



The Mental Health Of Looked After Children In Public Care

Drop in the Ocean: An Examination of Current Specialist Mental Health Projects for ‘looked after’ children within England

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1. Introduction

Children who have the state acting as their parents are amongst the most disadvantaged children within our society. Evidence on outcomes would suggest that the state does not make a good substitute parent. But it is not so easy as to correlate the outcome measures achieved by children in state care, to the state's care alone. Most often children in care have had to cope with appalling and difficult experiences and circumstances very early in life. This can and does frequently impact on every sphere of a child's life, whether that is in school, in forming relationships with adults, peers, on the development of a healthy self esteem, on achievements, lack of opportunities for excelling in particular areas where a child or young person shows talent and flair, or lack of opportunities for receiving quick and ready access to supportive services.

In the UK there are in excess of 50,000 children in care (DOH, 2002). Of this number, c18,000 children live in residential establishments. There is now clear evidence to show that looked after children have incredibly complex health and social needs and this includes much higher prevalence rates of mental illness than children who are not looked after and live with their birth families (Meltzer, 2003). For children in foster care the rate of disorder is assessed at 40%, whilst the figure for children in residential care is nearly double at 72%.

These children aren't born damaged. It is their life experiences that have such a lasting influence on outcomes and make these children vulnerable. The disadvantage that children in public care experience plays itself out in many ways; most notably in the outcomes society expects from these children and the outcomes they in turn achieve in their childhood.

Many of the histories of children in public care are incredibly complex. Professionals' current knowledge base of effective interventions to support children who carry and bear enormous emotional trauma is very challenged by the complexities of these children's lives and the impact that their experiences have on them. Solutions are not quick fix and require dedication from a whole range of people involved in children's lives. Central to this is the emotional support children are given.

The English study has examined current specialist mental health projects for 'looked after' children within England. During the last 5 years there has been an increasing interest in providing new money to fund innovative service development in this area, beginning with the Department of Health funding 24 specialist projects via the Mental Illness Specific Grant in 1998 for 3+ years. A significant proportion of those projects developed services for looked after children (Richardson and Joughin (2000); Kurtz, 2003; James, 2002). This initiative was launched at a similar time as the Department of Health's 'Quality Protects' programme (also a three year programme), and represented an investment of new money into children's services. The new money was closely tied to the government's agenda for modernising public

sector services and demonstrable improvements in services and outcomes for children in need, including those in public care, were expected as a result of this investment. Please see page 19 - 33 of the UK partner research/literature review for further information on other policy developments which have affected this area of work.

As a result of this interest in improving services, a variety of new projects have been set up across England with the express purpose of working to improve the mental health of children in public care. The aim of the English study was to try and find out more about these projects: how they were set up, funding arrangements; staffing numbers; types of professionals involved; services offered and evaluation methodology used. This was done through a questionnaire to all projects in order to ascertain whether any key learning, themes or developments had emerged from this considerable investment in specialist services.

This report consists of seven parts. First, the research objectives and the specific research questions are listed in chapter 2. Second, the methodology of the study is described in chapter 3, in particular the sample selection, the instruments, the procedures and the response rate. Third, the results are presented in chapter 4. We give descriptions of the projects; services provided and description of evaluation methodology used by the projects and other data. Fourth, the experience and views of children and young people in care who access mental health services of young people in care are discussed in chapter 5. Fifth, a number of case studies are selected as good practice examples according to identifiable criteria. Sixth, the significance of the findings will be judged, before moving on to consider practice and policy implications in chapter 7. Chapter 8 will briefly consider overall recommendations before concluding.

2. Objectives and research questions

The reasons for children's entry into the care system within each country are varied, and you will hear further information on this issue in this morning's presentations. An examination of this contextual information shows that there are a number of different factors in individual countries that have influenced the development of services generally for children in state care in that particular country. Additionally, different information was known in each country about outcomes for this group of children. As a result of this, the research methodology of the study was different between the UK and the other 2 European partners. This was due to three main factors.

- a. The UK already had information available on prevalence rates for looked after children and mental health disorders from a variety of studies. Nothing further could be gained by repeating the exercise, and
- b. A major government study examining the prevalence rate of the mental health of young people looked after by local authorities in England, was in process with the report due for publication in spring 2003.
- c. Given the nature of the proposed research there would have been problems for the UK partners in getting any prevalence study through an ethics committee in time for the time schedules attached to this project.

A decision was therefore made by the partners for the UK aspect of the project to have a different focus. The UK would concentrate on examining specific projects where services were being provided to children and young people in public/state care with mental health problems. The UK would also take responsibility for conducting an international literature review. Belgium and Greece would undertake a prevalence study.

The UK study has three basic objectives:

- To undertake a review of current specialist mental health services available to looked after children within England and other European countries;
- To identify which of the available services appear to work best within the range of projects examined; and
- To identify whether evaluations of these services are routinely undertaken.

Following specific research questions can be formulated:

- Is there a best practice model that could be developed for services to looked after children.
- How robust are the evaluations that are completed?

3. Methodology:

The methodology of the study is described in this chapter, in particular the sample selection, the instruments, the procedures and the response rate.

Sample Selection and Procedures

Within the UK a large number of services provide mental health services to looked after children. Some of these services are generic in their referral criteria (e.g. mainstream CAMHS services that provide mental health services for looked after children at tier 3 of NHS services), whilst others are specialist (e.g. specific projects for looked after children only, or specialist services for particular mental health difficulties which looked after children can access as well as other children who have specific difficulties. This is at tier 4 and 5 of NHS services). To date there is no one publication that summarises all services in England, the UK or in Europe, although Richardson and Joughin's (2001) publication contains a list of specialist services in England.

Within England there are 150 Local Authorities. Because of recent developments listed below, each Local Authority already has or is in the process of setting up specialist services for looked after children who have mental health difficulties. This is the potential sample size of the study.

The Government announcements and initiatives regarding specialist CAMHS services are:

- On 17/1/03 The Department of Health issued a Local Authority Circular (LAC) outlining the Child and Adolescent Mental Health Service (CAHMS) grant guidance 2003/04. This announced a substantial increase in funding to Local Councils, with the total CAMHS grant in 2003/04 set at £51M. £44.1 M is allocated directly to councils, and is an increase of £28M on the grant available during 2002/03. The remaining money is to be used for funding specific projects. This is a sizeable investment towards services that have almost no evidence of effectiveness. Small no of projects that are well researched and have good evidence base.
- This links with a vision for CAMHS improvements set out in 'Improvement, Expansion and Reform: The next Three Years Priorities and Planning Framework 2003-2006' published in October 2002.

- During the last 5 years there were a number of reports published that highlighted the need for service review in this area Richardson and Joughin (2000), Audit Commission (1999) and Mental Health Foundation (1999).
- In 1999 The Department of Health allocated 24 projects Mental Illness Specific Grant Funding, and a number of these projects deal directly with looked after children. A summary of these projects can be found on the 'Young Minds' website or in the Richardson and Joughin (2000) publication. These 24 projects were subject to an overall evaluation, (Kurtz and James, 2003) which is also available from Young Minds.

Identifying a maximum sample size required publicity within academic, research and local authority service areas. We were most interested in the specialist mental health services available to looked after children, as opposed to generic services.

The following strategies were used to gather data:

- The Association of Directors of Social Services UK Research Committee approved this research study in 2002, thereby giving a clear message to all its members in the UK that this was a project that had ADSS approval and support.
- Letters were sent to the Directors of Social Services of all 150 Local Authorities in England in December 2002. In order to enhance the response, a stamped return envelope was included.
- A call for information was put on the Focus website in December 2002
- A call for information was circulated to members of EUSARF in December 2002

A two-stage data gathering process began shortly after this time, using proforma's developed by Barnardo's.

The selection of projects we have included in this study was not technically a randomised sample, and a control group had not been identified to compare specialist services with more generic services that children and young people in care can access.

Instruments

Barnardo's research team had developed 2 proforma's as a part of the study (see Appendix 1 and 2). The first of these proforma's was referred to as 'The Mental Health of Children in State Care: Promising Practice Questionnaire'. The questionnaire comprised 11 open ended questions concerned with identifying:

- Information about the informant and name of project
- Aims
- Activities
- Organisation and Staffing
- Target Group

- Specialism
- Access
- Geographical Area
- History
- Evaluation
- Other information from the informant not covered in the questionnaire

This proforma was sent out to all the Local Authorities for individual projects to record basic information about their services. This information was then sent back to The Bridge for collation. The projects were given 4 weeks for data completion and return from the beginning of January 2003. The last form was sent to The Bridge in August 2003.

In addition a further telephone interview proforma had been developed for follow-up responses with those projects where strengths in practice or evaluation had been identified by the research team. This proforma comprised 14 open ended questions, with an additional 2 questions for the interviewer to assess:

- The category of the project (a selection of 5 options given)
- The strength of the service in relation to 7 factors. The 7 factors were:
 1. Clarity of outcome objectives
 2. Evidence base
 3. Evaluation
 4. Achievement of Outcomes
 5. Participation of Young People
 6. Participation of Carers
 7. Inter-agency working

The interviewer was asked to rate each of these areas on a 5 point scale ranging from very strong to very weak.

Two members of staff undertook these additional interviews with specific projects. These occurred from March 2003-June 2003.

