social care
institute for excellence

Improving mental health and emotional wellbeing support for children and young people in care

Project Scope

Table of contents

Introduction

This document sets out the context for the project, current services and practices, relevant legislation and guidance, and outlines the project scope.

The working title for the project is 'Improving mental health and emotional wellbeing support for children and young people in care'.

Project Context

1. Background

1.1 The Social Care Institute of Excellence (SCIE) has been asked by the Department of Health to develop care pathways, models of care and quality principles (referred to in this document collectively as 'guidance') to help ensure that in the future there is better access to high quality services to address the mental health and wellbeing needs of looked after children, those adopted from care and care leavers. The project also involves producing tools to encourage and support their use.

1.2 The project will focus on:

- Looked after children as defined by the Children Act 1989 and accompanying statutory guidance;
- Care leavers – eligible, relevant and former relevant children up to the age of 25 as defined under the Children (Leaving Care) Act 2000;
- Children who have ceased to be looked after under special guardianship arrangement orders or through being adopted from care.

In this document, the term 'looked after children' is used to encompass the groups above, although we recognise that this term is contested, and there is a preference in the sector to refer to 'children and young people in care.'

1.3 All looked after children are in scope for the purposes of this project. If the guidance is to be successful then it must address the needs of looked after children in general. However, as the work progresses, it may be necessary to consider the particular needs of certain groups within the looked after children population, for example, looked after children on remand, unaccompanied asylum seeking and trafficked children, and children who have returned to their birth parents. The precise approach to this will be considered further by the Expert Group once the work is underway.

1.4 **T**he pathway(s), models of care and quality principles will cover services supporting looked after children's emotional wellbeing and mental health needs. Further detail on this scope is on page 21.

2. The need for this project

2.1 The importance of supporting the emotional and mental wellbeing of looked after children has been outlined in a number of recent statutory guidance and policy documents, in particular in the joint Department of Health and Department for Education 2015 guidance *Promoting the health and wellbeing of looked after children,*[1] the report of the Children and Young People's Mental Health and Wellbeing Taskforce *Future in Mind*[2], and the recent report of the House of Commons Education Committee *Mental health and wellbeing of looked after children.*[3]

2.2 There is recognition that looked after children require support, partly related to the reasons behind their entry to the care system: 62% of looked after children are placed in care because of abuse or neglect, which can have a significant and lasting impact on their mental health and emotional wellbeing.[4] However, according to a recent study by the Children's Society, many looked after children are not receiving the support they need, nor is the information relating to their mental health widely available, with only five trusts out of the 36 that responded able to provide information on children from vulnerable groups.[5] In addition, the study provides evidence that among these 36 trusts almost a third of children from vulnerable groups did not have their referral accepted and 15% of these were not accepted without further action (i.e. a signposting to another service). Previous studies also found that, of the 63% of looked after children who were assessed as having a mental health problem, only one third (32%) received support from CAMHS.[6]

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[1] Department of Health et al (2015) *Statutory guidance on Promoting the Health and wellbeing of Looked after Children*, Nottingham: DfE and DH

[2] Department of Health and NHS England (2015) *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.* London: Department of Health and NHS England

[3] House of Commons Education Committee (2016): *Mental health and wellbeing of looked after children*, HC 481 2015-2016.

[4] Department for Education (2014), *Children in care*, report by the Comptroller and Auditor General ,HC 787 2014-15

[5] Abdinasir,K., and I, Pona., (2015) *Access Denied: A teenager's pathway through the mental health system*. The Children's Society, London

[6] Bonfield, S ., Collins, S., et al (2010) Help-seeking by Foster-Carers for their 'Looked after' Children: The role of mental health literacy and treatment attitudes, *British Journal of Social Work*, No. 40. Pages 1335-1352.

2.3 In order to meet these needs the 2015 statutory guidance *Promoting the health and wellbeing of looked after children* emphasises that under the Children Act 1989, CCGs and NHS England have a duty to comply with requests from a local authority to help them provide support and services to looked after children, and that cooperation between local authorities, CCGs and NHS England is required under section 10 of the Children Act 2004.[7]

2.4 In order to build upon these duties *Future in Mind* promotes the development of a "flexible integrated system to meet the needs of vulnerable children and young people".[8] The report proposes that:

> "Commissioners and providers across education, health, social care and youth justice working together to develop appropriate and bespoke care pathways that incorporate models of effective evidence-based interventions for vulnerable children and young people".[9]

2.5 This project aims to support this development, across commissioning and practice, by providing evidence based guidance on current best practice in relation to care pathways and models of care for looked after children with mental health and wellbeing difficulties. The guidance will focus upon the experiences and needs of this vulnerable group recognising that, as highlighted in *Future in Mind:*

> "If we can get it right for the most vulnerable, such as looked after children and care leavers, then it is more likely we will get it right for all those in need".[10]

[7] Department of Health et al (2015) *Statutory guidance on Promoting the Health and wellbeing of Looked after Children*, Nottingham: DCSF
[8] Department of Health and NHS England (2015) *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.* London: Department of Health and NHS England (p. 51)
[9] Ibid. (p. 55)
[10] Ibid. (p. 51)

3. Key Facts and Figures

3.1 Children and young people in care are specified as a vulnerable group under the United Nations Convention on the Rights of the Child (UNCRC).[11] The convention highlights areas of key importance to this group through articles, 9, 20, 21, 22 and 25 mainly defining state responsibilities, including those concerning the need for regular reviews.[12]

