbeing. This involves:

- Compiling a child-centred chronology from records in the social care database with as much detail as possible about the child's relationships, experiences and development;
- Providing a reflective consultation with the social worker to review the child's experiences and how they may impact on current relationships, vulnerabilities and strengths, and to address care planning issues with a focus on psychological well-being.

- One session with the child or young person, usually together with their carer; either in the clinic or with young people in residential or secure settings; or, for babies and younger children, a nursery or school observation or a foster home visit.

A report including a history, formulation and recommendations is uploaded to the social care database where it can be accessed by other professionals and inform LAC reviews. Referral to CAMHS or another service is made as required.

For children entering care, First Step offer up to six further sessions to support the child, the carer and/or the professional network. This may include providing advice to professionals; working with foster carers to promote sensitive, attuned care; offering a brief direct intervention for the child or young person or convening the professional network to coordinate psychologically informed support around care-planning issues, such as transitions, contact or life story work. The service also provides support for family rehabilitation and training in child development and mental health for social workers and contact supervisors.

First Step screens the psychological health needs of more than 500 children and young people each year and provides recommendations for care planning and promoting psychological health. Clear communication routes and co-working have been established with social care colleagues and the children in care health team. The consultation service is well used, with over 70 consultations each year. Feedback from service evaluations indicates that the screening process and reports, consultations and trainings are highly valued by our social work and foster care colleagues. An impact study is being carried out to evaluate the service in more detail.

Young people may also have views about how they want their new placement to start, including the number of times they would like to meet their new carer before a transition takes place. A system that prioritises the emotional wellbeing of looked after children should seek to understand and honour these wishes, to help children's placements start as positively as possible.

### Improve access to support for looked after children and their carers

As case holders, social workers must ensure that difficulties identified through looked after children's mental health assessments are acted upon, through providing access to appropriate support. It is the responsibility of commissioners and senior managers to shape a system that makes this task as straightforward as possible.

Chapters 3 and 4 show that barriers to accessing additional support for children and their carers can occur at any stage, including:

- Failure to identify children in need of specialist support.
- Failure to make appropriate referrals (for example due to workload pressures or an expectation that the referral will not be accepted).
- Inappropriately restrictive eligibility criteria for services, resulting in referrals being turned down, long waiting times for services, and a lack of services for children with lower-level needs.
- Long delays for young people who are placed out of area while health services negotiate the cost of their mental health assessment and treatment.

To tackle these barriers, children's initial health assessments should lead to the development of a support plan detailing any further assessments or interventions the child or their carer may need. Independent reviewing officers should keep track of actions in the plan to ensure that they are carried out and should review progress regularly.

Looked after children, and their carers, should have access to early help to ensure that children's emotional wellbeing is well supported in their placements from the outset. This early help is

critical to prevent children's needs from escalating, which all too often leads to placement breakdown, crisis interventions and children becoming 'hard to place'.

There is an urgent need to ensure that spending is balanced toward early intervention rather than crisis intervention, placement changes and the use of high cost placements as a 'last resort'. The cost analysis presented in Chapter 4 suggests that early support for looked after children and their carers is likely to be more cost-effective, as well as preventing the distress caused to children by placement breakdown.

Therefore, it is critical that local commissioners provide a spectrum of integrated services and support that meet the needs of looked after children and young people in their area. The English Government's recent *Future in Mind* report called for "A step change in how care is delivered, moving away from a system defined in terms of the services organisations provide (the 'tiered' model) towards one built around the needs of children, young people and their families".<sup>122</sup>

An early intervention approach to promoting the emotional wellbeing of looked after children will require effective joint commissioning arrangements between health, social care and education to design integrated services for looked after children, their carers and birth families. These services should offer the following forms of support:

- Robust early assessment of children's emotional wellbeing, mental health and development, and carers' support needs by a qualified mental health professional.
- Provision of evidence-based training programmes for carers, social workers, teachers and other professionals to help them understand and meet children's emotional and mental health needs.
- Expert advice for carers, social workers, teachers and other professionals from a mental health professional who can discuss a child's behaviours and presenting needs, and can recommend appropriate actions and strategies.

122 Department of Health and NHS England (2015), p16

- A range of accessible and evidence-based therapeutic services for looked after children and care leavers. This should include non-clinical services to promote wellbeing and resilience<sup>123</sup> for looked after children as well as specialist therapeutic services.
- Expert advice for professionals and carers seeking to undertake life story work with a child or young person.

Central governments must consider how these critical services will be resourced. In England, Ofsted and the Care Quality Commission (CQC) should inspect on local arrangements for early help for looked after children to ensure that children's needs are identified and they are receiving appropriate support for their wellbeing and mental health as soon as possible. In Wales this role should be carried out by the Care and Social Services Inspectorate Wales (CSSIW).

Local authorities should put in place mechanisms to gather and act upon information about service failures. For example, if referrals to local services are inappropriately turned down, these should be logged with senior managers who can challenge these decisions. If therapeutic services simply do not exist, information should be shared with senior strategic leaders to shape the future commissioning of services. As Chapter 4 shows, failure to provide prompt access to support services has a detrimental impact on looked after children and can lead to significantly higher costs.

Delays in accessing therapeutic support for young people in out-of-area placements are causing challenges nationally. This issue requires central government action to ensure that these young people have prompt access to mental health services. The new statutory guidance in England on promoting health and wellbeing for looked after children is clear that delays in young people accessing a service are not acceptable.<sup>124</sup> At a local level, health agencies can help to reduce delay by providing more proactive and assertive case management. However, the problem remains. To

address delays in access to mental health support for looked after children who are placed out of area, central governments should investigate setting national tariffs for the assessment of looked after children's mental health by CAMHS (following the model of national tariffs for health assessments for looked after children living out-of-area, which are now in place in England<sup>125</sup>). They should also increase the accountability of local providers by requiring that they make a decision within four weeks about the therapeutic services they can offer.

Figure 21 summarises the process of assessment and care planning that should take place when a child enters care, to ensure that their emotional and mental health needs are identified and supported.

### Support children and young people to develop a coherent understanding of their identity

The four local authorities who partnered on this project identified increased access to life story work as a key priority for improving support to looked after children. Carers and social workers view life story work as a valuable way of helping young people to develop a coherent sense of their identity, past experiences and family relationships. Research finds that while there is currently a lack of robust evidence about the impact of life story work on looked after young people's wellbeing outcomes, "life story work is viewed positively by young people and carers".<sup>126</sup> Guidance published by NICE and SCIE states that "Life story work, as an ongoing activity, can help children and young people understand their life history and life outside of care".<sup>127</sup>

There should be clear leadership within local authorities that all looked after children should be supported to complete life story work from their earliest point in care. Opportunities for life story work should be available throughout the child's care journey and during their transition to independence. Those tasked with completing life story work must understand that this can be a

123 See the resilience frameworks developed by Professor Angie Hart and colleagues – [www.boingboing.org.uk/](http://www.boingboing.org.uk/)

124 Department for Education and Department of Health (2015)

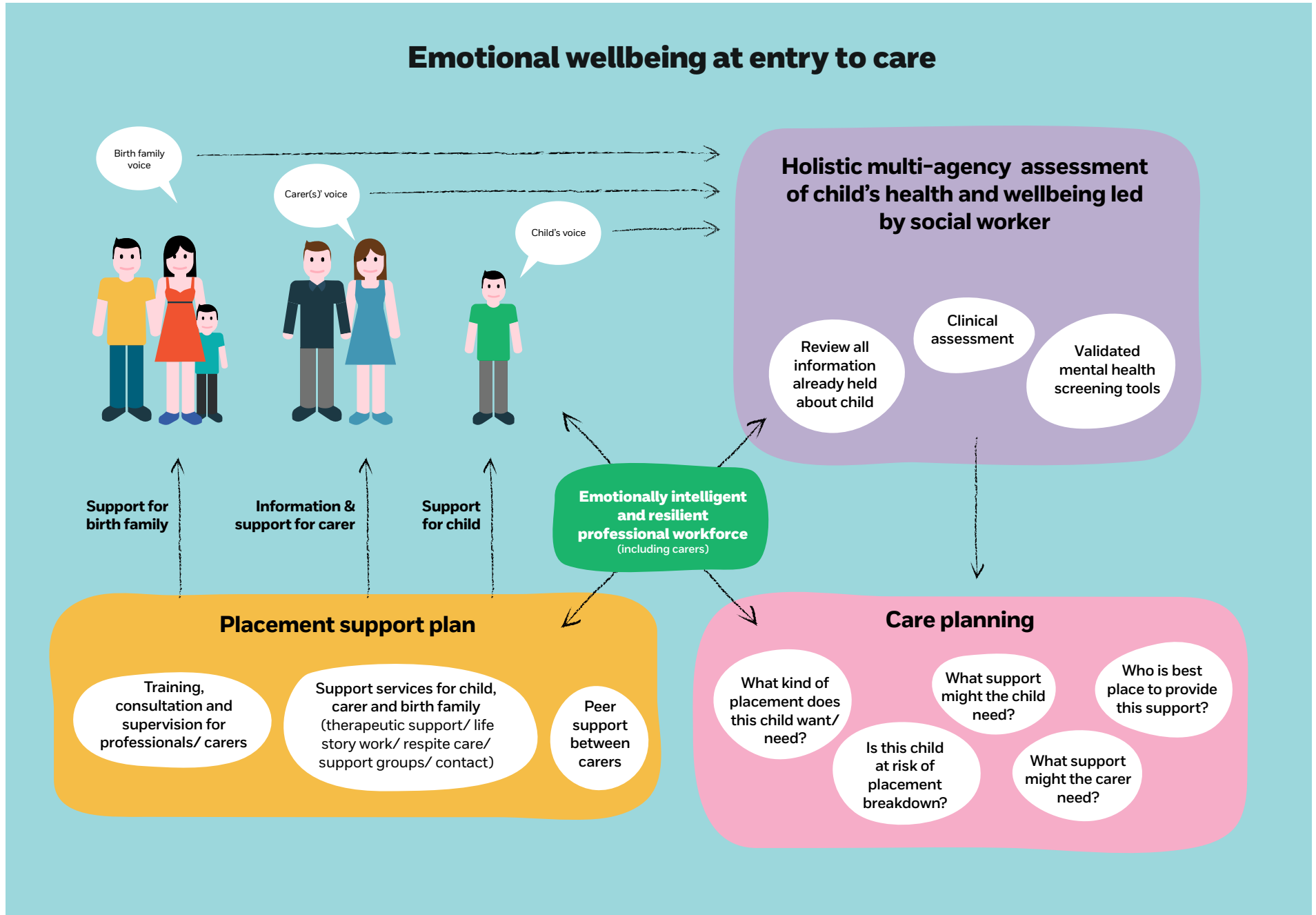
125 Monitor and NHS England (2013)

126 Luke et al (2014), p96

127 NICE and SCIE (2013), p40–41



Figure 21



complex undertaking that requires clear information about the child's past, good communication skills, sensitivity to the child's needs and, above all, willing engagement from the child or young person. Life story work is much more than collecting information about a child's life; it requires a process of active engagement with the child to help them formulate and tell their own story.<sup>128</sup>

Care planning should involve identifying who is best in the child's network to undertake life story work with them: their social worker, carer or another professional. It may be wise to encourage carers to lead on life story work as they will know the child best and will have the most opportunity to undertake this work. However, carers will need to be supported by the child's social worker to access key information about the child's past.