4. Results

Response rate

Data collection occurred between January '03 and June '03. From the initial data received, a summary of basic information is as follows:

- We received a total response rate of 68: 59 responses received from England; 3 from Scotland; 3 from Wales; 3 from Europe. The 59 responses from England represented a 39% response rate, based on a total sample size of 150.
- 21 responses (36%) were from health services.
- 38 of these responses (64%) were received from a mail out to Local Authorities in England. There are 150 Local Authorities in England, so the return rate is 25.3% of all local authorities in England.
- The majority of the Health and Social Services projects were jointly commissioned by the local authority and PCT (Primary Care Trusts) and provided by the relevant Mental Health Trust. This is a fairly typical/acceptable response rate from a mail out questionnaire.
- In total 24 'Promising Practice Questionnaires were returned to the Bridge. There may be a number of reasons for the low return rate, including other Local Authorities not having particular services for looked after children. Also, because there is no identifiable directory of services for mental health and LAC nationally all letters had to be sent via directors of social services and therefore may have taken some time to reach the lead person responsible for any local projects. Given the bureaucracy in some organisations, some local authorities may have chosen not to return the questionnaire due to it arriving with the correct person close to the closing date marked on the paper. I was contacted by a number of project managers regarding late returns for this reason.
- A further 26 replies were received from a call for information placed on the 'Focus' website; these contacts were either from academic institutions or projects located in health services.
- Finally, four responses were received from a call for information via the EUSARF mailing list.

The proformas were well completed and additional information was supplied in most cases. The information was a fair representation of how the project would present itself to an external audience.

The initial data was entered into a table designed by the Barnardo's team to assist with analysis of the data provided by the projects. The table consisted of 14 topic areas:

	Table Headings:
1	Service Name
2	Strategic Objectives
3	Activities
4	Organisation
5	Staffing
6	Service Target Group
7	Specialism
8	Access
9	Coverage
10	Outcomes
11	Evaluation
12	Other
13	Promising Practices
14	Comments

Of the information returned by the projects, 47 replies were valid and could be used for the purposes of the research. The following results arise from the analysis of this data.

1. Description of the projects

The projects included in this review are spread throughout England, with a small number of returns received from Scotland, Wales and one project in Belgium. 17% of the projects included in the study are based in London.

Table 1: Geographical Location

National	1
Scotland	2
Wales	1
England (not London)	34
London	8

Belgium	1
Total	47

2. Strategic (and other) Objectives

All bar one of the projects listed aims and objectives for their service. These ranged for specific objectives:

'To provide the mental health of children looked after by providing support and guidance to care staff and offering a 'fast track' to a range of CAMHS services. 1. Weekly consultations with children's community homes staff; 2. Weekly consultations to local area foster carers and social workers working with looked after children; 3. Training for workers and carers to raise awareness and improve delivery of services in mental health issues.'

Children Looked After Mental Health Service (Nottingham)

to objectives that are far less easily measurable;

Providing safety and security to allow each individual to: 1. Grow and fulfil their potential; 2. make positive and informed life choices; 3. Establish a positive sense of self and identity; 4 have a healthy resilience to overcome life challenges.

Lifescop: The Inter-agency Service for Children Looked After (Norfolk)

The 6 most common objectives are (in numerical order):

1	Promote the mental health of looked after children	30%
2	Training for foster carers and other staff	23%
3	Direct therapeutic work with child	19%
4	Improve access to existing CAMHS services	17%
5=	Assessments of mental health needs for looked after children	14%

5=	Consultation sessions	14%
5=	Reduce placement breakdowns	14%
5=	Multi-disciplinary aspect to service	14%
6	Direct therapeutic work with carers	10%

Only one project specifically mentioned research activity in its objectives.

The objectives listed by the projects generally state the broad aims of the respective services. Many services do not link their objectives to the services they provide, instead referring to more general statements about improving mental health without specifying how this will occur. This makes evaluation of service activity very difficult. It also makes assessments of improvement in the mental health of children and young people vague, improvements in the skills and capacity of carers difficult to measure and

3. Activities and description of services provided

A wide variety of activities are listed in the schedule. These are broken down into 4 headings: assessments; therapy; training; and access to other services.

a. Assessments:

1	General Mental health assessment	11
2	Non-specific assessment	6
3	Education assessment	3
4	Cognitive behavioural assessment	3
5	Attachment assessments	2
6	Health assessment	1
7	Multi-agency assessment	1

b. Therapies:

1	Non-specific clinical interventions, therapeutic treatments and other direct work	18
2	Family therapy	6
3	Play therapy	5
4	Counselling	5
5	Art, drama and music therapy	4
6	Psychotherapy	3
7	Group-work	4
8	Psychotherapy for children in transition	1
9	Attachment intervention	1
10	Adolescent counselling services	1
11	Eye movement desensitisation and reprocessing	1
12	Systemic therapy	1
13	Cognitive therapy (to child)	1
14	Psychoanalytic therapy	1
15	Social skills training	1
16	Leisure activities (e.g. scuba diving and horseriding)	1

c. Training:

1	Training and skills development for foster carers	14
2	Training for other professionals (including residential workers)	7
3	Cognitive Behavioural Therapy training for foster carers	1

d. Other:

1	Case consultation	16
2	Support for foster carers	11
3	CAMHS liaison	8
4	Advice and information for social workers	5
5	Consultancy to children's homes	5
6	Research and audits	2

7	Production and dissemination of information for carers and children	1
8	24 hour support	1

One project specifically mentioned services and assessments for children from ethnic minority communities (*Greenwich*).

One project listed the specific therapeutic models used by the service (systemic therapy, cognitive therapy, psychoanalytic therapy, play therapy and counselling) (*The Wickham Project – Lewisham*).

One project uses a specific model for training foster carers (Cognitive Behavioural Therapy) (*Fostering changes – Southwark*)

At least 40% of the projects are providing non-specific clinical interventions, therapeutic treatments and other direct work. This does not include those projects that offer Art, drama and music therapy and leisure activities. The figure is then just over 50%.

Most projects offer more than one service, so getting an accurate picture of the types of assessments and interventions is difficult. A variety of approaches are used by individual projects.

4. Organisation:

Funding:

1	Joint funded (Health and SSD)	20
2	Health (CAMHS)	12
3	Joint funded (Health, SSD, Education and Voluntary organisation or other combination)	8
4	Not specified	4
5*	CAMHS Innovation – DOH, SSD and Health	2
6	Voluntary sector	2
7	Social Services	1

Category 5 is additional to other categories. Each project's funding source indicated the category in which it was placed. 60% of the projects are joint funded initiatives – the majority are funded with health and social services resources.

5. Staffing

Professional discipline:

1	Social workers	44
2	Clinical psychologist	27
3	Health professionals	23
4	Specialist nurse (including 1 CPN)	16
5	Teacher	9
6	Psychiatrist	9
7	Therapists (non-specific)	7
8	Education psychologist	7
9	Mental health worker	5
10	psychotherapist	5
11	Family therapist	5
12	Assistant psychologist	2
13	Psychiatric social workers	2
14	Art therapists	2
15	Research Officer	2
16	Play therapist	1
17	Assistant social worker	1
18	Counsellors	1
19	Youth worker	1
20	Drug worker	1
21	Occupational therapist	1
22	Consultant in learning disabilities	1

Numbers of staff in the project:

1	One staff member	7
2	Two - four staff members	15
3	Five – nine staff members	9
4	Ten or more staff members	11
5	Information not given	5

Numbers of staff recorded above do not reflect full-time equivalents. Many staff in health services offer a number of sessions per week only. This is certainly the case for child psychiatrists.

6. Target Group and Specialism

1	Looked after children	35
2	Foster carers	7
3	Working with staff who are working directly with looked after children	2
4	Children who are in danger of coming into care	1
5	Doesn't specify	3

7. Access:

The majority of projects operate a system of referral via the child's social worker. Some projects with more of a multi-agency focus will also accept referrals from other institutions that know the child, such as school, GP, YOT's, school medical services or residential staff. Some projects will accept self-referrals from looked after children themselves whilst others won't.

8. Outcomes

The outcomes particular projects believed they have achieved are many and varied. These outcomes are listed in categories identified by the review team. It must be noted that the review team have not had access to any additional information or evidence to support claims regarding outcomes achieved by projects. This section links closely with and should be read in conjunction with the evaluation section.

Thirty four (74%) of the 47 projects did not list any outcomes for their services. We specifically asked for this information. However we cannot conclude that this information doesn't exist, albeit this is a poor result.

The remaining 26% of the projects listed the following outcomes:

1	Reduction in future use of the public care system	5
2	Improving young people's access to mental	5

	health services	
3	Improving mental health	5
4	Reduction in educational failure	3
5	Reduction in risk of suicide , self harm, drug abuse	3
6	Increase in retention of foster carers	3
7	Reduce offending behaviour	2
8	To improve life chances for looked after children	1
9	Reduction of use of special schools	1
10	Avoiding the use of distant and expensive out of county placements	1
11	Reduction in likelihood of future referral to specialist mental health services	1
12	Decrease risk of family breakdown	1
13	Reduction in school exclusions	1
14	To improve attachment relationships	1
15	To improve interagency understanding and co-operation	1
16	Improve assessment and care planning	1

It would be very difficult to demonstrate a causal link between the outcomes identified by the projects and the cause of the positive change for the child being achieved directly because of the intervention of the project. Indeed this section has resulted in more questions for the reviewers concerning the evaluation methodology adopted by many of the projects and how outcome measures are identified and agreed.

The series of outcomes listed that begin, 'reduction in...' and 'reduction of...' are very vague.