3.2 In the year ending 31 March 2015, a total of 69,540 children were looked after by local authorities in England – which represents 60 per 10,000 children under 18 years. Children aged between 10 and 15 years represent the majority of the looked after population (38%), while children under one year old are in a minority (5% of the looked after population). The looked after population includes more boys than girls (55% compared with 45%). The majority of the looked after population is White (77%), with Mixed groups and Black or Black British making up approximately 9% and 7% of the looked after population respectively.[13]

3.3 There were 31,100 children who ceased to be looked after during the year ending 31 March 2015. In 2015, 8,410 children aged 1-4 ceased to be looked after. In 2015, there were 7,390 children who ceased to be looked after when they were 18 years old, and this represents 24% of all children ceasing to be looked after. In 2015 there were 26,330 former care leavers aged 19, 20 or 21.[14]

3.4 Children and young people in care are substantially more likely to have low subjective wellbeing than other children, with 52% of children in care having low subjective wellbeing compared to around 10% of children in the general population.[15] Further to this, according to recent NICE guidance, 60% of looked after children and 72% of those in residential care have a level of emotional and mental health problems.[16] In addition, children and young people in care are also are at increased risk of all childhood mental, emotional and behavioural problems, and six to seven times more likely to have conduct disorders.[17]

3.5 In terms of future outcomes, research has consistently found that for young people leaving care, their health and wellbeing is poorer than that of young people who have never been in care. Compared to within three months of leaving care, young people interviewed a year later were almost twice as likely to have

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[11] United Nations (1989) *United Nations Convention on the Rights of the Child (UNCRC)*, Geneva: United Nations.
[12] Article 9 of the convention emphasises the importance of family life, except when this is not in the best interests of a child; article 20 lays out the responsibilities of the state to children who enter public care; article 21 describes the place of adoption; article 22 summarises governmental responsibilities to asylum-seeking and refugee children. 25 outlines the need for regular reviews of a child's plan while in care, which is called a statutory review in England
[13] Department for Education (2015) *Children looked after in England including adoption: 2014 to 2015*
[14] The cohort for former care leavers was extended in 2014 to 20- and 21-year-olds and also changed to cover those looked after for a total of at least 13 weeks after their 14th birthday including some time after their 16th birthday.
[15] Rees G, Bradshaw J, Goswami H & Keung A (2010a) Understanding Children's Wellbeing: A national survey of young people's wellbeing. London: The Children's Society
[16] NICE (2010): *Promoting the quality of life of looked after children and young people*. London, NICE.
[17] HM Government (2012) Preventing Suicide in England; A Cross-Government Outcomes Strategy to Save Lives. London: DH

problems with drugs or alcohol (increased from 18% to 32%) and to report mental health problems (12% to 24%).[18] Children and young people in care and care leavers are between four and five times more likely to self-harm in adulthood.[19]

3.6 More recent data is available via local authority reporting of Strengths and Difficulties Questionnaire (SDQ) results. The Strengths and Difficulties Questionnaire should be completed for every child looked after for at least 12 months and aged 5 to 16 years old. 2015 returns show that half of all children looked after for at least 12 months at 31 March 2015 had 'normal' emotional and behavioural health.[20] A further 13% had emotional and behavioural health that is considered borderline and for 37%, it was considered to be a cause for concern.

3.7 Children and young people in care placed outside their home local authority in particular face additional risks to their health and wellbeing. As of 31st March 2014, there were 68,840 children looked after in England – of these 26,090 (38%) were placed outside their local authority and 9,120 (13%) were more than 20 miles away from home outside the local authority area. With little or no family contact and a lack of support networks those placed out of area face the additional issue of confusion in relation to responsibility for funding and the carrying out of health assessments.

[18] Children's Society and the Church of England (2015) *A joint evidence submission to the House of Commons Education Committee relating to mental health and wellbeing of looked after children.*
[19] Children & Young People's Health Outcomes Forum (2012), *Report of the children and young people's health outcomes forum*. London: DH
[20] Department for Education (2015) *Children looked after in England including adoption: 2014 to 2015. London.*

Current services

4. Definitions of wellbeing and mental health

4.1 Mental health encompasses wellbeing and is defined, by the World Health Organization (2005) as:

> "A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[21]

4.2 Wellbeing can be understood as:

> "How people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole."[22]

4.3 In relation to children NICE describe wellbeing within 3 domains:

- *Emotional wellbeing* – this includes being happy and confident and not anxious or depressed;
- *Psychological wellbeing* – this includes the ability to be autonomous, problem-solve, manage emotions, experience empathy, and be resilient and attentive;
- *Social wellbeing* – has good relationships with others and does not have behavioural problems, that is, they are not disruptive, violent or a bully. [23]

5. Child and Adolescent Mental Health Services

5.1 The current model of planning, commissioning and delivery of children's and young people's mental health services was developed from the initial recommendation of *A Handbook on Child and Adolescent Mental Health*[24] and *Together We Stand*[25]. This 4 tiered model (see Figure 1 below) promotes movement through the tiers in relation to changes of need in order to maintain mental health as defined above.