Independent Reviewing Officers should be tasked with holding the responsible person to account for making sure that life story work is undertaken within

an appropriate timeframe. Local authorities should identify 'champions' for life story work – experienced practitioners who can advise those who are about to undertake life story work with a child. Advice may include creative approaches that they can use to help engage the child; how best to relay difficult messages and/or how to involve other people in the work to help reinforce messages. Case study 6 describes a service provided by the Therapeutic Social Work Team in Leeds to support carers and other professionals to provide children with a sensitive and engaging experience of life story work.

### Monitor looked after children's emotional wellbeing effectively

Earlier in this chapter, we highlighted the important role of initial screening and assessment to ensure that looked after children's emotional and mental health needs are identified at an early stage. A truly preventative system will ensure early intervention throughout a child or young person's time in

#### Case study 6: Life Story Clinic, Therapeutic Social Work Team, Leeds

The Life Story Clinic is offered by the Therapeutic Social Work Team in Leeds. This team is staffed by 12 therapeutic social workers, two psychologists, 1.5 managers and 1.5 admin workers. The team works with looked after children, children subject to child protection plans, adopted children and children in kinship care placements. Its work is jointly funded by Leeds City Council and CAMHS.

The therapeutic social work team offers a life story clinic for social workers:

*"We appreciate that life story work can often feel a very big piece of work for the social worker and the child/young person. With our life story clinic we aim to help you think about and plan sensitive life story work in a way that is manageable for both you and the child or young person."*

The clinic was established because social workers in Leeds were referring young people for therapeutic work who were confused about their beginnings and did not have a clear understanding of their identity. Social workers were not always confident about how to approach life story work. The team offers a two-day life story work training

course for social workers. They also offer a monthly service for workers who are already involved in life story work. In a small minority of cases, the service will carry out direct life story work with children but only when the child's social worker is unable to or if it is an exceptionally complex case.

Questions the life story clinic might help a social worker to consider include:

- When is the right time for a child to do life story work?
- How might you get started and who needs to be involved?
- What is the best way to engage this child and tell their story in a way that they can understand?
- How are you going to share difficult information with the child?

For younger looked after children, life story work might include metaphorical storytelling to help them understand why they cannot live with their parents.

care, not just at entry to care. Therefore, effective monitoring of looked after children's emotional wellbeing is also an essential part of the process. As Chapter 3 shows, this is particularly important for young people who are placed out of area.

Local authorities should ensure that looked after children and their carers complete the same assessment measures at regular intervals, for example, to coincide with social work visits and/or statutory looked after child reviews. The same measures should be used consistently across agencies and used to inform relevant plans, such as children's Personal Education Plans. Providers of externally commissioned placements should

also be required to use these measures, to improve monitoring of the outcomes of young people being cared for in independent placements.

By encouraging children and carers to complete these tools on a regular basis, children's emotional wellbeing can be monitored more effectively and appropriate supportive interventions identified as and when they are needed.<sup>129</sup> Case studies 7 and 8 describe two innovative approaches to the ongoing monitoring of looked after children's emotional and mental needs.

### **Case study 7: The CloseUp Programme, University of Cambridge, Department of Psychiatry/NIHR CLAHRC<sup>130</sup> East of England**

The programme has been developed over 18 months with foster carers, young people and clinicians. The next step is to run a pilot/evaluation study. CloseUp includes a mental health training course for foster carers to help them identify and record possible signs of mental health difficulties. In a new recording tool, the Wellbeing Profile (Well-P), carers (and young people in self-report versions) record specific signs and symptoms of mental health. Completed Well-Ps are then reviewed by a mental health professional who will be able to make appropriate referrals if the Well-P suggests a possible clinical need.

The main aim is to facilitate early identification of potential mental health difficulties to access appropriate support services so that problems do not escalate. Carers and young people will provide clinical professionals with relevant, well-informed, well-recorded mental state information so that they can signpost further assessments or interventions. Early access to support should have positive effects on young people's long-term emotional health and life chances.

This three-day training course for foster carers includes:

- Overview of mental health problems common in young people (for example depression or ADHD).

- How to identify and record the core signs and symptoms covered in the Well-P (for example sleeping problems, restlessness, irritability, eating problems).
- Active listening and talking skills for broaching sensitive subject.

#### The Wellbeing Profile

- This covers six core items that occur across a range of mental health problems. Taken together, over time, they are likely to indicate potential clinical need.
- Over two weeks, carers record their observations of these core signs while young people complete self-reports (app.in development)
- Completed Well-Ps are reviewed by a clinical professional at the placement review meeting one month after the start of the placement or at routine health assessments.

This project is at a formative stage. The project lead is considering a range of applications for the Well-P to improve identification of looked after children's mental health needs.

129 Luke et al (2014), p15

130 Collaborations for Leadership in Applied Health Research and Care

## Case study 8: Assessment and monitoring using the Q Pack: St Christopher's Fellowship and Action for Children

In 2012, St Christopher's Fellowship developed a partnership with the Lifespan Research Group and Kingston University, to develop the Q Pack; a suite of assessment tools including:

- The Strengths and Difficulties Questionnaire (SDQ), which measures symptoms of distress
- A Vulnerable Attachment Style Questionnaire (VASQ), which measures young people's insecure attachment styles
- A Life Events Questionnaire (Child/Adolescent version), which identifies significant life events

Young people complete the Q Pack when they are admitted to a St Christopher's children's home. It is also completed separately by carers (and in some cases a teacher). The Q Pack is then completed every three–six months to coincide with looked after children reviews, in order to allow for monitoring.

Benefits of using the Q Pack identified by St Christopher's include:

- Staff are able to understand children's vulnerabilities and support needs from the outset
- It helps them identify when they need to make a referral to CAMHS
- There is a baseline so that staff can assess and monitor the effectiveness of their services
- Commissioners can collate outcome measures to assist their monitoring of the quality of care provided by St Christopher's.

More recently, Action for Children have started to pilot using the Q Pack in their fostering services, to enable greater tailoring of support and interventions. They are using the Q Pack to complement their attachment-focused training and support for carers. They will publish their evaluation findings in 2015.

## Summary of Recommendations: Take a proactive and preventative approach

5. To enable access to the right support at the earliest opportunity, the Government in England should introduce the right for all looked after children to have a specialist assessment of their emotional, mental health and other developmental needs by a qualified mental health professional. Their needs should be identified on entry to care and monitored throughout their time in care. The Government in Wales should issue equivalent guidance on the content of mental health assessments as part of the code of practice on part six of the Social Services and Wellbeing (Wales) Act 2014.
6. Looked after children should have the right to the support they need to promote good emotional wellbeing at the earliest opportunity, rather than waiting for a crisis before they can access support. Every looked after child should have a support plan setting out the support that they and their carer will receive, in order to secure good outcomes and keep the placement stable.
7. Social care, health and education should work together to jointly commission a spectrum of integrated services to support looked after children's emotional and mental health needs and build their resilience.
8. Looked after children should be supported to develop their sense of identity. Local authorities should ensure that children are supported to carry out life story work from an early point in their care journey.
9. To end delays in access to mental health support for looked after children who are placed out of area, central governments should set national tariffs for looked after children's mental health assessment and increase the accountability of local providers by requiring that they make a decision within four weeks about the therapeutic services they can offer.

## Give children and young people voice and influence

Children and young people in care and care leavers consistently report that good emotional wellbeing and *feeling listened to* are one and the same thing. Looked after children coming into care can often feel a sense of powerlessness. This can be alleviated by support from empathetic and caring adults who make children feel *respected and heard*. This was such a powerful message that one of the local authorities participating in this project made “understanding what feeling listened to should mean in practice” a priority theme for their future work.

### Enabling children to express their wishes

Every child and young person in care has their own individual idea of what contributes to their emotional wellbeing and what kinds of support will best help them achieve emotional wellbeing. Social workers and carers should support children to describe what is important to their wellbeing and how carers and professionals can help. Doing so can empower children and young people to feel more “in charge” of their own wellbeing and resilience.

Children and professionals also emphasise the importance of giving looked after children a voice in decision-making about their care. In one area, participants in an NSPCC workshop suggested that local authorities should develop a set of resources to help capture the child’s voice at different stages of the process. This might include:

- A workbook for the child to complete about what they want while they are in care
- A toolbox to help practitioners find creative ways for children to express their wishes
- A tablet for children to give feedback about their experiences and their placement

It is important that everyone in that child’s professional network recognises that ‘small things matter’. For example, a child’s stuffed rabbit may be

comforting to the child because it smells like home; therefore, the foster carer should not wash it without the child’s permission. Every carer and social worker should act as an advocate for looked after children, to help them to make their voices heard.