9. Evaluation: Description of evaluation methodologies used by the projects

The evaluation methodologies of the projects varied considerably. A number of projects did not have an evaluation strategy. 33 of the projects said that their services were evaluated. 8 of these projects did not send any evaluations with their return. The remaining 25 projects either sent additional evaluation reports or described in detail the methodology they were using.

1	External evaluation by university or equivalent	8
2	Internal evaluation	13
3	Feedback questionnaire or focus group from client, carer or social worker only	6
4	Undecided	3
5	Not enough detail given	2

A number of projects mentioned using assessment tools for analysis. Other projects may well have used externally validated assessment tools such as the SDQ in their work with clients but this was not specifically mentioned. Three projects had completed internal and external evaluations.

1	Assessment tools	3
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The amount of information provided by the projects was not comprehensive, so findings are not robust for this section. However, the evaluation reports that were read as part of this review were as much linked to larger organisational service review and PI's (e.g. reduce placement breakdown; improve educational achievement) as they were to monitoring the mental health of children and young people using the services. The methodology used by most projects was poor. The exceptions to this were the 'Fostering Changes' project in Southwark and the Leicester, Leicestershire and Rutland Joint Child Mental Health Strategy in Leicester.

10. Other information

Analysis in this section required the information obtained from the proforma completed by the project to be categorised into a range of outcome statements/measures. These are as follows:

	Categories	Number	Percentage
1	Responds to local needs	27	57%
2	Service based on evidence of effectiveness	13	28%
3	Clear objectives	28	60%
4	Feedback questionnaires for children, carers and professionals in service review	17	36%
5	Good communication between agencies	24	51%
6	Mechanisms for the meaningful participation of children in service review/development of service	4	9%

7	Specification of intended outcomes	23	49%
8	Evidence available of some outcomes being achieved	15	32%
9	Targets set in relation to outcomes	2	4%
10	Data collected against targets	4	9%

1.	No categories	7
2.	1 category	4
3.	2 categories	6
4.	3 categories	7
5.	4 categories	8
6.	5 categories	4
7.	6 categories	5
8.	7 categories	6

The majority of projects had more than one category (76.5%). 15% of the projects could not be listed in any category. In examining the spread of scores (from 0 to 7) the mid-point occurred in category 3. The average score was 5. The most common number of categories that each project had was 4.

11. Promising Practices

A number of the projects have developed specialist aspects to their services.

1	Specialist foster care programmes aimed at reducing placement breakdown	18
2	Initiatives aimed at increasing accessibility, take up and acceptability of mental health services amongst children and young people in care	5
3	Development in the assessment of mental health needs among the looked after population	13
4	Intensive, residential treatment programmes for children in crisis or with unmanageable behaviour	2

What is interesting is seeing that many projects recognising the importance of providing support to foster carers. Some projects do this alongside offering support to the child or young person, whilst other projects specialise in providing services to foster carers only.

12. Comments

Comments made by project workers/managers when completing the proforma indicate that there is insight into the range of difficulties many of the projects face with regard to lack of suitable staff, under-resourcing, lack of funding, and poor evaluations undertaken (in some cases no evaluations). Many of the returns were describing relatively new services in their first year of operation. So the need is being identified by the multi-agency community working with looked after children. One service had been commended by the SSI and Children First commission (Psychology team attached to the LOCATE service in Bath and North East Somerset) and one project was located in a beacon council (the Leicester, Leicestershire and Rutland Joint Child Mental Health Strategy in Leicester).

5. The Views of Young People in Care

THE VIEWS OF YOUNG PEOPLE IN CARE - SPECIALIST MENTAL HEALTH SERVICE PROVISION

INTRODUCTION

The views of young people in care are an important part of the jigsaw when trying to determine 'what works' in specialist mental health service provision for looked after young people. There have been a number of consultations with looked after young people in recent years but these have focused largely on prevalence and causes of mental health difficulties. We wanted to seek young people's views on service provision. Therefore, in August 2003 we carried out a small piece of research work with a group of young people with experience of the care system.

METHODOLOGY

Claire Turner and Sara Scott from Barnardo's Policy, Research and Influencing Unit carried out a focus group with five young people who are members of the YPInc group in Milton Keynes. This group meets regularly and provides an opportunity for looked after young people to meet, share social activities and get involved in the work of the Milton Keynes Children and Young People's Rights Service.

The aim of the focus group was to 'test out' models of service provision with young people, based on the examples received through our promising practice questionnaire (see chapter 6 for more details). We wanted to explore young peoples' ideas about 'what works' in providing emotional support for children and young people in care (see Figure 1 below for information leaflet).

We designed a number of focus group activities aimed at supporting young people to draw on their own experiences without having to share their personal stories in a group environment. The focus was on service development and support systems rather than on issues or causes of mental ill health.

Furthermore, we wanted to provide an opportunity for a two-way share of information. In addition to asking for young people's views, we shared information about the prevalence of mental health difficulties amongst young people in care and the findings from the promising practice questionnaires.

The group took part in a number of activities:

1. Introduction – what is mental health?

Young people were asked to brainstorm ideas about what mental health meant to them. This activity aimed to help break down barriers to discussing mental health and to contextualise the subsequent discussions: what are young people's definitions and associations with the term mental health?

2. Elements of specialist mental health service provision

The group was asked to prioritise elements of specialist service provision which were drawn from the promising practice examples. A diamond ranking exercise was used to aid discussion: elements of specialist mental health service provision were written on cards and young people were asked to create a diamond shape (or similar) with the cards in order to represent the elements they felt were most useful or important. The card at the top of the diamond represented the most useful/important and the card at the bottom the least useful/important.

3. Case studies

We presented the group with a number of short case studies about young people in care. In pairs, the young people were asked to reflect on the scenarios and suggest things that could help the young person in the case study. Ideas were then fed back to the rest of the group and discussed further. (See figure 2 for further details of the methodology.)

FINDINGS

Mental health

Young people adopted a very broad definition of mental health. This encompassed a spectrum of issues including relationship problems, arguments, stress, anger, depression, panic attacks, medication, 'feeling like you're not coping' and insanity. Some young people talked more about the causes of mental ill health, whereas others spoke about feelings and symptoms. Amongst the group there was a consensus that mental health covered a range of issues and experiences:

...there is so much in mental health though isn't there...

...it is not just relationship problems it is problems with exams or feeling that you not coping. There is loads of things...

Views on specialist mental health services

Unsurprisingly, young people found it difficult to prioritise the elements of specialist services. As a result, they did not produce a symmetrical diamond shape with their responses. Instead the group ranked the services under first, second and third headings as follows:

Rank	Specialist service
1.	Services that focus on stopping placements breaking down Information, advice and support for carers to help them support young people Young people being involved in designing services Services that support the whole family or placement
2.	Having a therapist allocated to a residential unit Young people having a say in their treatment or care Support services that are just for young people Training and support for staff in residential units to help them support young people Service which help with education issues as well as mental health
3.	A service which follows you if you move placement

The young people focused on a number of key issues during their discussions. These centred primarily on holistic support services, stopping placement breakdown, young people's involvement, needs-led services and services which follow young people if they move placement.

- Services which support the whole family or placement

The young people we spoke to felt it was important to offer support, not just to the young person in care, but to the other people in young people's lives, more particularly family members and carers:

It's everyone isn't it, it's not just the person (in care) it is everyone around them to (who needs support)

- Stopping placement breakdown

For the majority of young people who took part in the focus group placement breakdown was a central issue. On this basis, they placed importance on services that focused on stopping placement breakdown. Young people felt that when placements broke down this was likely to worsen any existing mental health difficulties. Stability was viewed as a key component of good mental health:

Placements breaking down are just going to make you feel worse. From our point of view that is what we are seeing...

- Involving young people in shaping services

Young people felt that looked after young people were best placed to advise on new or existing services specialist mental health services for young people in the care system. The young people in the group had experience of helping to recruit new staff and felt that this was a good way to involve young people in shaping services:

We interviewed some options workers for positions...because we know what we would expect them to be like...

You do get people with positions who have got no idea about how to talk to young people and how to relate to them don't you? And they have got to be able to do it. How's that going to work? How are they going to get the best out of the service if the person who is supposed to be the expert can't even speak to you?

- Needs-led services

Much of the group discussion related to the young peoples' personal preferences. For example, some young people thought that a therapist allocated to a residential unit was a good idea, whereas others preferred the idea of a more 'independent' support service. The key messages were that young people need to have choices and that services needed to be flexible in order to meet the range of needs of young people in care:

It depends what the young person wants, what they like...

And it depends on age as well...older young people are more likely to want to see someone for themselves and younger children might want someone they trust to go with them...

- Services which follow you if you move placement

At first glance this appears to be of low priority to the young people concerned as it was placed at the bottom of the table. In fact, the real reason for this was made clear upon further discussion. The young people we spoke felt that all services should follow you if you moved placement and that this should not simply be an element of specialist service provision:

I thought that would happen anyway...

...cos this should already happen. You shouldn't only have special services which only do this (follow young people if they move placement)

General support needs

Through the case studies young people explored more generally the emotional support needs of young people in care. Their responses have been clustered below:

- Mental health

The case studies enabled the young people to explore, in more depth, the issue of mental health. In relation to the examples given, the young people talked about anger, loss of control, fear and the need for attention. This highlighted the range of difficulties experienced by looked after young people:

He has got all that anger inside of him...he needs more attention...

...scared that she might end up like her Mum, losing it...

These foster parents are trying to replace his parents but at his age he is not going to understand...