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[21] World Health Organization, (2005). Promoting mental health: concepts, emerging evidence, practice. Geneva: WHO.
[22] New Economics Foundation (nef) Measuring wellbeing: A guide for practitioners. Available at http://www.neweconomics.org/publications/measuring-wellbeing
[23] NICE (2013) Social and emotional wellbeing for children and young people. London: NICE (p. 2)

[24] Department of Health. 1995. A Handbook on Child and Adolescent Mental Health. London: HMSO.
[25] Health Advisory Service. 1995. Together We Stand: The commissioning, role and management of child and adolescent mental health services. London: HMSO

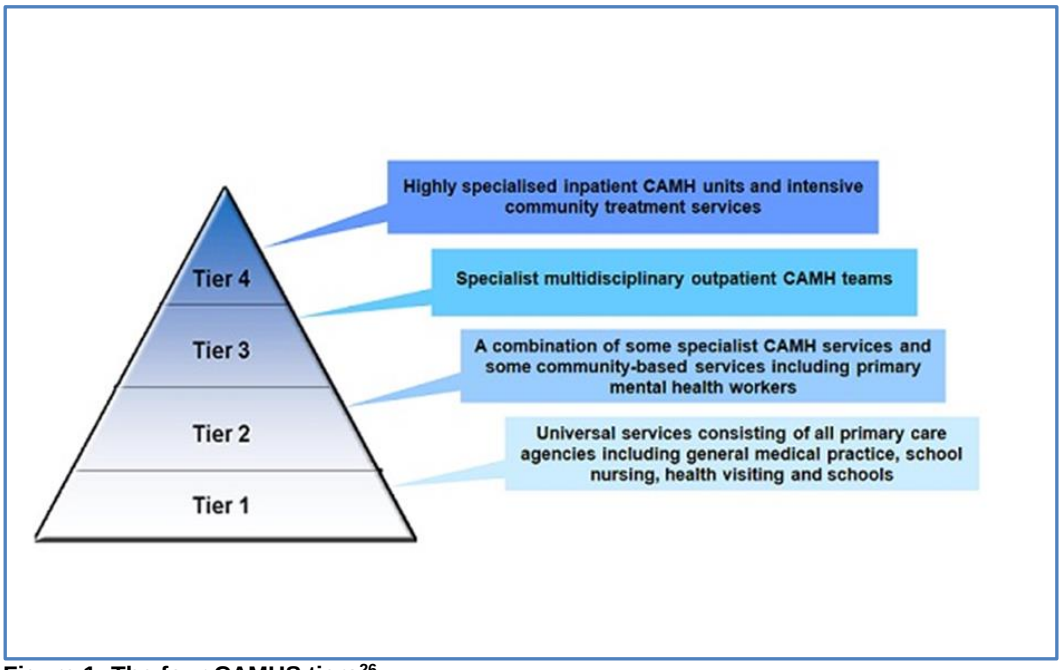

Figure 1: The four CAMHS tiers[26]

5.2 Tier 1 services are often described as Universal to Universal Plus and are focused primarily on preventative provision and early identification of needs. Services within this tier consist of non-specialist primary care workers such as school nurses, GPs and health visitors working with common problems of childhood. Tier 1 initially provides preventive services which aim to build self-esteem and resilience however they also recognise and support appropriate emotional responses to temporary situations. This need could arise from bereavement, parental separation or life transitions, including normal phases of growing up. These situations are experienced differently by all children and young people but can lead to indications of, for example, early signs of anxiety and low mood. This need is often met through early intervention services such as peer support, nurture groups, school counselling or 1-2-1 drop in sessions.

5.3 If a child experiences longer periods of emotional or behavioural difficulties or reactions to life events appear prolonged, their needs may be addressed by tier 2. Tier 2 does not involve direct clinical work but involves Primary Mental Health Workers delivering support and training to tier one professionals which enable them to provide support and interventions within community or educational settings. Tier 2 also often provides the beginning of assessments to identify if more intensive support is needed. These may be as simple as 'watchful waiting' but can also take the form of assessments and initial diagnosis by community paediatrics and educational psychologists, particularly in relation to needs such as behaviour and conduct problems; difficulties with attention and impulsive behaviour; social and communication difficulties; depression and low mood;

[26] Diagram from Integrated Care Pathways for Mental Health website: http://www.icptoolkit.org/child_and_adolescent_pathways/about_icps/camh_service_tiers.aspx

selective mutism; and abnormal eating patterns. In addition to these other needs which can be met by tier 2 include any behaviours or difficulties which may affect day to day functioning, such as anxiety, phobias and attachment issues, reaction to trauma and relationship difficulties. Many of these needs are met via family centres and school support staff, including counsellors.

5.4 Tier 3 is often described as 'specialist CAMHS' and meets the needs of children and young people whose needs are ongoing and can be described as 'complex', 'significant' or 'severe' but can be met in an outpatient environment. Needs that are met through tier 3 can include moderate to severe depression, post-traumatic stress disorder, deliberate self-harm, eating disorders, ADHD (with behavioural or mental health issues that have not been resolved in lower tiers), ASD (with behavioural or mental health issues that have not been resolved in lower tiers), Tourette's Syndrome, selective mutism and Obsessive Compulsive Disorder. These needs are met by a multi-disciplinary team including social workers; child and adolescent psychiatrists; clinical psychologists; community psychiatric nurses; child psychotherapists; occupational therapists, and art, music and drama therapists.

5.5 Tier 4 of the CAMHS service provides highly specialist services, mainly inpatient, to meet the needs of children and young people with chronic or acute needs. In particular, it aims to address major psychiatric disorders such as depression, early onset psychosis, Bipolar disorder, potential borderline personality disorder, suicidality and significant eating disorders. Tier 4 is serviced by the same multidisciplinary team as tier 3 however each tier 4 patient is likely to have their assessment and treatment overseen by a consultant child and adolescent psychiatrist or clinical psychologist.