However, as the NSPCC’s fieldwork has demonstrated, these relationships do not always work and children can be let down by professionals who they feel do not listen to their wishes or cries for help. One of the care leavers interviewed by the NSPCC talked about the importance of “Instilling confidence in young people to challenge decisions”. For some young people, advocacy services were an important means of gaining this confidence and it is important that every looked child is informed about advocacy services on a regular basis, receiving a clear explanation of what advocacy services are for and how they can help.

In Wales, the Government has already enshrined an expectation in the *Social Services and Well-being Act 2014* that looked after children will be involved in defining their own wellbeing outcomes. Other administrations should follow this example of involving children and young people in defining the outcomes that they wish to achieve while they are in care, and monitoring progress against the child’s chosen outcomes. This is also the approach taken by the NSPCC with the Face to Face service (see case study 1), and it is also an important feature of Children and Young People’s IAPT, which uses a variety of goal-based outcomes.<sup>131</sup>

### Regular opportunities to feed back on the quality of care and support

Some young people have very negative experiences of care. At its worst this can include experiences of abuse or neglect in care.<sup>132</sup> Young people told the NSPCC that it is critical that they should have effective mechanisms to feed back on the quality of their care and make complaints. One young person recommended that local authorities should “Take a survey on how the person feels with the foster carer very often”. Another suggested:

131 [www.corc.uk.net/measurestable.html](http://www.corc.uk.net/measurestable.html)

132 Biehal et al (2014)

*Social services should be accountable to young people. They should be able to give feedback, to highlight the good ones and to pinpoint the bad ones who are not going the extra mile.*

Some young people do not feel that their social worker is the right person to express their concerns to; they want alternative mechanisms for making their voices heard. It is, therefore, important that looked after children are given clear mechanisms for feeding back on the quality of their care and support, and shaping local services.

To show that looked after children's voices are valued and respected, local authorities should ensure that looked after children receive clear information at the outset of their time in care and at regular intervals after this point about:

- How they can give feedback – both positive and negative – about their carers, which will be listened to and, where necessary, acted on
- How they can escalate issues that are not addressed within a reasonable timeframe
- How they can access advocacy
- How they can participate in shaping local services

Looked after children and young people should also have the opportunity to contribute to their carers' annual reviews. The new quality rating system proposed for the inspection of regulated services under the *Regulation and Inspection of Social Care (Wales) Bill 2015* should give looked after children an opportunity to feed into the inspection process.

### **Co-design accessible services to support looked after children's resilience and emotional wellbeing**

Chapter 3 shows that children's mental health services have been slow to respond to messages from children and young people about what they want from a service. While young people want informality and flexibility from services and the opportunity to build trusting relationships with therapeutic staff, what they are offered is often an overly formal office-based service. This can mean

that children experience CAMHS as daunting and inaccessible, reducing their willingness to engage. Looked after children and young people's refusal to engage with CAMHS is too often viewed as a failure of the child rather than as a failure of the service.

Young people argue that mental health services should be delivered in a different way to make them more accessible. In particular, they told the NSPCC that they wanted therapeutic services to be more flexible and light-hearted:

*You need to mask counselling in a way. You need to make the environment fun [...]. It should be informal; you can talk about football.*

*It's about how you address the child's problem. You need to find out their interests, what they like doing.*

*CAMHS should make that effort to go out and do home visits.*

Young people also said that they wanted the opportunity to develop relationships with staff before therapeutic work begins (this finding is supported by recent consultation work by Young Minds<sup>133</sup>). They also spoke of wanting to be given the knowledge and skills to manage their own mental health better and to support other young people through peer support:

*It's about creating awareness of emotional wellbeing among young people.*

*It's about how you train young people in care. They will open up to another young person in a way they won't with a carer.*

Foster carers also wanted more flexible services that were more responsive to their needs:

*CAMHS come out of the office and come and speak to the child in the home or at school. [...] Then they'd get a better picture and understanding of that child. They are professionals so they should be able to see with their trained eye what we can't see, and advise us better.*

A review of CQC inspection reports carried out for NSPCC identified examples of 'child centred and innovative practice' by local health services:

*[Some areas] Had put in place creative strategies to engage young people who were reluctant to ask for help or have their health needs routinely screened. One CAMHS service organised regular joint football sessions with young people using its services. This approach was very effective in building trust and cementing what can often be a very difficult and exposing relationship for some young people who have been emotionally damaged or lack confidence and self-esteem. A therapeutic yoga group and a film and photography project had been set up in another area to promote the engagement of older looked after young people.*<sup>134</sup>

These examples of creativity and responsiveness in children's mental health services need to become the norm rather than the exception. Children's mental health services will only become more accessible once they are designed with young people's needs and wishes in mind. To ensure this, local commissioners should involve looked after children and their carers in the design of services at every stage of the process, so that children are offered a spectrum of support that meets their needs. The spectrum of services, as well as informal relationships, that promote looked after children's resilience, emotional wellbeing and stable placements, is set out in figure 22.

These services should be jointly commissioned by children's social care, health and education, and should be integrated across the tiers so that young people have easy access to services to promote their resilience<sup>135</sup>, as well more intensive therapeutic services where these are needed. Services should use consistent outcome measures, rated by children and young people themselves, to ensure that they can demonstrate how they are helping children. As the recent *Future in Mind* report has argued, "Services need to be outcomes-focused, simple and easy to access, based on best evidence, and built around the needs of children, young people and their families rather than defined in terms of

organisational boundaries".<sup>136</sup> Children's and Young People's IAPT is a good model for this integrated approach to service delivery, with local area CAMHS partnerships made up of the NHS, local authorities and voluntary sector organisations.<sup>137</sup> The literature review carried out by the Rees Centre to inform this project provides information about the existing evidence-base of effective therapeutic interventions for looked after children.<sup>138</sup>

Case studies 9 and 10 on pages 90 and 91 describe innovative services that have been designed to improve looked after children's emotional wellbeing, while responding to their individual interests and preferences.

### Valuing looked after children and care leavers as experts

Local authorities across the UK have mechanisms in place to enable young people's participation, such as Children in Care Councils. However, these vary in their structure and effectiveness. Through this project there was lots of discussion about how looked after children and care leavers could be consulted more often and more effectively about service improvement.

One care leaver told the NSPCC that "Once you leave care, instead of them helping you, they just let you leave. They don't make use of you". Looked after children and care leavers want to be valued by their local authorities as experts on the care system. There are lots of suggestions from young people about how they can be more involved in training professionals and carers, to help them to understand looked after children's perspectives and how to communicate with them effectively. Case study 11 on page 92 describes an example of how care leavers, supported by the Who Cares? Trust, have been involved in designing and delivering training for student social workers and newly qualified social workers.

134 Talbot (2013, unpublished)

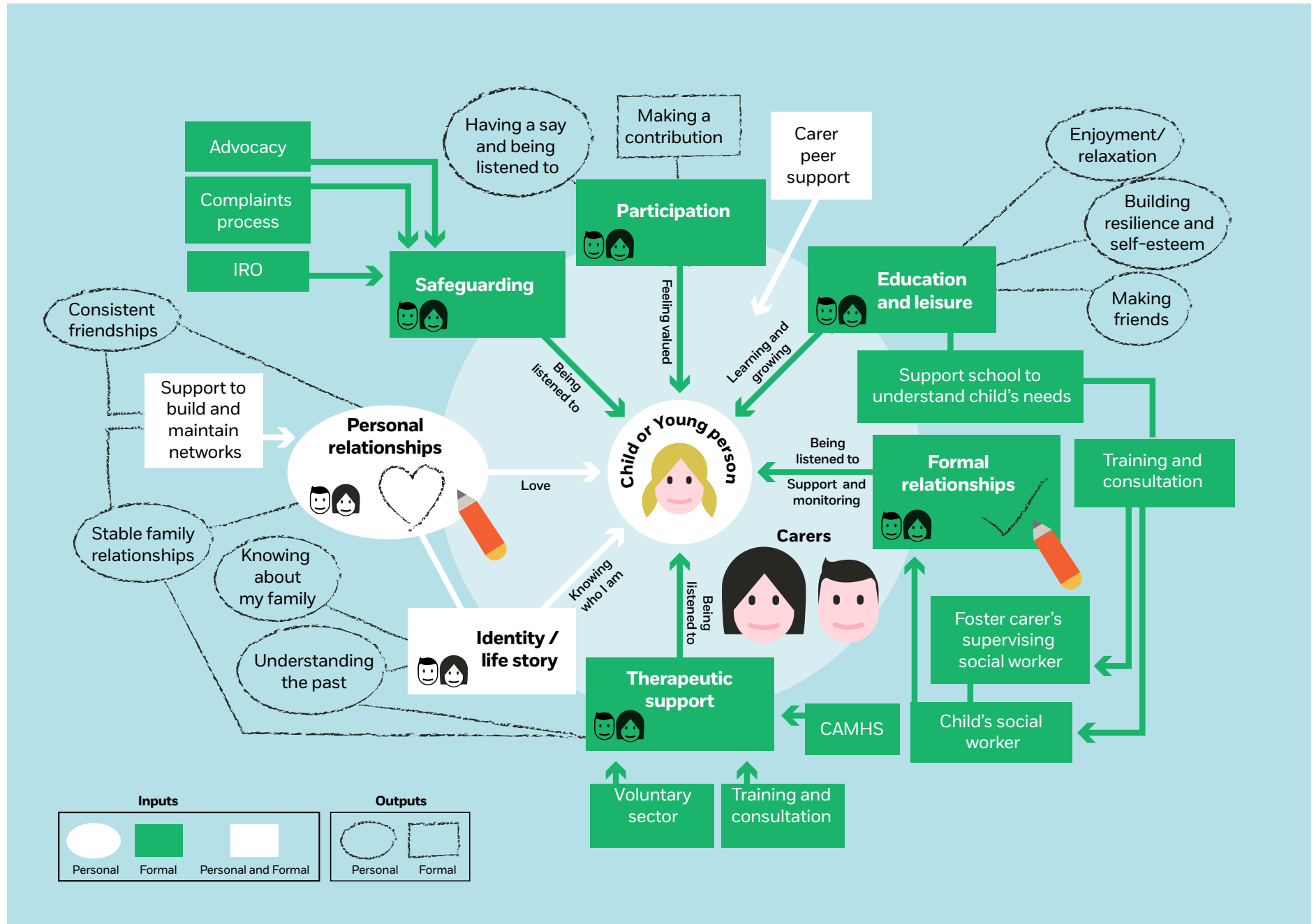
135 See the resilience frameworks developed by Professor Angie Hart and colleagues [www.boingboing.org.uk/index.php/resilience-in-practice/what-is-resilient-therapy](http://www.boingboing.org.uk/index.php/resilience-in-practice/what-is-resilient-therapy)