- Practical solutions

The young people we spoke to suggested a number of practical solutions to the problems faced by the young people in the case studies, which could be applied more generally to young people in care:

Someone to talk to – this was an overriding message from the young people who took part in the focus group. From their feedback it didn't seem to matter who that person was as long as it was someone a young person could trust and feel comfortable with. The young people suggested that the following things made them feel comfortable with a person: a 'befriender', someone you can do ordinary things with – walk and talk, someone you get to know and someone who can keep confidentiality:

Someone she can trust, someone she can maybe relate to or anyone really.

And it has got to be someone she feels comfortable sitting down and talking to otherwise she is not going to open up about her problems.

Peer support – most of the young people felt that it would be useful to have support from someone with a shared understanding. They suggested that this could best come from someone with experience of the care system. The young people talked about how, in their experience, this already happened on an informal basis:

A How many people talk to me about their problems?

B A lot

A If they are talking to someone who has like just come out of care and it might help them because the person has been there themselves.

Extra support – the young people suggested that, at times, a young person may need more than just someone to talk to. They believed that it was beneficial to have some sort of a release whether that was physical or emotional:

A punch bag...a sort of physical release

Someone to help with the fears – remember, talk and get it out...

CONCLUSION

Naturally, it is not possible to draw any generalisations from the views of such a small group. However, what is evident from the messages from these young people is that they have clear ideas about what they want from mental health service provision.

They placed importance on needs-led, holistic support services which focus on stopping placement breakdown and offer support to young people with a range of emotions and experiences. Furthermore, they felt such services would benefit from young people's involvement. More generally they believed that all services should follow young people when they move placement and that having someone to talk to should be central to any support service for looked after young people.

It is recommended that further research is needed on looked after young people's experiences of and ideas for mental health service development in order to explore whether the views of this group are more widely held amongst young people in care.

Figure 1

YOUNG PEOPLE IN CARE

IMPROVING MENTAL HEALTH

What do you think makes a good mental health service?

Barnardo's are working on a project which is trying to find out the best ways to improve the mental health of young people in care. The project is working in the **UK, Greece and Belgium.**

As part of our work we have asked organisations across the UK to send us examples of work they are doing to help improve the mental health of young people in care. We would like to know what you think about these examples.

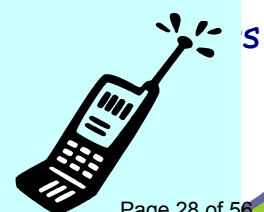
Could you give us some feedback on current services?

Telling us what you think would help and what

We would like to come along to your project in August and speak to a group of young people. It shouldn't take more than an hour and food and drink will be provided. We will use what you say in a report which will be presented at a conference in September. At the group session we will discuss how you would like feedback on what happens.



If you're interested in taking part please let someone at the project know. Or you could call or email Claire or Sara - we will be supported by people from Barnardo's who will be running the group session:



sometimes he shouts and smashes his room up. He can't concentrate at school and thinks he's treated like he's stupid. What does D need?

Y is 12, she was adopted when she was 8 and everyone thinks she has done really well to fit in with her new family but she had nightmares, sometimes she has them when she's awake, she bangs her head against the bedroom wall and pulls her hair out to make the nightmares go away, she hates to remember the things that happened to her when she was little but she can't help it and sometimes she wishes she was dead. What does Y need?

V is 15 she has been in care since she was 12 and although she has returned home a couple of times she is now in the residential unit. Her Mum has mental health problems and can't cope with V when she's not well, the rest of the family don't want to know, she is lonely and angry that nobody cares about her, she has weird thoughts sometimes and she thinks she is going to end up losing it, like her Mum.

6. Project Studies: Good Practice examples

A number of case studies have been selected as good practice examples according to identifiable criteria listed below. There was a long list of possible projects to include in this section. A number of projects from this list were chosen. Criteria for the short list included making sure the sample projects were located across England (and one in Scotland) and provide different examples of services for children and services specifically for carers.

Criteria for selection of 'promising practice' exemplars:

The research review clearly identifies some key issues in service development to meet the needs of looked after children. These are:

- The need for early identification of mental health needs amongst looked after children and young people.
- Services need to be non-stigmatising and both accessible and acceptable to children and young people in care.
- Initiatives are needed to increase placement stability for children with emotional and behavioural difficulties.
- The mental health outcomes of young people looked after in residential care are particularly poor.

The kinds of service development that are potentially most significant in relation to the most vulnerable of looked after children and young people are therefore:

- Specialist foster care programmes aiming to reduce placement breakdown for children with attachment and behavioural difficulties. Programmes include a range of additional training and support/consultancy for carers.
- Developments in the assessment of mental health needs amongst the looked after population.
- Initiatives aimed at increasing accessibility, take-up and acceptability of mental health services amongst teenagers and young people leaving care.
- Intensive, residential treatment programmes for looked-after children in crisis or with 'unmanageable' behaviour: self-harm, violence, eating disorders etc.

In addition to categorising services in terms of their contribution in these areas we will ask the following questions:

- Does the service/initiative respond to identified local needs?
- Is the service/initiative based on the best available evidence of effectiveness?
- Are its objectives clear?
- Do these include the specification of intended outcomes for looked after children?
- Are targets set in relation to outcomes?
- Is data collected against targets?
- Is there evidence available of outcomes being achieved?

- Are there mechanisms for the meaningful participation of children and young people in service review/development?
- Is there evidence of good communication between agencies to the benefit of looked after children?

Connections' in Dorset

- Background (service development history and policy context)

The 'Connections service' is one of the 24 CAMHS innovation projects jointly funded by the Department of Health from 1999-2004. The funding split is 70% monies provided by the DoH and match funding of 30% provided from both SSD and Health Authority. *(Funding received by the project: this is a gap and I need to chase information).*

The policy context for the identification of additional Government money for CAMHS support arose from 2 documents:

1. 'Together we stand' (Health Advisory Service, 1995)
2. 'Children in Mind' (Audit Commission, 1999)

The investment was considerable: £4 million each year for 3 years, and tapered funding during years 4 and 5. This money was essentially the first component designated for children and adolescents from the Mental Illness Specific Grant (MISG - now renamed the Mental Health Grant) that had been allocated to Local Authorities for years, for the development of mental health services for adults. The Department of Health has closely monitored the projects, and has funded a DOH project worker to oversee the projects as well as funded a children's mental health charity to write the over-arching evaluation report on the work of the projects.

- Project description (service provision, philosophy, evaluation and staffing)

Aims and objectives:

'Connections is an interagency project aimed at enabling a significantly higher level of provision of social care services for children and adolescents with mental illness.' (Mistral et al, 2002)¹

The remit of the project is to help looked after children who have disclosed abuse or whose profile indicates abuse and/or significant trauma, and young people who find it difficult to use conventional services. It aims to put in place a fast-track service with a range of interventions including art, drama and music therapies as well as psychotherapy, counselling and group work. Referrals are accepted from the responsible child care social worker. The service is open to

¹ Mistral et al wrote the evaluation report for the project. The authors of this report were all from the University of Bath.

children aged 8-18 in residential or foster care and provides a support package to carers as well as to the children themselves.

The aims of the project include:

- Reducing placement breakdown;
- Improving young people's access to mental health services;
- Avoiding the use of distant and expensive out of county placements;
- Reducing self-harm;
- Improving mental health.

Staffing:

1 project worker

1 social worker

1 social work assistant

1 administrator

Sessional therapists, commissioned to provide services

Services offered:

The project involves young people in planning intervention and collates information regarding their views of previously provided services. This process involves discussing the gender of the therapist, the venue, frequency of the sessions the materials that could be made available during the sessions, and so on. Because of the rural location it is expected that wherever possible, venues for sessions will be found in the area where the young person lives.

As well as traditional 'talking' therapies, the project can offer access to other types of activities such as horse-riding and other creative therapies, if these are assessed as being therapeutically beneficial.

For carers and professionals, the project offers training, consultation and education. The aim is to increase awareness around children's mental health and to increase the likelihood of placement stability for children by enhancing the skills and understanding of carers and professionals involved. The project will integrate with local CAMHS services, and will be funded as a mainstream service. The project has recently moved into new premises, comprising 7 therapy rooms, fully fitted kitchen, computer room and office space for project and sessional staff.

- Evaluation of project:

The mental health and research department at Bath University was responsible for writing the independent evaluation of the project. This report used quantitative and qualitative approaches and look at outcomes in terms of children's mental health, placement stability and educational issues.

Tools used to measure Children's mental health:

1. The strength and difficulties questionnaire.
2. Satisfaction questionnaire compiled by Bath University.
3. Interviews and focus groups completed by Bath University.

The methodology adopted for the evaluation involved creating a baseline from case summaries detailing the history of a number (62) of children /young people referred to Connections. A comparison group was obtained from studying the details of 18 young people from a neighbouring authority.

The particular areas identified against which outcome data is gathered and analysed is:

- Placement stability
- Challenging behaviour
- Young person/carer relationship
- Absconding behaviour
- Criminal activity
- Self harming/ risk-taking behaviour
- Education
- Attitude to mental health services
- General behaviour/presenting difficulties.