5.6 The current tiered model of CAMHS has been subject to review due to reported lengthy waiting times.[27] Recent audits have shown average waiting times as being up to 15 weeks in some areas and the service itself being described as "dysfunctional" and with "serious and deeply ingrained problems".[28]

6. Looked after Children and Care Leavers' experiences of CAMHS

6.1 Looked after children experience the same issues of access as the rest of the population. However, due to their needs and environmental factors, this experience is magnified. According to a 2010 study, even though up to 63% of

[27] In October 2015, new access and waiting times for some mental health services were introduced by Department of Health. These require that from April 2016:

- more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral
- 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral.

[28] House of Commons Health Committee (2015) *Children's and adolescents' mental health and CAMHS*. HC342 2014-15

looked after children were assessed as having a mental health problem only one third (32%) were receiving support from CAMHS.[29]

6.2 A recent report has shown that only one quarter of providers of specialist mental health services have clear policies to ensure that referrals of looked after children are followed through adequately at all stages of the process, including when they transition to adult services.[30] This could potentially mean that the needs of looked after children and care leavers are not adequately addressed or monitored.

6.3 Recent evidence of the experiences of looked after children has illustrated the difficulties this vulnerable group have in relation to accessing services.[31] Children and young people have reported problems such as:

- A lack of information on where to go initially, how to get a referral;
- Inaccessibility – with inconvenient appointment times, off putting venues and long waiting times;
- A lack of knowledge and support from family/carers;
- The impact of placement instability or being in care out of area – with services not being offered if placements are not stable, and when moving to a new area, having to start the process again;[32]
- Stigma – with the stigma of being in care being layered with more stigma around mental health;
- Difficult conversations – a lack of empathy in relation to understanding the experiences of being in care with no time to build up relationships with professionals consistently;
- Not being involved in decision making or the process around their mental health support;
- Cultural barriers – particularly for unaccompanied asylum seeking children who might be from cultures where mental illness is a taboo subject.

[29] Bonfield, S., Collins, S., et al Help-seeking by Foster-Carers for their 'Looked after' Children: The role of mental health literacy and treatment attitudes, British Journal of Social Work, No. 40. 2010. Pages 1335-1352.
[30] Abdinasir, K., and Pona, L. *Access Denied*: *A teenager's pathway through the mental health system.* London: Childrens Society.
[31] For example: House of Commons Education Committee (2016): *Mental health and wellbeing of looked after children*, HC 481 2015-2016 and Young Minds (2012) *Improving the mental health of looked after young people*, London: Young Minds
[32] Jones R, et al., 'The effectiveness of interventions aimed at improving access to health and mental health services for looked after children and young people: a systematic review', *Families, Relationships and Societies*, 1(1), 2012, pp.71-85

6.4 Some of these challenges have now been reflected in the recent statutory guidance, *Promoting the health and wellbeing of looked after children* which states that:

> "Looked after children should never be refused a service, including for mental health, on the grounds of their placement being short term or unplanned".[33]

6.5 Another reported cause of delay is the financial responsibility of the payment of commissioned services in relation to children who are placed out of area, despite guidance stating that out of area placements should take into consideration a child's health needs and available services within the area.[34]

6.6 Ofsted's 2014 thematic inspection looking at children living out of area found that:

> "Delays receiving CAMHS support could be most often attributed to a lack of local capacity, poor liaison between different local authorities and clinical commissioning groups, and lengthy disputes about funding. The varying cost of CAMHS provision across health boundaries often contributed to these funding disputes".[35]

[33] Department for Education and Depart Department of Health et al (2015) *Statutory guidance on Promoting the Health and wellbeing of Looked after Children*, Nottingham: DCSF (p. 6)
[34] "Where the child will require specialist health services such as CAMHS, the Clinical Commissioning Group (CCG) (local health board in Wales) that commissions secondary healthcare in the area authority should be consulted, so the responsible authority can establish whether the placement is appropriate and able to meet the child's needs." Department of Education (2015) The Children Act 1989 guidance and regulations Volume 2: care planning, placement and case review
[35] OFSTED (2014) *From a distance: Looked after children living away from their home area*. London: Ofsted (p. 24)

Current practices

This section outlines current practice in supporting mental health needs for:

- All looked after children;
- Children adopted from care, or on SGOs;
- Care leavers.

We anticipate that the particular circumstances of some children and young people in care will be considered during the project. For example, looked after children placed with parents, those in the youth justice system, and unaccompanied asylum seekers.

7. Current practice with looked after children

7.1 Children and young people enter into the care system for a range of reasons, and their initial journey and key assessments are outlined within statutory guidance. A child's Care Plan is central to identifying their ongoing needs and brings together information from across seven dimensions of a child's development in order to inform, for example, required services and the child's placement.

7.2 The health dimension of this plan is informed by the initial Health assessment and health review, which the child's social worker should ensure they receive after entering care. The health review is conducted by a registered medical professional and should cover all aspects of a child's health including their mental health. In addition statutory guidance states that in order to support this review:

> "Local authorities are required to use the Strengths and Difficulties Questionnaire (SDQ) to assess the emotional wellbeing of individual looked after children".[36]

Once completed the review should be completed every 6 months before a child's fifth birthday and every 12 months thereafter, in addition to the child's 6 monthly LAC review.