136 Department of Health and NHS England (2015), p14

137 Children's and Young People's IAPT [www.cypiapt.org](http://www.cypiapt.org)

138 Luke et al (2014)

Figure 22: Services and informal support for looked after children's emotional wellbeing





## Case study 9: Creative therapies, Coram

Coram developed their creative therapies programme to overcome barriers to young people's participation in therapy. The Head of Creative Therapies explained:

*In the past we have tried to attach adult solutions to young people's issues and it doesn't work. We tend to offer talking therapies but a lot of children are doers, not talkers. They want to express themselves through play or art. We talk about young people being difficult to engage, but it might be that the interventions we are offering aren't culturally relevant.*

Coram provides creative therapies for a variety of children and young people, including young parents aged up to 25; young people with offending behaviour; children excluded from mainstream education, and adopted children and young people. They received funding from the Department for Education to offer creative therapies to children post-adoption in six local authority areas. About 80 per cent of the young parents Coram works with are also care experienced.

Coram now employs a team of creative therapists with qualifications in art and music therapy. They offer 1-1 work, dyadic work with the child and their carer, and group-based work, depending on the child's needs. Some young people prefer group-

based work as it can feel less exposing and they have the security of their peers around them.

Coram's therapy model is psychodynamic and relationship-based. In music therapy, the child uses different types of music to express themselves and the content of sessions is tailored to each child. One child who was very traumatised wanted to scream through a megaphone. By bearing this noise, the therapist can show that the child is not alone and that they can bear the child's feelings. Art therapy helps the child to visualise their feelings and communicate what they may not have words to describe.

The child's outcomes are measured using the Strengths and Difficulties questionnaire at the start and the end of the intervention.

This approach benefits young people as art and music therapy can feel less blaming than traditional therapies. There is no need to use mental health language, which young people can sometimes find stigmatising and alienating. Young people can undertake therapeutic work through arts without necessarily feeling that they are engaging in therapy. During an art project they can experience a therapeutic release from discussion and using their empathy.

With full cost recovery, a session of creative therapy for a child costs approximately £100.

Other examples of participation work include a recent collaboration between Cambridgeshire County Council, the University of Cambridge and looked after young people and care leavers. Researchers worked with young people in care to co-produce a trilogy of short, animated films to portray their experiences of care. The first film My

Name is Joe, describes young people's experiences of being taken into care. Two additional films describe young people's experiences of living in residential care and leaving care. These films are now used in training courses for social workers and carers.<sup>139</sup>

139 My Name is Joe: [www.youtube.com/watch?v=ArBjWe3IWs0](http://www.youtube.com/watch?v=ArBjWe3IWs0)  
Our House: [www.youtube.com/watch?v=fs-RVgsFFcA&feature=youtu.be](http://www.youtube.com/watch?v=fs-RVgsFFcA&feature=youtu.be)  
Finding My Way: [www.youtube.com/watch?v=L1qZggHoFmM](http://www.youtube.com/watch?v=L1qZggHoFmM)

### Case study 10: Carefree, Cornwall<sup>140</sup>

Carefree was set up in 2005 by a youth worker and a group of six young people, two of whom were care leavers and four of whom were still in foster care. The charity now works throughout Cornwall with young people in and leaving care aged between 11 and 25, working with approximately 120 children and young people each year. It seeks to offer young people positive activities that “help them develop their social and emotional skills so that they have a better chance of growing up into positive healthy citizens”. Carefree is part-funded by Cornwall Council but the majority of its funding comes from independent sources.

Carefree has a strong ethos of participation and youth leadership, and works closely with Cornwall Council’s Children in Care Council. Carefree aims to build young people’s social and emotional skills through group work activities and trains young people to become peer mentors. Peer mentors plan, lead and support other young people to access activities. Carefree also employs care experienced mentors to lead work with care leavers, helping them into education, employment and training and offering drop-in support. The

Carefree staff team is currently about 30 per cent care-experienced.

Activities are shaped by the children and young people’s interests. In 2014, Carefree’s group-based activities with looked after young people included:

- Mindfulness and relaxation exercises
- Life story work
- Undertaking an award in ‘Emotional Intelligence’ through drama, role plays, discussions, arts and poetry
- Work on sexting and child sexual exploitation
- A ‘public transport challenge’

Every year, Carefree runs summer programmes for young people aged 11–17 that are led by trained peer mentors and young volunteers (aged 15+). This offers young people a progression route to positions of responsibility for other young people.

Carefree works closely with Cornwall Council. Carefree staff have received training in attachment and trauma and have benefited from group supervision from psychologists employed by Cornwall Council’s Early Help service.

### Case study 11: The Who Cares? Trust: Involving care leavers in training professionals

The Who Cares? Trust aims to improve the lives of children and young people in care. One way they do this is through supporting young people to train professionals who work with children in the care system. The Who Cares? Trust has worked in partnership with Southwark Council and alongside members of their participation group ‘Speaker Box’ to develop training in communication skills for their newly qualified social workers.

They delivered a series of three half-day sessions for social workers, and the young people set the social workers tasks to complete between sessions. In the second session, young people made up a case consultation panel to advise social workers on how they could approach particular challenges they experienced in their work with young people.

There was a strong emphasis on communication skills in all of the sessions. This included role play with young people where the social worker would try to find out information from the young person,

and the young person would then give them feedback about how interested they had seemed in their responses (or whether they had simply bombarded the young person with questions).

Southwark Council’s Practice Development Manager explained that they valued the Who Cares? Trust’s participatory approach to the training as it was engaging and fun for newly qualified social workers. By involving young people, the training sessions are very effective in making social workers think about how they communicate with young people, and making them more sensitive to the demands placed on young people to share personal information and how might this make them feel. Newly qualified social workers have given feedback like “When I’m writing my assessments I’m now going to have that young person’s voice in my head, so I will approach it differently”.

140 <http://www.carefreecornwall.org.uk/>

## Summary of Recommendations: Give children and young people voice and influence

10. Looked after children should be enabled to define what 'good emotional wellbeing' looks like for them. This vision should be the focus of the child's care plan. Local authorities must ensure that children are provided with meaningful mechanisms to feedback on their experiences of care.
11. Local commissioners should ensure that looked after children, care leavers and carers are involved in co-designing their local Children's and Adolescents' Mental Health Services (CAMHS), to develop a service offer that is attractive and accessible to children and young people.
12. Looked after children and care leavers should be viewed as experts on the care system. Local authorities should ensure that they have effective mechanisms for consulting them about service improvement.

## Support and sustain children's relationships

Looked after children and young people are very clear that whether they had a positive or negative experience of care was largely down to their relationships with carers, birth family members, friends and other professionals. In 2013, the report of the Care Inquiry argued that looked after children's relationships are "the golden thread" running through children's experiences of care:

*We need a care system that places at its heart the quality and continuity of relationships, and that promotes and enhances the ability of those who are important to children – care givers and others – to provide the care and support they need.*<sup>141</sup>

The importance of these relationships was also a key finding from the Rees Centre's literature review.<sup>142</sup> The Rees Centre identified that the quality of 'ordinary care' (for example, the child's foster or residential placement) is a 'powerful' influence on looked after children's emotional wellbeing.<sup>143</sup> Similarly, research by Tarren-Sweeney described looked after children's carers as 'the primary therapeutic agent for children in care'.<sup>144</sup> It is, therefore, critically important that local authorities put secure and stable relationships between

children and their carers at the centre of their service design, provision and commissioning.

## Supporting secure and stable placements

Chapters 3 and 4 demonstrate the impact of unstable placements on looked after children. Some of the young people experienced multiple placement breakdowns, which had an extremely detrimental impact on their emotional wellbeing. Conversely, young people also described the life-changing impact of positive placements. Foster carers spoke of the difference a good support package made to their ability to care for a child with challenging behaviours or other complex needs. In addition to the moral case for supporting children to find permanence and secure attachment in their relationships with caregivers, Chapter 4 set out the financial case. This analysis indicates that provision of therapeutic services to support looked after children and their carers and prevent placement breakdown could reduce the overall costs of care.

In England, NICE quality standards for looked after children recommend that they should "live in stable placements that take account of their needs and preferences".<sup>145</sup> NICE guidance also highlights that the need for permanence is a particular concern

141 p8 *The Care Inquiry*, 2013 [www.nuffieldfoundation.org/sites/default/files/files/Care%20Inquiry%20-%20Full%20Report%20April%202013.pdf](http://www.nuffieldfoundation.org/sites/default/files/files/Care%20Inquiry%20-%20Full%20Report%20April%202013.pdf)

142 Luke et al (2014), p112

143 Luke et al (2014), p8

144 Tarren-Sweeney (2010)

145 NICE (2013)

for babies and younger children in care.<sup>146</sup> In Wales, draft guidance issued under part six of the Social Services and Wellbeing (Wales) Act 2014 states that “permanence is a key consideration from the time a child becomes looked after and the care and support plan should set out how this is to be achieved.” Therefore, careful planning by social workers to minimise disruption and promote permanency for children is essential. Additionally, the local authorities participating in this project identified a variety of proposals for how looked after children could be supported to have more secure and stable placements with their caregivers. These include:

- Improving the recruitment of foster carers, so that people with the right skills and capacities are involved in fostering from the outset.
- Giving foster carers more status so that they are recognised and valued as advocates for the child, and are more easily able to directly access services on the child’s behalf.
- Providing foster carers with training and interventions to help them understand children’s needs, and ensuring that they have regular clinical supervision, with access to crisis support from CAMHS or experienced therapeutic social workers where this is needed.
- Providing intensive therapeutic support at *the outset* if a placement is expected to be challenging.
- Improving the routine monitoring of carers’ stress, so that potentially fragile placements can be identified early on and support can be provided, and giving carers access to respite to help them persist with more challenging placements.
- Sharing end-of-placement reviews so that lessons can be learned from placement breakdowns.