Outcome of evaluation:

+ve aspects of service

- Flexible young person centred service
- Young people were encouraged to at least try it! As a result many young people used the service, who otherwise would not have engaged with mental health services. Overall from the 62 young people reviewed in the evaluation, 8 (12%) refused to engage with the service at an early stage, resulting in no service.
- Wide variety of interventions and approaches available
- This project commissions services from a variety of therapists/ counsellors, depending on the need of the individual child. It can therefore be a lot more flexible than solely relying on the skillbase of a static team. *(This is the only service I know that offers this type of commissioned approach to service delivery)*

-ve aspects of service

- Comparison with national data re 'what works' with this client group is difficult, principally because the literature/evidence base in this field is very small.
- The approaches and interventions available to young people did not all have a therapeutic evidence base to support their effectiveness regarding long term success in reducing mental health difficulties in this client group

'Primary care and support project' in Worcester

- Background (service development history and policy context)

This project was established by Health, Education and SSD, and is joint financed with funding of £250,000 per annum. Initially this funding was agreed over 3 years from 1998-2001, including development of a pilot scheme. The project is managed by CAMHS.

In the initial stages of the development of the project an audit of local need was undertaken via questionnaire to local services, including foster carers and residential social workers. A number of conclusions were drawn from this exercise; the relevant ones are listed below:

1. A broad range of issues, needs and problems emerged, including difficulties in accessing the CAMHS service, dealing with challenging behaviour, the need for an out of hours support service and the lack of liaison between agencies;
2. The greatest perceived need was for psychological support and specialist training for carers;
3. Direct psychological support/intervention for carers and looked after children were also highlighted a needs
4. Improvements needed to be made with the education directorate, with an emphasis on developing joint service and improving understanding for carers of the education system via information and liaison.

The audit highlighted that those professionals supporting carers and looked after children saw the provision of a direct therapy service as a priority, with carers also expressing need for a more comprehensive support service to assist them in understanding the resulting emotional and behavioural issues as well as the systems they needed to deal with on a daily basis. This resulted in the project anchoring service development to the needs of carers and it gave practical direction, pulling the disciplines and agency perspectives into a holistic approach from the start. The project facilitators consider this to have been crucial in how the project has supported carers, placements and looked after children, as often it is difficult for carers and children to access services directly that meet their particular needs. Another added benefit of this approach described by the facilitators is the effect that this has had on the contributions made by stakeholder agencies, maximising skills and knowledge, and ultimately improving joint working at both a practice and strategic level.

- Project description (service provision, philosophy, evaluation and staffing)

The 'primary care and support project' is a multi-agency project that focuses on the provision of specialist support and training for specialist carers, foster carers and other professionals who work with children in Worcestershire.

Aims and objectives

The aims of the project are:

- To help establish an integrated service across Health, Education and SSD for carers, children and other professionals involved with Worcester looked after children system.
- To help promote positive, stable placements in the child's locality with the aim of reducing the number of moves a child has in their care career and the number of out of county placements.

- To provide direct support from the project to carers and children in the looked after system through consultation, specialist training and therapeutic input as appropriate, with particular reference to providing access to specialist knowledge of the psychological and emotional needs of looked after children.

Service provision:

The main focus for intervention is support to carers, the placement and the network around the looked after child or young person. Much of the activity does not involve direct intervention with the child but indirect work. This is done by increasing skills, knowledge and understanding of carers and others working with the child to promote consistency and a therapeutic environment to enable the child to develop attachments and build relationships, increase self-esteem, security, stability etc. Some short-term direct work with LAC children is undertaken if it supports this and is not available through mainstream CAMHS. Interventions are currently being developed, with carer and child together (Dan Hughes approach).

The following services were prioritised following the audit of need referred to previously:

1. Consultation, particularly relating to emotional needs of looked after children, attachment issues re. Behaviour, relationships, needs of carers, practical day-to-day management strategies to promote well-being and sharing of issues within the network to support the placement.
2. Liaison, to ensure links and communication across projects and services to promote interdisciplinary working and highlighting practice and policy issues/barriers to an integrated service.
3. Therapeutic support – planned telephone support to carers, home visits and office appointments, regular support to residential units, input to staff groups, psychological assessment of children, short term therapeutic intervention with children, group support to carers, interventions with carers and LAC together.
4. Training – specialised training and groupwork on attachments, parent training, education and health issues, behaviour etc.

Priority is given to:

1. Children whose placements were presenting difficulties for carers e.g. where education placement was unsteady; where children were experiencing relationship problems
2. Placements where children were exhibiting challenging and complex emotional and behavioural problems;
3. Involvement in placement planning and the assessment of needs.

Staffing:

This comprises:

- 1 FTE project manager
- 1.5 FTE social worker
- 0.2 FTE education psychologist

0.7 FTE B grade clinical psychologist
 0.8 FTE A grade clinical psychologist
 1 FTE administrator
 0.5 FTE team clerk

This is a mainstream project funded by Health and SSD and time allocation from Education. It is line managed jointly by Health and SSD. Project managers manage and supervise the service and individual disciplines have clinical supervision from their own discipline according to professional codes, and maintain link and identify with their own agency. A steering group provides input from senior staff from all three agencies and overall responsibility for the management of the project.

- Evaluation of project:

There have been 2 evaluation studies of the service: one external (University College Worcester) and one internal.

The methodology of the **external evaluation** comprises:

1. Semi-structured questionnaire during tape-recorded interviews;
2. Interviews of 12 residential and non-residential staff from health, education and social services, and 10 foster carers.

The evaluation methodology for the **internal study** comprised:

1. Collation of referral profile data
2. Ratings by project staff before and after consultations, which included assessment of the complexity, chronicity and difficulty of the problems and expected and actual outcomes of the consultations;
3. Consultation rating scales and feedback information from participants of consultations;
4. Pre and post questionnaires to group work participants;
5. Feedback forms for training;
6. Log of psychology input into the residential units.

Additional information was included in the evaluation study:

1. An independent evaluation of service user's satisfaction;
2. An independent evaluation of direct intervention with children by project staff;
3. Questionnaires to residential units;
4. A snapshot audit of liaison activity conducted over 1 week;
5. Education psychology log of all contacts over 1 year;
6. Clinical psychology log of additional support to foster carers over 1 year.

Outcome of evaluation:

The results of the external study were:

1. There had been an improved integration across agencies regarding services to looked after children seen by the project. The project had helped piece together the jigsaw for the carers

2. Areas of concern arose that could potentially hinder continued inter-agency integration:
 - A reliance upon the 'grapevine effect' for disseminating information;
 - Workers from outside of ssd were disadvantaged by not knowing about the project
 - Dissemination of written information had become lost in the plethora of materials circulating to professionals;
 - Some workers had concerns about the blurring of professional boundaries;
 - Some workers expressed reservations about who would be 'in charge' and take control of problematic foster placements.

1. There was evidence that the project had a positive input into placements
2. There was evidence that the project had a positive impact on the retention of foster carers and upon stabilising placements.
3. There was evidence to show that the project provided the intended direct support to carers and children/young people in the looked after system
4. The project had a clear influence upon the services for children and young people in the Worcester looked after system. Changes in practice were reported from those professionals interviewed.

The results of the internal study were:

1. The project had met its main aims and objectives, and the work of the project had been received well by the people who had used the service as well as strategically and this had led to a more integrated service for looked after children;
2. There were some tensions with regard to resource allocation to meet needs; outside agencies wanting to widen the brief of the project in order to refer children who were not receiving a service from other mainstream services; uncertainty about future funding which has affected recruitment and retention etc.
3. The provision of a range of services from a single point of access, underpinned by a common philosophy has meant a maximising of available resources.
4. The emphasis on providing support to meet the emotional need of carers and complex needs of children in the looked after system has identified the importance of recognising these needs. There was an added bonus of this service assisting with retaining foster carers, improving planning for children, helping prevent placement breakdown and help meet the therapeutic need of looked after children.

Comments made by the project manager:

'The project has been well received by all those involved. Integrated working requires a lot of thought, planning, energy and trust, not only at a service delivery level but also at a strategic planning level. This way of working often presents challenges to individuals, managers and agencies though undoubtedly represents a better way of delivering services to this group. Dedicated resources for this group are essential in order to achieve input appropriate to their needs but it shouldn't mean that other mainstream resources should not be available as well nor should it mean carers and support systems should not be able to access relevant expertise. The needs of looked after children are particularly complex and are set against the complexity of individual and hierarchical agency systems and funding arrangements where they compete alongside the needs of the general population. If we are serious about improving outcomes then funding, a compulsion to work together and more dedicated resources are required.'

'The Fostering Changes Programme' in Southwark (London)

- Background (service development history and policy context)

This project has links with the National Specialist Adoption and Fostering Team at Maudsley Hospital. This team is a multi-disciplinary clinical CAMHS team that provides assessment of children in foster placements and adoptive placements where difficulties have emerged. Over the years the feedback that the team has received from foster carers indicated a gap in practical skills and advice available to foster carers who were managing difficult behaviour exhibited by foster children. They expressed a need for specific support in managing and controlling disruptive behaviours.

Joint funding was received in 1998 by Health and Social Services to provide a service offering practical advice and skills development for foster carers.

- Project description (service provision, philosophy, evaluation and staffing)

Aims and objectives:

The aim of the project is to provide foster carers with practical skills in the management of child behaviour via training.

Service Provision:

A training course based on cognitive behavioural theory is provided. There are 2 different courses:

- One for carers of under 12's
- One for carers of teenagers

The group meets once a week for a three-hour session over 10 weeks. Groups consist of between 6-12 participants.

Each course has 4 essential components:

1. Introduction to social learning theory;
2. Using positive strategies to encourage pro-social behaviour;
3. Limit setting;
4. Additional issues which include problem-solving and stress management.