7.3 Although these responsibilities are clear within the statutory guidance the application of the assessment and related tools (such as the SDQ) has been seen as highly variable.[37] This variability is supported by research analysing 50 CQC inspection reports which found that:

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[36] Department of Health et al (2015) *Statutory guidance on Promoting the Health and wellbeing of Looked after Children*, Nottingham: DCSF

[37] House of Commons Education Committee (2016): *Mental health and wellbeing of looked after children*, HC 481 2015-2016

> "Children's emotional and mental health needs were not proactively identified or comprehensively assessed in some cases and SDQs were not consistently used to inform assessments of the child's emotional wellbeing".[38]

7.4 This lack of focus on a child's wellbeing has caused concern with the recent Education Select Committee report recommending that children should have a full mental health assessment by a qualified mental health professional and that statutory guidance should be amended to reinforce the use of a SDQ for every child entering care.[39]

7.5 A child's journey through the social care system is embedded within statutory frameworks. However, their journey through the health system, and in particular mental health provision, is less so. The statutory guidance relating to looked after children does outline the responsibilities of the various agencies in relation to broader health, assessments, commissioning and payment. However, there is a limited remit in relation to looked after children's mental health services, focusing mainly on the role of the Child and Adolescent Mental Health Services (CAMHS):

> "Child and adolescent mental health services (CAMHS) play a crucial role in assessing and meeting any needs identified as part of the SDQ screening process. CCGs, local authorities and NHS England should ensure that CAMHS and other services provide targeted and dedicated support to looked after children according to need. This could include a dedicated team or seconding a CAMHS professional into a looked after children multi-agency team. Professionals need to work together with the child to assess and meet their mental health needs in a tailored way."[40]

8. Current practice with 16 and 17 year olds who are looked after or care leavers

8.1 Under the Children (Leaving Care) Act 2000, looked after young people aged 16 to 17 who are still in care are categorised as being 'Eligible'. These young people are entitled to the same assessments and services as other looked after young people. This age group will also have a personal advisor and Pathway Plan to help them to prepare to live independently, including their health and developmental needs. This may include consideration of making a transition to any adult health and social care services as necessary. It is worth noting that for unaccompanied asylum seeking children (many of whom are 16 and over), this transition will depend on their eligibility for a pathway plan and also upon the

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[38] Bazalgette, L., Rahilly,T.,and Trevelyan, G.(2015) A*chieving emotional wellbeing for looked after children: A Whole System Approach* London,NSPCC (p.22)
[39] House of Commons Education Committee (2016): *Mental health and wellbeing of looked after children*, HC 481 2015-2016
[40] Department of Health et al (2015) *Statutory guidance on Promoting the Health and wellbeing of Looked after Children*, Nottingham: DfE

status of their asylum application.

8.2 Looked after young people aged 16 to 17 who are no longer in care are categorised as being 'Relevant'. Under the Children (Leaving Care) Act 2000 the local authority must take reasonable steps to keep in touch with a relevant child, and to appoint a personal adviser. If a pathway plan has not already been prepared, the authority must carry out an assessment of the child's needs and determine what advice, assistance and support they need and prepare a pathway plan, as for 'eligible' children this pathway plan should consider a young person's developmental and health needs.

9. Current practice with young people aged 18-21

9.1 Young people aged 18-21 are categorised as 'former relevant' young people. The local authority should take reasonable steps to keep in touch with former relevant young people. They must continue the appointment of a personal adviser for a former relevant child and keep the pathway plan under review. The local authority has a duty to give a former relevant child assistance to the extent that his/her welfare and his/her educational or training needs require it.

9.2 Children and Adolescent Mental Health Services are generally only supplied up to a child's 18th birthday. After this date a transition, if necessary, is made to Adult Mental Health services.[41] Current NICE guidance recommends that mental health treatment for young people should continue until a handover with an assessment and completed care plan has been developed with the most appropriate adult service.[42] In addition, the guidance states that if a young person does not meet the threshold for adult mental health services then other types of support should be identified in a pathway plan.

9.3 Due to the differences in diagnostic thresholds this transition can, in reality, be experienced as a 'cliff edge' for care leavers, which could, potentially, result in loss of services, despite the evidence that mental health needs increase as children go through adolescence and when they leave care.

10. Current practice with young people aged 21-25

10.1 Young people aged over 21 continue to be categorised as 'former relevant' young people if they have stayed in, or gone back to, education or training. Former relevant children pursuing education or training have the right to the same assistance as former relevant children, until the end of the agreed programme of education.

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[41] https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-transt-camhs-spec.pdf
[42] NICE (2013) *Looked after children and young people* London: NICE (p. 32)

11. Current practice with adopted children

11.1 17 % of those ceasing to be looked after are placed for adoption.[43] However, as noted previously, the relationship between mental health issues and breakdown in placements is still pertinent. Related studies have identified a number of consistent supplementary factors such as older age at placement and behaviour difficulties, birth family factors such as child maltreatment and domestic violence, and system related factors such as delay and lack of support to adoptive families. In addition there is also evidence that inaccurate assessments of a child's difficulties can also increase the risk of adoption placement breakdown.[44]

11.2 Despite this risk of placement breakdown, a recent report states that adoptive families have found access to support, in relation to mental health needs, problematic.[45] Under the Adoption Support Services Regulations 2005 adoptive families are eligible for an Adoption Support Assessment as and when they request it. This may conclude that the child and family is entitled to support under the Adoption Support Fund. The type of support that can be funded includes therapeutic support, which can be provided by the NHS or via a private provider.