We learned from carers that they can struggle to make their voices heard and sometimes they are left

to cope on their own with children who have very challenging behaviours. When poorly supported, this can lead to carers reaching breaking point and placements breaking down. Communication between social workers and foster carers is crucial to ensure that problems that could lead to placement breakdown are identified early and appropriate support is provided.

Local authorities should establish a robust monitoring system to enable foster carers to flag challenges they are experiencing and the impact on their own emotional wellbeing. An example of this approach can be found in the Multidimensional Treatment Foster Care Programme, which involves using a Parent Daily Report system to monitor both the child’s behaviour and carer stress.<sup>147</sup> A less intensive system might involve foster carers reporting their stress levels on a weekly or fortnightly basis using a tool like the Parenting Stress Index.<sup>148</sup> Joint visits between children’s social workers and supervising social workers could also help to facilitate open lines of communication and develop shared problem-solving approaches.

Case study 12 describes a service in Oxfordshire that was set up to help support stable placements.

### Continuous professional relationships

Young people are very vocal about the impact on their emotional wellbeing of having frequent changes in their social worker. This prevents trusting relationships from forming and disrupts supportive relationships that are already established. Foster carers describe how frequent changes of social worker can obstruct them from accessing therapeutic services for their foster children.

All local authorities working on this project identified that looked after children should have consistent, continuous relationships with professionals, particularly their social workers. To support these consistent professional relationships, local authorities will need to both reduce staff turnover where this is a problem, and ensure that the design

146 NICE and SCIE (2013), p36

147 p197 [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/249856/DFE-RR194.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249856/DFE-RR194.pdf)

148 Neece et al (2012)

## Case study 12: ATTACH Team, Oxfordshire County Council

Oxfordshire County Council's ATTACH team sits within the Children Young People and Families directorate. ATTACH works with children and young people in care, in special guardianship order (SGO) placements and those who are adopted. Their work is relational, involving parents and carers to increase understanding of early experiences of abuse and neglect on attachment and thinking about the implications of this for parenting/caring for children and young people.

The ATTACH team includes:

- Three clinical psychologists (two part-time and one full-time)
- 3 part-time senior social work practitioners

Core work of the ATTACH team includes:

- Offering consultation for social workers
- Working with foster carers, adoptive parents and SGO carers.
- Running Fostering Attachments training groups for foster carers and adoptive parents (two times per year)
- Using the Dyadic Developmental Psychotherapy (DDP) approach developed by Dan Hughes. This may involve working just with the carers/parents or may involve working together with the carers/parents and the child to build secure attachments, facilitating communication and emotional connection.

- CBT for teenagers to help them to manage anxiety and resolve trauma
- Siblings together or apart assessments

The ATTACH team also monitors the Strengths and Difficulties Questionnaires (SDQs), which carers complete on an annual basis, coordinated by the looked after children's nurse. Significant scores are sent to the ATTACH team who then contact the child/young person's social worker to discuss further options.

The team requires a social work referral for children in care because they believe it is important that the social worker is aware of issues that require support from the ATTACH team. In the case of adoptive families and those with an SGO, the ATTACH team works closely with Adoption Support Colleagues. There is no time limit on how long the team works with carers and families, with individuals able to return to the ATTACH team if they need further support.

The ATTACH team aims to work closely with social workers to increase their awareness of children's emotional and mental health needs. The team runs regular consultation slots for social workers in all localities. They have also offered an abbreviated Nurturing Attachments training group for social workers.

of their services does not require unnecessary changes in children's social workers. For example, a transition between a looked after children service and a 14+ service might mean changing a child's social worker unnecessarily.

Where there is a need to change a child's key worker, local authorities should ensure that there is sufficient flexibility in the system for this change to be made at the most appropriate time. Changes should not take place at the same time as other significant transitions or changes in their lives, for

example when a child is also changing placement or leaving care to live independently for the first time. Transitions must be made sensitively, with plenty of warning for the child and opportunities to be introduced to their new key worker in advance. Case study 13 describes an innovative new service that has been designed in North Yorkshire to provide looked after children, care leavers and children on the edge of care with more consistent professional relationships as they move through care.

### Case study 13: No Wrong Door service, North Yorkshire County Council

Launched in February 2015, *No Wrong Door* has been developed by North Yorkshire County Council with funding from the Department for Education's Innovation Programme. The Council is committed to mainstreaming the model after the initial pilot.

No Wrong Door aims to provide young people in care or on the edge of care with seamless support from a dedicated and highly trained team as they move into care, return home or leave care to live independently. At the centre of this model is the commitment to give each young person a consistent relationship with their key worker. If the young person leaves care or return home, their key worker will continue to provide outreach support.

No Wrong Door will have two integrated hubs, one in Harrogate and one in Scarborough. Each hub will bring together a variety of accommodation options, including residential placements, supported accommodation, high needs supported accommodation, bespoke placements and family placements with foster carers. The model also brings together a range of services and outreach support under one umbrella to enable a flexible approach driven by the needs of the young person.

Outcomes that the model will seek to achieve include:

- Improving young people's safety and stability
- Reducing young people's vulnerabilities
- Engaging young people in education, training and work readiness
- Improving young people's emotional wellbeing
- Reducing criminal activity
- Raising levels of engagement
- Reducing costs to the system

Each hub will be staffed by a team of residential support workers and transition workers who will work flexibly with young people across a variety of accommodation options. They include the specialist roles of a life coach (a clinical psychologist), a communication support worker (speech therapist), an education employment and training worker and a family circles worker who will focus on rebuilding relationships between young people and their families.<sup>149</sup>

### Supporting birth family relationships

As the children's social network diagrams in Chapter 3 show, most looked after children and care leavers continue to see their families as central to their lives after they enter care. While these family relationships may be problematic, they are often life-long and many children leave care to return to their birth families. For most (although not all) children, contact with their birth families is essential to their emotional wellbeing. Many young people told the NSPCC about the distress caused by failures to support their contact with a parent or sibling.

Professionals working with looked after children recognise the great importance of looked after children's family relationships, both while the child is in care and after they leave care. However, once

children enter care, their birth families can often fall down the list of priorities for overstretched local authority teams. This is particularly the case if a child's permanence plan is to remain in care.

The right of looked after children to maintain contact with their birth families – should they wish to – is clearly enshrined in law. However, there is often a lack of consideration about the quality of looked after children's contact with their birth families, and how this contact affects children's emotional wellbeing. NICE guidance for England is clear that contact with a child's birth family should be promoted when it is "personally valued by the child or young person [and] felt to be in their best interests" but that contact with family members should 'diminish' when it is contrary to the child's wishes".<sup>150</sup>

149 North Yorkshire County Council (2014)

150 NICE and SCIE (2013), Recommendation 24, p41

Where children are to return home to their birth families, they may need support to repair their family relationships.<sup>151</sup> Research has shown that foster carers and residential care workers can make an important contribution to this process both before and after a child returns home to their birth family.<sup>152</sup> Once a child has returned home, ongoing support may be needed to help ensure that the return home is successful. Research by Loughborough University suggests that supporting successful returns home will be substantially more cost-effective than failed reunifications that lead to children subsequently re-entering care.<sup>153</sup>

We learned from local authorities and CAMHS workers that in the context of overstretched services, crucial opportunities to support secure

attachments between looked after children and members of their birth family are being lost. Senior social work managers and mental health professionals argue that greater priority should be given to exploring how contact between children and their birth families could be more effective in supporting looked after children and young people's emotional wellbeing and building secure attachments. However, there is currently a lack of evidence-based models in this area and more research is needed to identify effective approaches. New models for working with the birth families of children whose permanence plan is to remain in care should be supported by programmes like the Department for Education's Innovation Programme in England.

### Summary of Recommendations: Supporting and Sustaining Children's Relationships

13. Local authorities should work to improve the status of foster carers in the children's workforce. Foster carers should be provided with high quality training and support to help them understand and address the emotional needs of looked after children. Local authorities should monitor carers' emotional wellbeing, and promote early intervention to support stable placements
14. Local authorities must seek to address the structural boundaries between teams that lead to looked after children experiencing unnecessary changes in their key worker. Where changes cannot be avoided, transitions should be flexible so that they do not coincide with other significant changes in an individual child or young persons life.
15. Local authorities and health services must recognise the importance of supporting positive relationships between looked after children and their birth families (where children wish these relationships to continue). Central governments should invest in research and service development to identify effective ways of supporting the relationships between looked after children and their birth families to promote children's emotional wellbeing.

### Support care leavers' emotional needs

The local authorities who partnered on this project identified support for care leavers' emotional needs as an important priority for system design. The transitional period when care leavers approach independence and the time immediately after they leave care can present significant challenges to

their emotional wellbeing. Some care leavers' mental health worsens in the period after they leave care.<sup>154</sup> As shown in Chapter 3, this is a time when support can be withdrawn very abruptly, at the same time that care leavers become at greater risk of social isolation due to leaving their placement, living alone for the first time and potentially moving to a new area away from friends and family.