The course has been developed by drawing from various parent training programmes that have proved to be effective:

- Webster-Stratton, 1992;
- Neville et al, 1998;
- Sanders, 1999;
- Sutton, 1999

Learning principles adopted during the courses:

1. Collaboration or 'collaborative-mode' (Webster-Stratton and Herbert, 1994)
2. Respecting carers experience;
3. Active learning;
4. Empirical learning
5. Valuing carers
6. Having fun

Staffing:

1 part-time project worker

1 part-time co-ordinator

Support from other professionals associated with the Maudsley adoption and fostering team (social work, clinical psychology, child psychiatry).

There have been recent national advertisements for staff, indicating an expansion of this service in the near future.

- Evaluation of project:

Quantitative measures:

1. User satisfaction questionnaire (Webster-Stratton, 1989)
2. Carer Behaviour: Foster carers are asked to complete several short questionnaires including the Carer-Child Dysfunctional Interaction Scales from the Parenting Stress Index (Abidin, 1995)
3. Child behaviour: A number of scales are completed: Difficult child scale (from the Parenting Stress Index); Concerns about my child scale (Scott et al, 2001); Strengths and difficulties questionnaire (Goodman, 1999)

Outcome of evaluation:

+ve aspects

The evaluation suggests that for many carers the training brings about improvements in the emotions and behaviour of the children in their care and a better quality of relationships and interactions with them. It also had a beneficial effect on carers' sense of confidence and self-efficacy. Sinclair (in preparation) has found that carer confidence and child problems were the best predictors of placement breakdown. It is therefore likely that this training promotes the stability of placements and helps children form stable attachments through trusting relationships.

-ve aspects

The project believes that a controlled trial is now required to check that the improvements noted were due to the training, and would not have happened anyway and to see whether they are maintained over time.

The project wants to further develop its links with social workers, including district and fostering social workers.

The project is aware that current resources, placement availability; recruitment and retention issues and current policy changes are all factors which have enormous implications for placement choice for looked after children and consequently have an impact on the future development of this service.

SSLAC - Sheffield support service for looked after children

Background (service development history and policy context)

The service started in spring 1999 through a CAMHS Innovations Grant (guaranteed 3 years funding) this funding has been extended until April 2004 and is expected to continue. The team was established through the partnership of several agencies: NSPCC, Sheffield Social Services, Community Health Sheffield and Sheffield Education Authority. The service is managed by the NSPCC and has membership of the CAMHS strategy group.

The income for the service is predominantly from CAMHS, in addition to some funds from NSPCC and Social Services. Furthermore, contributions in kind come from Community Health Sheffield and Sheffield Education Authority.

Project description (service provision, philosophy, evaluation, staffing)

The overall aim of the project is to improve the mental health of LAC in Sheffield, aged 0 – 16. Over the 3 years 168 children have been referred to the service, of those 132 have received services, 65 for over 12 months. The service primarily works with LAC in residential and foster care and carries out limited work with children and families in adoption.

Referral process – initial referrals are identified by social services and priority is given to those who have unmet health needs, a number of moves within the care system and educational difficulties. Professionals can make subsequent referrals from social services, health, education and the voluntary sector. Referrals can also be made by foster carers and young people themselves.

The service offers a range of face to face **therapeutic work** with LAC (inside and outside schools): art therapy, play therapy, family therapy, Circle of Friends (Wilson and Newton 1999). In addition, SSLAC offers a support service to carers (this takes up between 25-30% of its work). The project points to the need for tenacity in engaging the young person/family, a long term commitment, a flexibility of approach e.g. working with non-attendance and effective 'working together' within the wider system.

The approach of the service has been informed by the need for coherent **networking** throughout the looked after system. Staff begin all work by hosting multi-agency meetings. A shared narrative and understanding is seen as central to success, as is a common language. The SSLAC consultation model is a consistent format for meetings, which explains the service, gathers a narrative of the young person, hears current concerns and sets out an action plan.

TRUS teams (the residential support teams) – SSLAC initiated the establishment of multi-agency support teams linked to residential units in July 1999. The teams were set up to provide an advisory resource for the units. Half yearly reviews of these teams are co-ordinated by SSLAC's education psychologist.

Typically, a TRUS team membership is made of: the manager of the residential unit and the unit's education link worker, one or two CAMHS professionals (clinical psychologist, community nurse, social worker/family therapist, an education psychologist and support teacher, a specialist nurse.

Residential unit managers within the support team negotiate how the team can be useful for the unit and a range of services have developed. Examples of work undertaken include: half-termly network meetings, training on a range of issues and consultation meetings.

An evaluation officer has been with the team for much of the project. YoungMinds are responsible for guidance and co-ordination of all CAMHS (innovation) funded projects in relation to monitoring and evaluation.

An annual report for 2002 is available which contains the findings of the evaluation. Data has been collected through monitoring information from referral forms, a strengths and difficulties questionnaire (Goodman 1997) for children and young people, 'user' feedback (children and young people, carers and parents and professionals). SSLAC stresses the importance of research, evaluation and reflective practice and uses this to inform its work. For example, a survey of foster carers identified training needs and subsequently, a training pack was designed and delivered by the service.

Central to the SSLAC model is working in partnership with other agencies and the service stresses the importance of a multi-disciplinary approach in addressing every dimension of a child's life. In addition, staff believe that there is a need for specialist but co-ordinated services for LAC.

Staffing:

- 2 art therapists (PT)
- 1 team manager (FT)
- 1 social worker (FT)
- 1 team administrators (FT)
- 1 clinical psychologists (FT)
- 1 play therapist (PT)
- 1 team secretary (PT)
- 1 educational psychologist (PT)

STARLAC

Background (service development history and policy context)

STARLAC is a partnership between the department of clinical psychology, RMCH and Salford Social Services Directorate as is supported by a multi-agency steering group. It is jointly funded by health and social services monies. Funding for social work post was obtained from mainstream funding in April 1999 and for 7 sessions of clinical psychology and health improvement monies in 1999. Further funding has been obtained from modernisation monies. The project has increased its staff team over time. The service was established following identified need, in line with Quality Protects Objectives.

Project description (service provision, philosophy, evaluation and staffing)

The target group for the service is all children looked after by the local authority. The service works on issues around mental health and promoting permanency of placements. Its main objectives are:

- To provide clinical psychology service in collaboration with social services, residential and family placements services to LAC
- To liaise effectively with CAMHS within the city in relation to LAC
- To provide a responsive service that is accessible to children, young people, carers and frontline staff, uniformly provided across the city and sensitive to ethnic and cultural diversity

The service receives referrals from social workers, residential social workers, family placement workers, child and adolescent psychiatry and GPs.

The main activities of the service are:

- Individual therapeutic work with children and young people
- Individual work with foster carers promoting understanding and management of young people's difficulties

STARLAC emphasises the value of working at a systematic/organisational level, with a view to contributing a psychological perspective. As such they offer:

- Consultation and support to residential and field social work staff
- Consultation to a number of individual children's residential homes
- Training for frontline worker on issues related to the mental health needs of LAC

Staffing:

- 4 x clinical psychologists (1.3 wte)
- 1 x child and adolescent psychotherapist (0.2 wte)
- 1 x social worker (1 wte)

Addressing the mental health needs of looked after children in Glasgow**Background (service development history and policy context)**

- Clinicians in paediatrics and psychology recognised the need for *specific* work with LAC.
- SWs repeatedly frustrated when referrals of LAC to CAMHS came back: "Can't help because there's no mental illness".

The intention to develop a strategy was inspired by *Together we stand* (Health Advisory Service, 1995) which highlighted the need for better co-ordinated, more accessible and integrated services for young people, especially those at greatest risk of mental ill health in later life. The tiered model of services proposed by *Together we stand* insisted that identification, assessment and intervention happen earlier, at a lower level (Tier 1), and that staff/carers who deal directly with young people are better trained and supported and their work valued and legitimised. In addition the *Looking After Children in Scotland* materials (Scottish Office, 1997) focussed on the contribution of the day to day experiences of looked after children to their poor outcomes in relation to education, offending and social exclusion in later life – including their over-representation in adult psychiatric services:

Unfortunately some young people still experience the 'care system' as one that seems specifically designed to maximise their chances of suffering from a mental health problem.

Friday, 1998: 17

Who Cares? Scotland

In 1999 The Scottish Office invited bids for the Mental Health Development Fund. Three MH&LAC projects were initiated (funded for 1 year).

Project description (service provision, philosophy, evaluation and staffing)

The three new projects were:

1. Assessment programme (Christine DelPriore)– one-off assessment for every child at entry into care and provision of positive tailored advice in relation to child's needs, development of emotional vocabulary etc.
2. Open Door (Michael Van Beinum) was linked closely with Social Services in East Dumbarton. The team attached themselves to three very small residential units (set up after the closure of a larger 10 bed unit) and worked very closely with the staff – providing a weekly clinic for consultation and direct work. The guiding principle was the skills

identified as the province of mental health professionals had to be made available to, and translated into practical tools for front-line social work staff. Care staff had to become familiar and comfortable with operating in areas normally reserved for 'high status' child mental health professionals. THE CONVICTION THAT THE WORK OF THOSE DIRECTLY INVOLVED WITH YOUNG PEOPLE IS AT LEAST IF NOT MORE VALUABLE THAN THE WORK OF CLINICIANS is now well supported by research (Arcellus, Bellerby and Vostanis, 1999; Cottrell et al, 2000).