12. Current practice for children and young people under Special Guardianship Orders

12.1 11% of children cease to be looked after if they are under Special Guardianship Orders (SGOs).[46] Those subject to a SGO, and their guardians, can apply for a Support Assessment in relation to any arising need. However, similar to their adopted counterparts, this group have also reported issues in relation to accessing support services. A 2014 report for the DfE found that issues with access to a wide range of support and services were common with one-third of guardians reporting that services had not been made available or had proved too difficult to access.[47] There is currently no available issue breakdown of data relating to access to particular services (i.e. CAMHS).

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[43] Department for Education (2015) *Children looked after in England including adoption: 2014 to 2015. London*
[44] Sellick I and Thoburn J (1996) *What works in child and family placement*. London, BAAF
Dance C, Rushton, A., and Quinton, D. (2002) Emotional abuse in early childhood: relationships with progress in subsequent family placement. *Journal of Child Psychology and Psychiatry* 43:3, 395-407 Dance, C. and Rushton, A. (2005) Predictors of outcome for unrelated adoptive placements made during middle childhood. *Child and Family Social Work* 10:4, 269-280
Dance, C., Ouwejan, D., Beecham, J., and Farmer, E. (2010) *Linking and Matching: a survey of adoption agency practice in England and Wales*. London, BAAF
Coakley, J. F., and Berrick, J. D. (2008) Research review: In a rush to permanency: Preventing adoption disruption. *Child and Family Social Work*, 13, 101–112
[45] Selwyn, J., Wijedasa, D., and Meakings, S. (2014) Beyond the Adoption Order: challenges, interventions and adoption disruption. Department for Education.
[46] Department for Education (2015) *Children looked after in England including adoption: 2014 to 2015.* London
[47] Wade, J., Sinclair, I., Stuttard, L. and Simmonds, J., (2014). Investigating Special Guardianship: experiences, challenges and outcomes. Department for Education

Legislative and policy context

This section provides a brief overview of potentially relevant legislation, guidance, policy documents and NICE guidelines that will need to be taken into account when developing the guidance for this project.

13. Government legislation and guidance

13.1 *Children Act (1989):* The Children Act 1989 sets out many of the duties, powers and responsibilities which local authorities hold in respect of their looked after children and care leavers.

We will need to take in to account the following statutory guidance relating to the Act:

- Department for Education (2010) The Children Act 1989 guidance and regulations: volume 2 – care planning, placement and case review;
- Department for Education (2010) The Children Act 1989 guidance and regulations: volume 3 – planning transitions to adulthood for care leavers (amended in 2015 to include suitable accommodation);
- Department for Education (2011) The Children Act 1989 guidance and regulations: volume 4 – fostering services;
- Department for Education (2011) Children Act 1989 guidance and regulations: volume 5 – children's home;
- 'Staying put': arrangements for care leavers aged 18 and above to stay on with their former foster carers (as part of the Planning Transition to Adulthood for Care Leavers Regulations and Guidance 2010 and the Fostering Regulations and Guidance 2011 (Children Act 1989)

13.2 *Adoption & Children Act (2002)*: This act places a duty on local authorities to maintain an adoption service and provide adoption support. The Act introduced Special Guardianship Orders (SGO) which meets the needs of children separated from their birth parents. SGOs offer stability and permanence but without severing all legal ties with their birth parents, as is the case with adoption. Anyone with whom the child has been living for 12 months or more can apply to the Court for a Special Guardianship Order. This can include foster carers, grandparents, or family and friends foster carers.

13.3 *Children and Young Persons Act (2008)*: This legislates for the recommendations in the Department for Education and Skill's 2007 Care Matters white paper to provide high quality care and services for children in care.

13.4 *Children and Families Act (2014):* Introduced 'staying put' arrangements which allow children in care to stay with their foster families until the age of 21 years. This is provided if both the young person and the foster family are happy to do so.

13.5 *Care of unaccompanied and trafficked children statutory guidance for local authorities on the care of unaccompanied asylum seeking and trafficked children (2014):* This guidance outlines statutory Local Authority responsibilities in relation to unaccompanied asylum seeking and trafficked children and builds upon their rights under acts and statutory guidance related to looked after children.

13.6 *Promoting the health and wellbeing of looked after children (2015):* Replacing the 2009 guidance, this guidance explains how local authorities and health agencies should go about carrying out relevant duties under a number of pieces of legislation including the 1989 and 2004 Children Acts, 2006 NHS Act (as amended in 2012) and the care planning and placement and case review regulations

13.7 *Care leaver strategy (2013):* A cross departmental strategy for young people leaving care. This sets out the actions that government departments would take in order to improve the support care leavers receive during their transition to adulthood and independence

13.8 *Adoption: A Vision for Change (2016):* This sets out a vision for 2020 of a reformed adoption system. It includes the detail of what the Government plans to do over 4 years to address the decline in adoption numbers, and other challenges.

14. Relevant policy documents

14.1 *No Health without Mental Health* (2012) sets out the Government's plan to improve mental health outcomes for people of all ages. The foreword states that:

> "By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does."

14.2 *The Implementation Framework for No Health without Mental Health* (2012) describes how different bodies, such as schools, employers and local authorities, should work together to support people's mental health. It recommended that schools promote children and young people's wellbeing and mental health.