151 Wilkins and Farmer (2014)

152 Wilkins and Farmer (2014)

153 Holmes (2014)

154 Dixon et al (2006)

## Preparing for leaving care

Discussions with young people and professionals indicate that preparation for leaving care tends to be focused overwhelmingly on practical concerns rather than on emotional preparation. These practical concerns can significantly impact on young people's emotional wellbeing (for example the stress of insecure housing). However, there are also purely social and emotional dimensions that need to be addressed. Critical to this is the question of "What will my support network look like after I leave care?"

Local authorities must ensure that care leavers' emotional wellbeing is a key theme within pathway planning. Leaving care services should see emotional preparation for leaving care as one of their key areas of responsibility. They should ensure that other decisions, such as the location of their new accommodation, are made with young people's emotional needs in mind. Preparation work for young people leaving care should include helping care leavers to develop and maintain relationships with people who will be able to continue supporting them after they leave care. This work should start as early as possible so that when young people leave care they have a set of strong relationships that they will be able to rely on for emotional support.

Part of preparation for leaving care might involve helping care leavers to manage contact with family members from whom they have become estranged, or to discuss how they will stay in touch with carers after their placement ends. Housing options for care leavers should be considered in relation to how close they are to friends, family or previous carers. This may also be an important time to resume life story work, to help a care leaver reflect on their past relationships and what they might want from them in the future.

During this project, one group of professionals identified the idea of holding a 'life appreciation day' for care leavers to mark and celebrate their transition to independence. The young person would decide who they wished to invite to their celebration, which might include friends, family,

carers and professionals who have been important to them while they have been in care. This is an opportunity for celebration but also to help the young person to make contact with people they wish to stay in touch with after they leave care. These networks are likely to be an important part of developing and maintaining the young person's resilience.

Figure 23 sets out the process of assessment and planning that should take place to prepare a child or young person for leaving care, either to return home to their birth family or when moving on to independence.

## Continuing to support care leavers' emotional needs

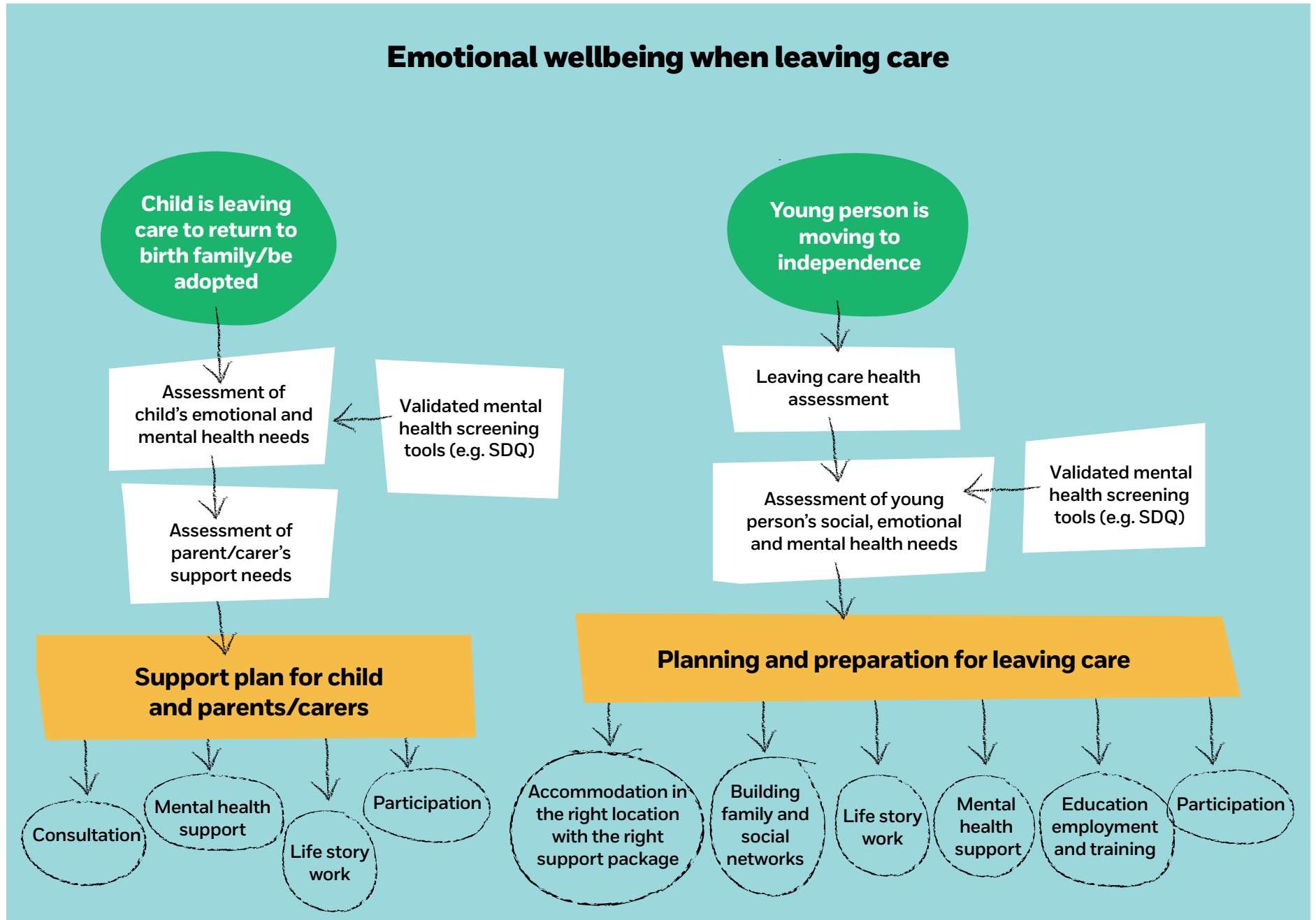
When care leavers turn 18 (or in some cases 16), they become ineligible for CAMHS and other support services. These young people are still viewed as a former looked after child by children's social care. However, health services view them as adults whose eligibility for mental health support is no different from anybody else, creating significant gaps in support. One CAMHS manager commented:

*I think that the issues for leaving care are so complex that their emotional and mental health needs can fall through the net. What they really need is a team of social workers, mentors and mental health workers providing an intensive support package that includes addressing their social, housing, education, training and employment needs as well support in navigating renewed relationships with birth family.*

Professionals agree that emotional and mental health support for care leavers is inadequate and there needs to be a step change in the support available to them, to help ensure that their transition to independence is successful. Some local areas are already responding to this challenge by embedding a part-time CAMHS worker in their leaving care team, to improve care leavers' access to therapeutic support and giving social workers' access to clinical support to improve their understanding of care leavers' emotional needs.



Figure 23: Preparation and support for children and young people leaving care



This priority access to adult mental health services should be extended to all care leavers, with all local authorities and health agencies putting arrangements in place to ensure that care leavers can still access therapeutic support up to the age of 25, with smooth transitions from CAMHS for young people who are already accessing services. National governments should review the support needed to put these arrangements in place.

Portsmouth City Council has recently publicised its commitment to provide care leavers with access to mental health services until their 25<sup>th</sup> birthday.<sup>155</sup> This is as a result of a project called *New Belongings*, led by care leavers, which brought nine local authorities together to explore “a better deal for care leavers”.<sup>156</sup> Case studies 14, 15 and 16 describe examples of other service models that have been developed to support care leavers’ emotional needs.

### Case study 14: Emotional Support Project, Mind in Haringey

The Emotional Support Project for care leavers began in 2011. It is funded by Haringey council, and designed and delivered by Mind in Haringey. They work specifically with young people aged 14–21-years-old, offering a wraparound service of interventions to assist with the transition to adulthood.

Mind was tasked with working with 30 young people in year one, 40 young people in year two and 40 young people in year three. They work with young people who are experiencing multiple disadvantages or mental health problems; are living a chaotic lifestyle; and have medium to high support needs.

The project offers young people:

- A 1-1 worker who works with care leavers on all areas of their life and links in with their existing support networks (for example their personal advisor).
- Coping with Life skills group: This runs three times each year, for eight–10 weeks. This is a psycho-educational, CBT-based group with life skills work, which builds young people’s emotional resilience. Seven modules are covered, which include managing self-esteem, anger, significant loss and change, stress, depression, anxiety and assertiveness.

- Up to 10 sessions of counselling.
- Life coaching: Young people who graduate from the life skills group and are fairly settled in their life can work with a life coach for up to three months. This is focused on planning their future.

The service is staffed by professionals from a variety of professional backgrounds. The 1-1 workers are qualified counsellors or community and youth workers, some with up to 20 years’ experience. The Coping with Life Skills group is run by an experienced counsellor and clinical social worker. The life coaches are volunteers with relevant professional backgrounds, for example psychologists, social workers and counsellors, often in training.

Some young people have not got as far as life coaching, and some people will take part in more than one set of Coping with Life Skills sessions. Some young people have gone through the whole ESP programme and continued on to university.

The service is evaluated using the Outcome Star, other psychological scales (the Rosenberg Self-esteem scale and Novaco Anger inventory) and evaluation tools to capture young people’s outcomes and their journey through the project.

155 [www.thecareleaversfoundation.org/sitedata/files/Independent%20Ev.pdf](http://www.thecareleaversfoundation.org/sitedata/files/Independent%20Ev.pdf)

156 [www.thecareleaversfoundation.org/sitedata/files/Independent%20Ev.pdf](http://www.thecareleaversfoundation.org/sitedata/files/Independent%20Ev.pdf)

## Case study 15: Care leaver-led charity Pure Insight, Stockport Council

Pure Insight was established in January 2013 as a direct response to the unmet needs of care leavers in the local community. It is led by a care-experienced team who connect with young care leavers, local businesses and organisations in the local community to develop needs-led projects. Pure Insight is currently working on four projects with care leavers:

1. Café Zest, was developed with young people to combat loneliness and isolation. This is a weekly drop-in facility for care leavers living in Stockport. A team of skilled volunteers, including care-experienced people, provide practical and emotional support. Young people are helped to develop support networks and learn practical skills, such as cooking and managing on a low budget.
2. A weekly peer support group for care leaver parents who support each other and gain access to information or explore local facilities. They are supported by a small team of volunteers, including those with care experience.