- In its first year Open Door provided 176 consultations and 102 assessments and clinical sessions.
- They worked with the Scottish Institute for Human Relations to provide training in psychoanalytic approaches to child development for the staff.
- Reasonably stable staff team and lower levels of formal psychiatric illness than in Oxfordshire or Glasgow studies.
- Evaluation conducted by Scottish Health Feedback and reports are available. Open Door is interested in developing longer-term evaluation tools and techniques to try to assess the impact of services on outcomes for young people.
- Project ongoing and will become part of permanent service.

Staffing:

FT psychologist

FT social worker

.2 psychiatrist

3. LACES (Graham Bryce) A team in East Glasgow based on (social work) answers to the question 'If we had a good mental health service what would it look like?'
 - Not diagnosis lead
 - Available to those in settled placements too
 - Works with and through foster carers and residential staff
 - Continuous when children move health authorities

Starting point is a consultation on *any* referral. Whole approach is consultative – about a third is consultation to foster carers. The aim is to increase confidence of carers in order that they can provide more containment for the child. Based on belief that understanding the origins of a problem will lead to better communication with a child. Help them understand the dilemma of trusting new carers from a child's point of view and ask: 'what is it about you and this child that isn't clicking?' Often have to overcome the 'rugged self-sufficiency of short-term foster carers'. Direct work takes various patterns: consultation with carers only (under 9s), parallel sessions with carers and child; family therapy and individual work with adolescents.

Across the three pilot schemes there has been real interest in evaluation and the difficulties of effective evaluation. LACES wanted to evaluate project re outcomes to be able to answer the question: does a tailored MH intervention make a difference? And does it make any more of a difference than foster parent training? However, LREC insisted that in order to administer Strengths and Difficulties through carers the consent of both child and parent

with responsibility was required. Impossible so, have only been able to administer a carers questionnaire.

Staffing:

Half-time psychiatrist

FT assistant psychologist

FT nurse specialist

Cost £150,000 in 02/03, £300,000 in 03/04

As well as the above there is a leaving care project: The Big Step which is not formally a MH project but with which the other services are increasingly working.

Projects 1,2 & 3 are going to be brought together within the Child Health team (rather than Child and Family Psychiatry) and going city-wide (referring some work on to the community teams but providing initial consultation, consultation to foster carers and residential work themselves) . No prior assumptions about which discipline should lead (but interestingly there is no social worker in planned team). Mainstream funding is being provided for:

1x B grade psychologist

2x A grade psychologist

1x nurse therapist

2x H/G grade nurses

1x psychiatrist

1x family therapist

1x child psychotherapist

1x senior manager (probably)

The Leicester, Leicestershire and Rutland Joint Child Mental Health Strategy

(Panos Vostanis, Consultant Child and Adolescent Psychiatrist) Service has NHS Beacon Status.

The Leicestershire Partnership Trust's young people's team was set up in 2002 to provide a service to hard-to-reach young people who were:

- Homeless
- Young offenders
- Looked-after

The staffing consists of:

4 x primary mental health workers for homeless children and families

4 x primary mental health workers for two youth offending teams (YOTs)
2 x primary mental health workers for the looked after population
2 x psychologists
1 x psychiatrist

However, in addition the CAMHS already has a specialist therapeutic social work team covering the same area and providing long-term psychotherapy. This team includes two psychologists and a psychiatrist. This is why the two PMHWs focus on consultation to carers and joint work with social work staff (each residential unit has a designated PMHW as their link to MH services). The aim is 'to empower frontline staff and carers with basic mental health skills' so they are better able to identify those at risk of difficulties and can 'build resilience'. They do some direct work with YP who don't 'meet the threshold' for seeing a psy-professional.

The total population in care in the health district is c. 800 about 100 of which are in residential care and the rest fostered.

The direct work with young people during the first phase of the service has been evaluated (50 consecutive referrals to team). We have no information on which professionals were providing the therapy or how much was individual/with carer, or whether the intervention was cognitive-behavioural or 'brief psychodynamic'. There was no control group so it is impossible to accord responsibility for improvement to the intervention rather than to increased placement stability or other factors. Evaluation tools used at point of referral and follow up at 5 months:

- HoNOSCA scales
- SDQ
- Service satisfaction questionnaire

At follow-up statistically significant differences showed on the following scales:

- Disruptive, anti-social or aggressive behaviour
- Self injury
- Emotional and related symptoms
- Family life and relationships

Almost all carers thought the service offered was appropriate to the needs of the young person in their care; half thought it had been effective and 71% that there had been at least some improvement during treatment. 65% felt they had learnt new MH skills in interaction with the clinician.

Amongst the 12 young people interviewed at follow-up three quarters felt they had been helped.

7. Discussion of results:

This project gave us the opportunity to examine whether the current mental health services provided to children in public care were making a significant difference to the lives of these vulnerable children. Some of the results confirmed what was known about current service provision (i.e. that this is currently an area of expansion and development; the majority of services are provided by multi-professional teams; joint funding arrangements exist, etc.), whilst other results were more surprising (i.e. the low number of service evaluations undertaken).

What has become clear from undertaking this research is that many more areas for development exist, especially if the current UK Government interest in this area (including an increase of resources) is going to be used to full advantage. The first important finding in relation to this point concerns many of the projects' descriptions of their aims and objectives and how this then links to the methods of evaluation chosen to demonstrate outcomes. Our research found that frequently the relationship between objectives and measurable quantitative outcomes was poor. Additionally very little qualitative outcomes were also used. Where outcomes and evaluations did occur, there was no consistent methodology used between projects to enable any comparison across projects. This is a lost opportunity, but also reflects the results of an earlier study commissioned by the Department of Health evaluating the Department of Health funded 24 CAMHS innovation projects (Kurtz and James, 2003).

The majority of services are multi-disciplinary with split funding arrangements involving at least Health and SSD. Most are based in CAMHS and line-managed through CAMHS. The favoured management model was via a 'steering group' with stakeholder representation. Evaluating the results of such funding arrangements is crucial in understanding how organisations work together to safeguard the welfare of vulnerable children, including sharing resources and responsibilities for service development. The development of 'seamless services' across organisational boundaries is of great political interest, so there is benefit in further examining this area.

From a child's rights perspective, our research showed that there is still a lot more to be done to ensure that the views and wishes of children and young people are heard and shared across the board with service providers as well as policy makers. Some services made no attempt to take on board the views of children and young people in the development of their service. This also includes the steering group.

One of the other points emerging from this study is individual project's limited use of the 'evidence base' in respect of 'what works' with this client group to support provision of and development of services to children in public care. Very few projects were able to be specific about the type of interventions they offered to children and young people with mental health difficulties. Most services offered generalised assessments and interventions. More work needs to occur examining how projects use the evidence base and skills available to them with regard to interventions and how they in-turn contribute to the knowledge base in this area. Social care and health are very good at responding by 'doing something'. However, Macdonald, (2001:xviii) observes that,

'...having good intentions is not enough; the helping professions have an immense capacity to do harm as well as good, and there is ample evidence that we tend to overestimate the latter and underestimate the former.' The question that must be addressed is whether what is being done is effective? Clearly this is a difficult question as not all changes in behaviour and emotional health shown by children and young people during the course of referral, assessment and therapy/intervention can be solely attributed to the mental health practitioner. For looked after children complex factors are often at play and variables cannot be isolated to prove the link between change and behaviour and successful intervention. It would be very difficult to demonstrate a causal link between the outcomes identified by the projects and the cause of the positive change for the child being achieved directly because of the intervention of the project. Indeed this section has resulted in more questions for the reviewers concerning the evaluation methodology adopted by many of the projects and how outcome measures are identified and agreed.

This research also examined which professionals were involved in providing mental health services to looked after children. Overwhelmingly in the projects canvassed for this study, the most common professional employed in these specialist projects was a social worker. Given that Meltzer et al (2003) reports a very high rate of psychiatric disorder amongst this population of children, it is surprising that social work staff are given primary responsibility for supporting very vulnerable children given their limited training in this area. Wolkind (1989) offered similar observations. He notes that;

- Children in care have been cared for by people who are expected to be experts on the emotional needs of children, who often do not have the necessary training to support them in dealing with difficult and demanding behaviour;
- As a group children in care have a higher risk of psychiatric ill health and social deviance than any other easily identified group in society;
- As adults, people who have been in care are more likely than others to look back on their childhood as having been an unpleasant and sad experience;

'Taken together, these three facts should be a totally unacceptable statement for a society that claims to care for its children'.

Wolkind, 1989:37

The question must be asked as to whether social workers currently have the necessary skills and knowledge base to effectively work with these vulnerable children in a prime capacity, given the type of behaviours and difficulties that children are presenting with. Is the match between the services available and the needs of the children, the right one? Additionally, are the projects operating at the right level? In CAMHS tiers most projects are operating at level 1 or 2 (out of a possible 5 levels, where 1 is general universal services and 5 is very specialist hospital based services). Is this right for the level of need within the looked after children population?

In addition to this point, currently there is confusion and uncertainty about who is 'in charge' of the mental health and welfare of individual children. There are differences of professional opinion as to whether a child psychiatrist is required to take overall clinical responsibility for mental health

work with children. This debate needs to occur between stakeholders, including social care and health, so that the expectations and responsibilities of partner organisations is clear.