14.3 *Closing the Gap (2014):* priorities for essential change in mental health. This outlines areas for immediate change to improve mental health care, including specific commitments for children and young people such as:

- There will be improved access to psychological therapies for children and young people across the whole of England, so that early access to treatment is available;
- Schools will be supported to identify mental health problems sooner through guidance published from the Department of Health.

14.4 *Future in Mind* (2015) makes a number of proposals the government wishes to see in place by 2020. These include:

- Tackling stigma and improving attitudes to mental illness;
- Introducing more access and waiting time standards for services;
- Establishing 'one stop shop' support services in the community;
- Improving access for children and young people who are particularly vulnerable.

The report also sets out how this can be achieved through better working between the NHS, local authorities, voluntary and community services, schools and other local services.

14.5 *Five Year View of Mental Health (2016)* sets out how national bodies will work together between now and 2021 to help people have good mental health and make sure they can access evidence-based treatment rapidly when they need it.

15. Key NICE guidelines

15.1 The list below outlines examples of some of the NICE guidance that are relevant for the project. This includes guidance on some individual conditions, but is not exhaustive:

- Looked after children and young people, NICE guideline 28 (May 2015);
- Social and emotional wellbeing: early years NICE guideline 40 (Oct 2012);
- Transition from children's to adults' services for young people using health or social care services Nice Guideline 43 (Feb 2016);
- Depression in children and young people: identification and management
- NICE Clinical Guidelines 28 (March 2015);
- Common mental health problems: identification and pathways to care NICE Clinical Guideline 123 (May 2011) NICE Guideline 20 (Sept 2012);
- Obsessive-compulsive disorder and body dysmorphic disorder: treatment NICE Clinical Guideline 31 (Nov 2005);
- Psychosis with substance misuse in over 14s: assessment and management Nice Clinic Guideline 120 (March 2011);
- Antisocial behaviour and conduct disorders in children and young people: recognition and management NICE Clinical Guideline 158, (March 2013).

The Project scope

16. Population

16.1 As outlined on page 3, the focus of this project is on:

- *Looked after children* as defined by the Children Act 1989 and accompanying statutory guidance – a child who is subject to a care order, or is accommodated by a local authority (for example, with foster parents, at home with their parents under the supervision of social services, in residential homes, schools or secure units). As outlined on page 3, the project is likely to consider the needs of particular groups within the overall looked after children population, for example, children in the criminal justice system, unaccompanied asylum seeking and trafficked children, children who have returned to their birth parents.
- *Care leavers* – eligible, relevant and former relevant children up to the age of 25 as defined under the Children (Leaving Care) Act 2000:
    - Eligible – those young people still in care aged 16-17 (and who were looked after for at least 13 weeks from the age of 14;
    - Relevant – young people aged 16-17 who have left care (and who were looked after for at least 13 weeks from the age of 14, and were looked after at some time while 16 or 17;
    - Former relevant – young people aged 18-21 who have been eligible and/or relevant children;
    - Young people aged 21-25 in education or training where the local authority still has a duty to support them (new duty introduced in 2011).
- *Children who have ceased to be looked after* under special guardianship arrangement orders, or through being adopted from care.

16.2 The following groups will not be covered:

- Young people who do not meet the criteria of looked after as defined in the Children Act 1989;
- Care Leavers over 21 not receiving continuing support from their local authority (e.g. if they are not in education or training). However, in light of upcoming changes in the Children and Social Work Bill, it is likely that the Group will consider all care leavers 21-25 when this legislation has been passed;
- Care Leavers over the age of 25.

17. Levels of need

17.1 The project involves considering mental health and wellbeing difficulties which encompasses a wide range of difficulties, ranging from low self-esteem or problems with bullying to diagnosable mental illnesses. There is recognition that the work of the project must also focus on empowering people to help themselves, assessing their strengths, and not regarding needs solely as problems.

17.2 The THRIVE model was developed through a collaboration between the Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre. This proposes a replacement of the current tiered model with a whole system approach, and draws a clearer distinction between treatment and support, moving away from access based on diagnostic criteria alone. 'Thriving' is the state that everyone should aim for:

> "Where services are and should be helping with prevention, promotion, awareness raising work in the community to support this, and may involve consultation and training that is not focussed on particular children or families".[48]

17.3 The THRIVE model involves 'needs-based groupings':

- *Coping* – interventions in the community, signposting, self-support;
- *Getting help* – focussed evidence-based treatment;
- *Getting more help* – extensive treatment;
- *Getting risk support* – risk management and crisis support.

17.4 This model will help guide the work of the project in terms of thinking about the full spectrum of need, and the role of universal prevention services at different points of a looked after child's journey in terms of supporting wellbeing, and managing demand at higher tiers. The project recognises the need to support a cultural shift towards providing 'whole person' support that considers the context, and includes support which can be provided at an earlier stage through more informal routes.

[48] Wolpert, M et al (2014) *Thrive: the AFC-Tavistock Model for CAMHS* London: CAMHS Press (pg. 10)

18. Key definitions

18.1 This project involves developing care pathways, models of care, and quality principles. The following definitions will be used:

- **Care pathways** – the journey that can be taken by a young person in order to get help from different services. The journey through the pathway will not be linear, and will reflect that the focus is on accessing support when it is needed and when the person is ready. The care pathway will not go into detail about what interventions/treatments are recommended, and will instead use the blanket term 'appropriate evidence-based intervention';
- **Models of care -** the resources that need to be available, *how services should be organised and configured*, and the processes that need to be followed to ensure the efficient and accessible provision of interventions of proven clinical and cost effectiveness. This definition reflects the one NICE uses for service guidance. This is distinct from clinical guidance, which advises on what interventions should be provided, for example cognitive behaviour therapy;

- **Quality principles** - concise statements and associated measures that set out markers of high-quality services for children and young people in care, and who is responsible for making sure this is achieved in practice.