3. A mentoring program, which gives care leavers access to a consistent adult role model who can support them through their transition to independence and beyond. Support is tailored on an individual basis for a minimum of two years. Mentors are highly skilled and supported volunteers from the local community, including those who have experienced the care system.
4. Platform 28, a training program for care leavers to deliver bespoke training to providers and others interested in learning from people with personal experience of care.

Pure Insight has recently been commissioned by Stockport Council to lead their Care Leavers' Forum, which gives Stockport care leavers a platform to have their voices heard and influence current and future service delivery. Pure Insight are also working alongside Stockport's Clinical Commissioning group piloting Personal Health Budgets for care leavers with mental health needs. Creative solutions are being found for young people who were frequently presenting at A&E.

## Providing a range of housing-with-support options

Interviews with young people reveal that some have struggled with feeling under pressure to leave their placement before they were ready, and had become depressed or anxious under the strain of living on their own. In many cases the transition was stark; from living with the support of a foster carer to living alone in a house or flat. However, there were also examples where young people had benefited from models of housing with support, where they had benefited from live-in support or had received regular visits from a key worker.

Participants in this project suggested that to tackle this problem, local authorities should develop a variety of housing options for care leavers with varying levels of support. These might include

staying put arrangements; supported lodgings and tenancies with tailored packages of support (for example daily or weekly visits from a key worker). Local authorities must ensure careful planning is put into working with young people to decide what level of support they will need after leaving care and (as mentioned above), consideration is given to locations that will help the young person to access and sustain their existing support networks.

This could be an important aspect of the implementation of the provision in the *Social Services and Well-being (Wales) Act 2014*, which states: "A local authority looking after a child must advise, assist and befriend the child with a view to promoting the child's well-being when it has ceased to look after the child".<sup>157</sup>

## Case study 16: Dramatherapy for Care Leavers, Young Futures

Young Futures provides housing and support services for over 40 care leavers, working with six local authorities in London and the Midlands. A 24-hour unit is in its final stages of development and will offer 24-hour support to an additional nine vulnerable young people in local authority care.

Young Futures currently provides each care leaver with a bespoke 1-bedroom flat in the community; a key worker who supports the young person with work and learning, health, money and practical life skills; weekly night visits and welfare checks; a 24-hour 'on call service'; and access to dramatherapy.

Young Futures employs two Health and Care Professions Council registered dramatherapists. Work begins on a 1-1 basis in the young person's own home to overcome potential barriers around timekeeping, attendance, consistency, social anxiety and budgeting.

The service was introduced in 2011 in recognition of a shortage of outreach therapeutic support locally. Dramatherapy can be both short- and

long-term although the majority of clients access long-term therapy.

Creative expressive techniques are used with an emphasis on 'here and now' feelings. This might include using masks, puppets, role-play, story work and art materials. This offers a creative and indirect way into feelings that might be difficult to articulate verbally. Dramatherapy is designed to help young people better understand and process difficult feelings or experiences.

Two models for measuring the impact of dramatherapy have been developed:

- CARE – Continuous Assessment, Reflective writing and Evaluation
- CAIT – Creative Analysis in Therapy

Each depends on the young person completing a self-evaluation form at the end of every session. This provides a consistent way for clients to reflect on their work and notice changes.

## Summary of Recommendations: Support care leavers' emotional needs

16. As part of their preparation for leaving care, local authorities should work with young people to help them identify and strengthen their support networks, identifying how these can help boost young people's resilience and support good emotional wellbeing during a transition to independence.
17. Young people should not experience a 'cliff' edge in support for their mental health when leaving care; health services should recognise the same corporate parenting responsibilities demonstrated by local authorities. Local authorities and health services must work together to improve this transition and identify support for the mental health and wellbeing of care leavers up to age 25. Central governments should review the resource needed to ensure these arrangements can be put in place.
18. Access to adequate ongoing support is critical to sustaining care leavers' emotional wellbeing after they leave care. Local authorities should work with care leavers to identify their specific requirements and put in place a tailored housing-with-support package that meets their emotional and practical needs.

# Appendix: Looked after children and care leavers involved in the fieldwork for this project

In this project we conducted detailed life story interviews with 20 care experienced children and young people. A further 22 care experienced children and young people took part in semi-structured focus group discussions. The age and gender of fieldwork participants is set out in table 6.

Table 6: Age and gender of all fieldwork participants

	8–11 years	12–15 years	16–17 years	18+ years	Total
Female	1	6	9	5	21
Male	1	7	4	9	21
<b>Total</b>	<b>2</b>	<b>13</b>	<b>13</b>	<b>14</b>	<b>42</b>

Table 7: Care experience of interview participants

The types of placements that interview participants had experienced are summarised here. If young people had lived in more than one type of placement, they are included in more than one row. We did not record placement types for the participants in focus groups so they are not included here.

Type of placement	Number of interviewees who had experienced this placement type
Foster care	15
Children's home	11
Boarding school	1
Friend and family care	6
Adoption	1
Custody	2
Women's refuge (aged under 18)	1
Hostel (aged under 18)	3
Semi-independent living, aged under 18 (e.g. supported lodgings)	8
Independent living, aged under 18 (e.g. living in a flat)	1
<b>Total number of young people interviewed</b>	<b>20</b>

# References

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- Adi Y., Kiloran, A., Janmohamed K., Stewart-Brown, S. (December 2007) *Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools, Report 1: Universal approaches which do not focus on violence or bullying*. University of Warwick and NICE. Available from: [www.nice.org.uk/guidance/ph12/evidence/universal-approaches-which-do-not-focus-on-violence-or-bullying-warwick-university-review-1-2](http://www.nice.org.uk/guidance/ph12/evidence/universal-approaches-which-do-not-focus-on-violence-or-bullying-warwick-university-review-1-2)
- Audit Commission (2014) *Councils' expenditure on looked after children: Using data from the Value for Money Profiles*. London: Audit Commission. Available from: [webarchive.nationalarchives.gov.uk/20150421134146/http://www.audit-commission.gov.uk/information-and-analysis/value-for-money-briefings-2/](http://webarchive.nationalarchives.gov.uk/20150421134146/http://www.audit-commission.gov.uk/information-and-analysis/value-for-money-briefings-2/)
- Barber, J.G., Delfabbro, P.H., and Cooper, L.L (2001) The predictors of unsuccessful transition to foster care. *Journal of Child Psychology & Psychiatry & Allied Disciplines*, 42 (26), pp.785–790
- Biehal, N., Cusworth, L., Wade, J., and Clarke, S. (2014) *Keeping children safe: allegations concerning the abuse or neglect of children in care: final report*. London: NSPCC. Available from: [www.nspcc.org.uk/preventing-abuse/research-and-resources/keeping-children-safe-allegations-of-abuse/](http://www.nspcc.org.uk/preventing-abuse/research-and-resources/keeping-children-safe-allegations-of-abuse/)
- Biehal, N., Ellison, S., Baker, C., and Sinclair, I. (2009) *Characteristics, outcomes and meanings of three types of permanent placement – adoption by strangers, adoption by carers and long-term foster care*. Research brief DCSF-RBX-09-11, London: Department for Children, Schools and Families
- Beck, A. (2006) 'Users' views of looked after children's mental health services. *Adoption and Fostering*, 30, 2, pp.53–63
- Bonfield S., Collins S., Guishard-Pine, J., and Langdon, P. (2010) Help Seeking by Foster-Carers for their 'Looked After' Children: The Role of Mental Health Literacy and Treatment Attitudes, *British Journal of Social Work*, 40, pp.1,335–1,352
- Briskman, J., Castle, J., Blackeby, K., Bengo, C., Slack, K., Stebbens, C., ... and Scott, S. (2012) *Randomised controlled trial of the Fostering Changes programme*. London: Department for Education (DfE)
- CAMHS Review (2008) 'Children and young people in mind: the final report of the National CAMHS Review'. [www.webarchive.nationalarchives.gov.uk/20081230004520/publications.dcsf.gov.uk/eorderingdownload/camhs-review.pdf](http://www.webarchive.nationalarchives.gov.uk/20081230004520/publications.dcsf.gov.uk/eorderingdownload/camhs-review.pdf)
- Care and Social Services Inspectorate Wales (2015) *National Inspection of safeguarding and care planning of Looked After children and care leavers who exhibit vulnerable or risky behaviours*. Cardiff: Care and Social Services Inspectorate Wales
- Children and Young People's Mental Health and Wellbeing Taskforce (2015) *Vulnerable Groups and Inequalities Task and Finish group Report*. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414326/Vulnerable\\_Groups\\_and\\_Inequalities.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414326/Vulnerable_Groups_and_Inequalities.pdf)
- Curtis L. (ed) (2014) *Unit Costs of Health and Social Care 2014*. Kent: Personal Social Services Research Unit
- Department for Education (2013) *Data Pack: Improving Permanence for Looked After Children. September 2013*, London: Department for Education. Available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/264952/final\\_improving\\_permanence\\_data\\_pack\\_2013\\_sept.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/264952/final_improving_permanence_data_pack_2013_sept.pdf)
- Department for Education (2014) *Children looked after in England, including adoption*. National tables: SFR36/2014. London: Department for Education. Available from: [www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption--2](http://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption--2)
- Department for Education and Department of Health (2015) *Promoting the health and well-being of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England*. London: Department for Education and Department of Health