In summary, the conclusions reached by the project team are:

- Currently there is no consistent way of evaluating 'what works' with this client group, which means that results from the work of the projects can not be easily compared across projects. The overview of the 24 projects funded by the DOH is a useful starting point in this area, but their evaluation points to the same difficulties (Kurtz and James, 2003). One of the recommendations arising from the study is that guidance should be given on a reasonably rigorous methodology for evaluation that could be applied across CAMHS work with looked after children that could take into account the different interventions and form of service offered to these children;
- The majority of the projects do not appear to be providing robust enough services for looked after children, and many of the evaluations are poor.
- Short term interventions are not shown to be effective, yet they are the favoured model of service delivery by agency stakeholders. This presents the practitioner and service with difficulties;
- Managing the multi-agency aspects of the projects has had mixed success and presents stakeholders with challenges. Invariably these projects have a range of stakeholders, including health and social care. Depending on local partnerships and arrangements for working across agency boundaries, including line management responsibilities for projects and individual staff working in the projects, sources of tension can dramatically affect the success/failure of projects.
- Additionally, projects that attract new funding and new resources can attract an element of professional jealousy from other mainstream CAMHS services who do not enjoy the level of resourcing of the time-limited project, but face many of the same issues.
- There is a chronic shortage of suitably qualified staff in all key areas is impacting on the service offered to looked after children. Currently there are shortages in staff in many of the professional groups employed in this area of work. Invariably these teams are not fully staffed, which has implications on the amount of throughput of the service, and the staff in the service may not be from the desired professional background.

The challenges are:

- How to involve service users in the (individual and service/policy) development of the service in a meaningful way that is not just tokenism;
- How to engage young people in receiving services. The experience of some of the projects (e.g. 'Connexions' in Dorset) is that this can be done, however there are resource implications. Often this means working outside of the traditional CAMHS model of service delivery (i.e. from 9-5, for 50 minute sessions held at a hospital outpatients clinic that the young person travels to each week for a series of sessions), and managing an appointment

system that fits with school and home life commitment of the child or young person. This is especially relevant for looked after children who may have missed long periods of school at some stage in their academic history.

- Professional conflicts have emerged regarding whether it is appropriate to undertake therapeutic work with children 'in transition'. Further debate is needed as many of the children who require mental health services are children 'in transition', where decisions still have to be made about permanency plans;
- The development of the National Service Framework for children by the Department of Health (due out later this year) will assist in the drive in continuing to mainstream specialist services (including mental health) for looked after children in the UK. There should be better systems in place to undertake earlier detection of mental health issues within the looked after system. Assessing the mental health of looked after children and providing services should be a measurable Performance Indicator;
- There is a need to develop a holistic service that does not just provide services to the child but also to the network of people involved caring for the child and providing services to the child (e.g. social workers, teachers, residential social workers and foster carers).

8. Conclusion.

Themes and Recommendations

The recommendations will differentiate between the micro-level and macro level to consider practice and policy implications as well as highlight recommendations for improvement in services.

Micro Level

Recommendation:

1. That robust evaluation methods are considered by all projects with regard to providing and strengthening evidence that whatever services projects are providing are based on evidence from the mental health literature concerning 'what works' and that evaluations and reviews of services are regular. It would assist if the evaluations followed a similar methodology, as then results could be disseminated across the projects. In addition efforts to improve children's mental health need to be planned and evaluated in a coherent strategy across and between agencies (BMA, 1999; Audit Commission, 1999);

Recommendation

2. There should be a central information service register of all mental health projects specifically for looked after children, either an extension of the FOCUS publication, or via a voluntary organisation such as 'Young Minds'. This occurs already within informal channels but information exchange does not routinely occur across the country. As yet the implication of Children's Social Services joining with the Government Department of Education and Skills (as per the Green Paper) remains unknown for those services that are more traditionally located within Health, such as CAMHS. For those local authorities, PCT's and mental health trusts still in the process of setting up specialist services, information on evaluation and learning regarding process would save time and many mistakes being repeated.

Recommendation

3. That management hierarchies and links between multi-agency stakeholders are debated at an early stage, including how services are provided; how to consult with users of services, the professional skills of staff and attitude of staff working with children (Audit Commission 1999; Mental Health Foundation, 1999). Working in partnership across organisational boundaries is the aim; the provision of a seamless service is the objective, but both are difficult to achieve in reality without willingness, co-operation, skill and negotiation throughout the different hierarchical levels within the organisation.

Recommendation

4. Some funding should be preserved for prevention and early intervention, despite high demand for acute services;

Recommendation

5. There should be better systems in place to undertake earlier detection of mental health issues within the looked after system. Children coming in to care should be routinely screened for mental health issues by qualified staff as this could lead to earlier access to services and better support being provided to foster carers and residential staff on issues to do with managing difficult and or challenging behaviour. No project that we came across had a model based on this type of intervention. All direct service projects worked with the child or young person following a referral from a professional once they were in care. This type of approach would build on an earlier Scottish study (Dimigen et al, 1999) and would provide information for service planning based on local need.

Macro Level

Theme:

6. The NHS, Social Care and Health modernisation agenda assumes that there is a core of skills amongst professionals. There is such a recruitment and retention problem within social care and health currently that this cannot fail to impact on staffing of specialist projects, and this is likely to be the reality for quite some time.

Theme:

7. Recent Government funding (£84 million for CAMHS modernisation, £500 million for Sure Start (under 5's services), expanded role for health visitors, and increased state benefits are all encouraging developments, but ring hollow when services at a local level are still facing cuts and closures (BMA, 1999:147).

Recommendation:

8. The Central Government resources allocated for development of mental health services for looked after children should continue to be ringfenced, so that services can be created for this vulnerable group of children throughout England. Hopefully this will avoid the 'postcode lottery' approach to service provision as each area will receive 'new money' for service creation.

Recommendation:

9. The Department of Health (and new equivalent in the DFeS) should have the mental health of looked after children as a measurable PI in routine statistical returns, along with physical health and educational achievement. Currently there is no PI and so immediately the mental health of looked after children is less important. As a result there is no standardised methodology to information collation, no benchmarking, and no comparison.

Conclusion

In summary, in the UK mental health issues for children in public care is a huge problem that has not been given the profile it needs. In our study we found this to be the case not only in England, but in Belgium and Greece too.

In England historically this area of service has been under-resourced. The Audit Commission (1999) described Child and Adolescent Mental Health Services (CAMHS) as a 'postcode lottery'. In other words it depended on where you lived as to what sort of service you received. Some children waited over 2 years to be seen by a mental health specialist. The cost of this under-resourcing and lack of focus has been borne by the damage to these vulnerable children and the impact of this damage has been most acutely felt by the carers of these children.

The challenge now is to better understand the mental health needs of children in state/public care and how these needs can be met by services designed to meet their needs. The role of research and service evaluation is crucial in determining 'what works' and whether what is being provided is making a positive difference toward improving the lives of these vulnerable children. This project has enabled an examination of the current issues facing the development of services to children and young people in state care in England, and it is hoped that the dissemination of the results of this project will assist in improving mental health services to children in public care in every sphere of their development.

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Appendix

Appendix 1: The Mental Health of Children in State Care: Promising Practice Questionnaire

A pro-forma for telephone interviews with service managers.

1. Give description of overall project and specific UK study of 'promising practice'.
2. Name and title of interviewee
3. Name and title of project manager (if other than interviewee)
4. Brief description of service (staffing, funding, management etc)
5. Brief description of client group (age range, source of referrals, catchment area etc)
6. How and when was the service set up?
7. Did the service/initiative respond to identified local needs/problems?
8. What are the overall objectives of the service/project?
9. (If not included in above) What are the intended outcomes for looked after children of using the service?
10. Is there evidence available of these outcomes being achieved? (If 'no'/anecdotal only, ask if any evaluation of the service is underway or planned? If 'yes' ask about methodology of evaluation?)
11. What evidence was drawn upon in planning, designing and developing the service? (Follow up with questions about the theory-behind-the-practice or the theoretical affiliations of senior practitioners)
12. How do children and young people participate in service review/development?
13. How do carers participate?

14. What are the strengths and weaknesses of local liaison/communication between agencies working with looked after children? How does this impact on the outcomes for children? (Prompt for information: Joint Strategy, new Identification, Tracking and Referral arrangements etc)

Project documentation needs to be requested as follows:

1. Letter head information (Project name, address, public telephone number etc)
2. Statement of service objectives
3. Philosophy of care
4. Most recent annual report
5. Most recent Inspection report (if relevant)

Interviewees should be informed that this information will be used to produce a directory of UK services and initiatives.

Interviewers assessment

Does the project/initiative fall into one of the following categories:

- A. Specialist foster care programmes aiming to reduce placement breakdown
- B. Developments in the assessment of mental health needs among LAC
- C. Initiatives to increase access to mental health services by teenagers and young people leaving care.
- D. Intensive, residential treatment programmes for children in crisis or with 'unmanageable' behaviour.
- E. Please categorise

On the basis of this interview what is your *impression* of the strengths of this service/project in relation to the following factors:

Clarity of outcome objectives	Very Strong/Strong/Moderate/Weak/Very Weak
Evidence base	Very Strong/Strong/Moderate/Weak/Very Weak
Evaluation	Very Strong/Strong/Moderate/Weak/Very Weak
Achievement of outcomes	Very Strong/Strong/Moderate/Weak/Very Weak
Participation of young people	Very Strong/Strong/Moderate/Weak/Very Weak
Participation of carers	Very Strong/Strong/Moderate/Weak/Very Weak
Inter-agency working	Very Strong/Strong/Moderate/Weak/Very Weak

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