19. Activities – key areas and issues that will be covered

19.1 In developing the guidance, we will take a child and young person-centred approach; that is to say, our framework and focus will be the journey of the child or young person in care through (and within) services, as well as in and out of the care pathway as determined by their needs.

19.2 Whilst the project is primarily focussing on processes particular to children and young people in care, the work of the project will be firmly embedded within the broader approach to improving mental health support for all young people (reflecting the fact that young people can frequently move in and out of care). In some instances processes for assessment and accessing care for looked after children may be similar to those relevant to the general population.

19.3 Specifically, we will consider:

- **Service configuration and care pathway:** Integrated and accessible care pathways and models of care delivered by a multi-agency team. As outlined in paragraph 17, this will acknowledge the role played by wider services and

settings in prevention, in so much as they relate to the needs of specific looked after children.

- **Assessment:** Advice on the pros and cons of specialist assessment, and consideration of the optimum method of assessment (specifically referencing Development And Wellbeing Assessment (DAWBA), Comprehensive Health Assessment Tool (CHAT) and the use of the Strengths and Difficulties Questionnaire (SDQ);
- **Waiting times:** considering expectations about how quickly the groups in scope of this project should receive help, and how to balance quality and timescales;
- **Provision of interventions:** Guidance on follow up after assessment with appropriate services and interventions;
- **Measurement**: Measurement of progress and outcomes in relation to the individual, as well as the wider systems outcomes;
- **Workforce:** The quality of relationships (not just systems) will make a difference in terms of improving support for the population in scope. Considering who should be providing particular services, as well as the level of support and type of workforce development required for professionals, including those who refer/commission services and those who deliver services, to enable them to achieve the best for the child during their journey of care. The latter will be primarily explored in relation to how best support the implementation of the guidance this project will be producing;
- **Personal budgets:** The use of personal budgets (in terms of how these are being used by those who have taken them up) to meet mental health needs. This is likely to only apply to a small proportion of the groups in scope as it is not a widely available option.

19.4 Areas and issues that will **not** be covered:

- The universal service element of organisations that do not explicitly relate to looked after children's wellbeing and mental health needs;
- The effectiveness of specific health treatments, therapies or interventions;
- Any service or intervention with no emotional wellbeing and mental health component.

20. Settings

20.1 Services to support the population groups in scope may be provide by a range of settings and providers. The project will consider the whole system, recognising that there are many services, organisations and people responsible for improving outcomes for the population in scope. These include:

Community:

- NHS CAMHS services, GPs, children's nurses;
- Social care – support provided by social workers, personal advisers for care leavers, IROs;
- Home – with birth parents, adopters, foster carers, relatives
- Education - recognising the key role that schools can play in supporting looked after children and the value of 'whole school approaches' to emotional wellbeing and mental health. Key people involved include teachers, head teachers, SENCOs, learning mentors, pastoral staff, virtual head teachers, and specialist staff within schools, e.g. school counsellors, educational psychologists, and school nurses;
- Voluntary sector;
- Private therapeutic provision;
- Regional Adoption Centres and their potential role in providing support for children and young people.

Residential/inpatient:

- NHS – impatient CAMHS;
- Social care – therapeutic placements e.g. therapeutic foster care, therapeutic residential care, secure accommodation;
- Education – therapeutic residential school;
- Criminal justice – therapeutic support provided whilst in Youth Detention Accommodation;
- Private sector therapeutic residential provision on behalf of the NHS.

20.2 The consideration of different settings relates closely to workforce issues that the project might consider throughout the course of the work – this needs to relate closely to work already being undertaken by Future in Mind workstreams, and ensure there is no duplication.

21. Audience

21.1 The primary audiences for the guidance produced by this project are:

- Looked after children and young people
- The parents/family of looked after children
- Foster carers, adoptive parents and guardians.
- Local authorities in their role as corporate parents – particularly lead members and the statutory lead officer
- NHS and local authority commissioners and providers
- NHS providers, particularly in CAMHS including psychiatrists, clinical psychologists, therapists
- Social workers, personal advisors, named nurses and named teachers working with looked after children, including those working in residential settings and secure units
- Education – teachers, educational psychologists, virtual head teachers, pastoral staff, SENCOs, Learning Mentors
- Criminal justice – those working in youth detention accommodation, particularly secure units
- External Providers

22. Outputs

22.1 The format of the guidance produced by the project is yet to be determined, but it is likely to be electronic, and consist of guidance in a report format, as well as an online element that can be visually navigated through.

22.2 The outputs will need to be useful to different audiences including people at frontline, and more strategic roles within their organisations. The online versions will involve easy to navigate sections where people can access the content that is most relevant to their positions.

22.3 There will be a young person's version of the guidance, but it is an important principle that all outputs will be considered in terms of their accessibility and comprehension from the point of view of young people and their carers.

22.4 The project will involve a full consideration of issues and challenges around implementation of the guidance, who needs to be involved, and different strategies to encourage take up.