- Department of Health and NHS England (2015) *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. London: Department of Health and NHS England
- Department of Health, Social Services and Public Safety (2007) *Care Matters in Northern Ireland – A Bridge to a Better Future*. Belfast: Department of Health, Social Services and Public Safety
- Dixon, J., Wade, J., Byford, S., Weatherly, H. and Lee, J. (2006) *Young people leaving care: A study of costs and outcomes*. York: University of York. Available from: [www.york.ac.uk/inst/spru/research/pdf/leaving.pdf](http://www.york.ac.uk/inst/spru/research/pdf/leaving.pdf)
- Dozier, M., Peloso, E., Lewis, E., Laurenceau, J. P., and Levine, S. (2008) Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. *Development and Psychopathology*, 20(03), pp.845–859.
- Fernandes, P. (2015) *Evaluation of the Face to Face service: Using a solution focused approach with children and young people in care or on the edge of care*. London: NSPCC. Available from: <http://www.nspcc.org.uk/services-and-resources/research-and-resources/face-to-face-final-evaluation-report/>
- Ford, T., Vostanis, P., Meltzer, H., and Goodman, R. (2007) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. *The British Journal of Psychiatry*, 190(4), pp.319–325
- Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., and Janson, S. (2009) Burden and consequences of child maltreatment in high-income countries. *The Lancet*, 373(9,657), pp.68–81. DOI:10.1016/S0140-6736(08)61706-7
- Grazioplene, R. G., DeYoung, C. G., Rogosch, F. A., and Cicchetti, D. (2013) A novel differential susceptibility gene: CHRNA4 and moderation of the effect of maltreatment on child personality. *Journal of Child Psychology and Psychiatry*, 54(8), pp.872–880. doi:10.1111/jcpp.12031
- Goodman R., Ford T., Gatward R., and Meltzer H. (2000) Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *The British Journal of Psychiatry* (2000), 177, pp.534–539
- Hannon, C., Wood, C., and Bazalgette, L. (2010) *In Loco Parentis*. London: Demos
- Hardy C. and Murphy E., (2014) Social-emotional screening and intervention for 0–4 year old children entering care, *Mental Health Services for Vulnerable Children and Young People*, Ed. Tarren-Sweeney M. and Vetere A. Routledge: London. pp.102–116
- HM Government (March 2010) *The Children Act 1989 Guidance and Regulations. Volume 2: Care Planning, Placement and Case Review*. London: HM Government. Available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/336072/The\\_Children\\_Act\\_1989\\_Care\\_planning\\_placement\\_case\\_review.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/336072/The_Children_Act_1989_Care_planning_placement_case_review.pdf)
- Holmes, L. (2014) *Supporting Children and Families Returning Home From Care: Counting the Costs*. Loughborough: Loughborough University.
- Hyde-Dryden, G. Holmes, L. Lawson, D. and Blackmore, J. (2015) *Taking Care: Practice Framework for Reunification: Evaluation report*. Loughborough: Loughborough University
- Luke, N., Sinclair, I., Woolgar, M., and Sebba, J., (2014) *What works in preventing and treating poor mental health in looked after children?* London: NSPCC and the Rees Centre, University of Oxford. Available from: [www.nspcc.org.uk/preventing-abuse/research-and-resources/what-works-preventing-treating-mental-health-looked-after-children/](http://www.nspcc.org.uk/preventing-abuse/research-and-resources/what-works-preventing-treating-mental-health-looked-after-children/)
- McDermid, S., and Holmes, L. (2013) *The cost effectiveness of Action for Children's Intensive Family Support Services*. Loughborough: Loughborough University. Available from: [www.lboro.ac.uk/media/www/lboroacuk/content/ccfr/publications/Report%20-%20Intensive%20Family%20Support%20Services.pdf](http://www.lboro.ac.uk/media/www/lboroacuk/content/ccfr/publications/Report%20-%20Intensive%20Family%20Support%20Services.pdf)

- McDermid, S., Hyde-Dryden, G., and Ward, H. (forthcoming) *Looking for long-term outcomes: What early interventions are needed for children and young people at risk of maltreatment in England?* Irish Journal of Applied Social Sciences. Article due for publication June 2015.
- Meltzer, H., Corbin, T., Gatward, R., Goodman, R., and Ford, T. (2003a) *The mental health of young people looked-after by local authorities in England*. Office for National Statistics, London: HMSO
- Meltzer, H., Corbin, T., Gatward, R., Goodman, R., and Ford, T. (2003b) *The mental health of young people looked after by local authorities in Wales*. Office for National Statistics, London: HMSO.
- Memarzia, J., St Clair, MC., Owens, M., Goodyear, IM., and Dunn, VJ. (2015) Adolescents leaving mental health or social care services: predictors of mental health and psychosocial outcomes one year later. *BMC health services research*, 15.1 (2015): 185
- Monitor and NHS England (2013) *2014/15 National Tariff Payment System*. London: Monitor and NHS England. Available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300547/2014-15\\_National\\_Tariff\\_Payment\\_System\\_-\\_Revised\\_26\\_Feb\\_14.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-_Revised_26_Feb_14.pdf)
- National Assembly for Wales (2007) *The Placement of Children (Wales) Regulations 2007*. SI 2007/310. Cardiff: National Assembly for Wales
- Neece, CL., Green, SA., and Baker, BL. (2012) Parenting Stress and Child Behavior Problems: A Transactional Relationship Across Time. *American Journal on Intellectual and Developmental Disabilities*, January 2012, Vol. 117, No. 1, pp.48–66
- NICE (2013) Quality Standard 31: The health and wellbeing of looked-after children and young people. Statement 3. Manchester: NICE.
- NICE and SCIE (Issued October 2010, Modified April 2013) Looked-after children and young people. NICE public health guidance 28. Manchester: NICE.
- North Yorkshire County Council (August 2014) *No Wrong Door: Rethinking Care for Adolescents*. North Yorkshire: North Yorkshire County Council.
- Radford, L., Corral S., Bradley, C., Fisher, H., Bassett, C., Howat, N. and Collishaw, S. (2011) *Child abuse and neglect in the UK today*. London: NSPCC. Available from: [www.nspcc.org.uk/preventing-abuse/research-and-resources/child-abuse-and-neglect-in-the-uk-today/](http://www.nspcc.org.uk/preventing-abuse/research-and-resources/child-abuse-and-neglect-in-the-uk-today/)
- Richardson, J. and Lelliott, P. (2003) Mental health of looked after children. *Advances in Psychiatric Treatment*, Jul 2003, 9 (4) pp.249–256. Available from: [www.apr.rcpsych.org/content/9/4/249](http://www.apr.rcpsych.org/content/9/4/249)
- Rock S., Michelson, D., Thomson, S., and Day, S. (2013) Understanding Foster Placement Instability for Looked After Children: A Systematic Review and Narrative Synthesis of Quantitative and Qualitative Evidence. *British Journal of Social Work*, (Impact Factor: 1.19). 01/2013; 45(1), pp.177–203
- Rubin, David M., et al (2007) The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics* 119.2 (2007): 336–344.
- Selwyn J., Frazer L., and Quinton, D. (2006) Paved with good intentions: the pathway to adoption and the costs of delay. *British Journal of Social Work*, 36: pp.561–76
- Sempik, J., Ward, H., and Darker, I. (2008) Emotional and behavioural difficulties of children and young people at entry into care. *Clinical child psychology and psychiatry*, 13(2), pp.221–233. doi:10.1177/1359104507088344
- Schofield, G and Beek, M. (2005) Risk and resilience in long-term foster care. *British Journal of Social Work*, 35 (2005), pp.1,283–301



StatsWales (2014) *Children starting to be looked after during year to 31 March by local authority and need for care*. Knowledge and Analytical Service, Welsh Government. Available from: [statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-Looked-After/ChildrenStartingToBeLookedAfterDuringYearTo31March-by-LocalAuthority-NeedForCare](http://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-Looked-After/ChildrenStartingToBeLookedAfterDuringYearTo31March-by-LocalAuthority-NeedForCare)

Talbot, S. (2013, unpublished) 'How good are local health services at meeting the emotional and mental health needs of children and young people who are looked after?' Analysis of the last 50 Safeguarding and Looked After Children inspections undertaken in partnership between Ofsted and CQC from January to July 2012

Tarren-Sweeney, M. (2010) It's time to re-think mental health services for children in care, and those adopted from care. *Clinical Child Psychology and Psychiatry*, 15 (4) pp.613–626

Tarren-Sweeney M., and Vetere A. (2014) *Establishing the need for mental health services for children and young people in care, and those who are subsequently adopted*. In 'Mental Health Services for Vulnerable Children and Young People', Ed. Tarren-Sweeney, M., and Vetere, A. London: Routledge, 2014

Tarren-Sweeney, M. J., Hazell, P. L., and Carr, V. J. (2004) Are foster parents reliable informants of children's behaviour problems? *Child: Care, Health and Development*, 30.2 (2004): pp.167–175

The Scottish Executive (2007) *Looked after children and young people: we can and must do better*. Edinburgh: The Scottish Executive

The Scottish Government (2014) *Guidance on Health Assessments for Looked after Children and Young People in Scotland*. Edinburgh: The Scottish Government. Available from: [www.dera.ioe.ac.uk/20171/1/00450743.pdf](http://www.dera.ioe.ac.uk/20171/1/00450743.pdf)

Ward, H. (2009) Patterns of instability: moves within the English care system: their reasons, contexts and consequences. *Child and Youth Services Review*, 31, pp.1,113–18

Ward, H., Holmes, L., and Soper J. (2008) *Costs and consequences of placing children in care*. London: Jessica Kingsley Publishers

Wilkins M., and Farmer E. (2014) *Reunification Practice Framework and Guidance: An evidence and practice informed approach*. London: NSPCC.

Woolgar, M. (2013) The practical implications of the emerging findings in the neurobiology of maltreatment for looked after and adopted children: recognising the diversity of outcomes. *Adoption & Fostering*, 37 (3) pp.237–252

Wrench K. (2013) *Life Story Work With Children Who Are Fostered or Adopted: Creative Ideas and Activities*. London: Jessica Kingsley Publishers

Young Minds (2012) *Improving the mental health of Looked After Young People: An exploration of mental health stigma*. London: Young Minds. Available from: [www.youngminds.org.uk/assets/0000/1440/6544\\_ART\\_FINAL\\_SPREADS.pdf](http://www.youngminds.org.uk/assets/0000/1440/6544_ART_FINAL_SPREADS.pdf)

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