Stakeholder's event 13 March 2017

Friends House London

Background

This is a summary of a stakeholder's event held as part of the SCIE project: *Improving mental health and emotional wellbeing support for children and young people in care, leaving care and those adopted from care.*

One hundred stakeholders from across the health, education and social care sectors attended. We would like to thank all attendees for their outstanding contributions and intend this to be the beginning of an ongoing dialogue with all key stakeholders.

The event supported the aspiration of the project's Expert Working Group (EWG) to complement its work at a national level with contributions from local, frontline services. We are also testing our early findings with a stakeholder's event for children and young people, a children's reference group and national bodies in the sector. In total we will hear from over 400 stakeholders and 100 young people. This wide consultation will ensure that the recommendations of the EWG will be founded on evidence *and* informed by key stakeholders, including children and young people themselves.

Our final recommendations will be published in October 2017.

Summary

Session 1: What should be the key features of a model supporting emotional wellbeing of children in care, leaving care and those who are adopted?

Holistic and 'non-medicalised' model: There was consensus that a model must have, at its core, a broader understanding of emotional health and wellbeing, not driven solely by a medical understanding of mental health. Creating this shift in understanding was identified as a crucial step in creating a model of care that can meet the unique needs of looked after children and support their emotional, behavioural, and social, health and wellbeing.

Continuity of care and attachment: Participants were clear that the system as it is currently designed can be incapable of providing the continuity of care that is essential to looked after children's wellbeing. High levels of turnover amongst practitioners (particularly social workers) and the wide variety of professionals with whom young people are expected to engage were identified as contributory factors, as were being placed out of area or leaving care.

Person-centred care and support that is needs led: Many emphasised that care and support should be person-centred, and guided by the needs and preferences of the young person. Professionals should proactively engage looked after children in

care planning in order to develop a comprehensive and holistic understanding of their needs (and strengths). Young people should be offered meaningful choice wherever possible and resourcing concerns should not dictate the type of support available. Whilst access to the full range of support and practitioners should be available as required, the number of professionals involved in the life of a looked after young person should be kept to a minimum.

Support for children and their carers: Although specialist input from CAMHS was acknowledged as important, the majority of participants felt that for many young people this could be unnecessary and in some cases not helpful. Instead, the model should refocus on prevention by providing better support to carers. The objective should be to help carers understand the emotional and mental health needs of looked after children and to more effectively manage behavioural issues and stress on a day-to-day basis. This support should be made available to anyone who provides day-to-day care for the young person regardless of their status or the care setting. An example given in one group was the inclusion of residential care workers, particularly given the important role they play in providing care to young people with very high level needs.

Support for practitioners: Attendees felt that a preventive focus could be further embedded by providing support to practitioners. Many participants highlighted consultative models which enabled access to advice and support from a specialist mental health professional. This often included training in addition to advice (i.e. in trauma and attachment). Whilst social workers and residential care workers were identified as those who would benefit from this type of support, it was also suggested that education professionals could find this useful. There was broad agreement about the value of this type of approach; however, participants noted that it could be difficult to record this activity or express it in a pathway. There were also concerns about the extent to which non-direct work is currently 'valued' by the system when it is often not included in contractual arrangements.

Integration: Underlying much of the discussion regarding the key features of a care model was the belief that greater integration of services would go some way to addressing some of the difficulties in providing effective support. Developing a 'shared language', and improving communication and information-sharing processes were seen as key. It was thought that integration was required in terms of multi-agency delivery of frontline services, supported by integrated operational and strategic management and commissioning.

Accessibility and eligibility: Many participants were keen to stress that all looked after children should be entitled to a 'minimum' level of support given their experiences of trauma and adverse events. Attendees also agreed that services should be flexible enough to respond to the peaks and troughs in the young person's need for support. It was suggested that services should be 'open access' (i.e. open to all ages, with referrals accepted from the young person, their carer, or other relevant persons). It was thought this would enable a rapid response to prevent crises (e.g. placement breakdown). Similarly, services should enable rapid 're-engagement' and the system should 'remember' the young person and the support they have received in the past. Participants also thought it would be beneficial for services to engage young people more proactively, reaching out to those who may

feel uncomfortable in ‘clinical’ settings, by offering community-based support.

Support into adulthood: Many participants emphasised that the model must provide better support to care leavers given the likelihood that mental health support needs will persist into adulthood for this cohort. Of particular concern for some attendees was the expectation that *all* care leavers would be able to live independently without support. This was in the context of recognising the impact that trauma can have on development and attachment. Members in one group were concerned about the quality of supported housing, and in particular the suitability of this for young people with very high needs (i.e. those who had lived in residential care).

Strategic planning and commissioning: Participants agreed that to be effective, multi-agency approaches should be embedded at all levels of the model and should be reflected in planning and commissioning strategies. Participants from one group *(there were six groups in total)* suggested that a team with national responsibility for LAC services could help to overcome some of the commissioning and funding barriers that local teams often face.

Information recording and sharing/‘memory’ of the system: Many attendees reported that existing information-sharing protocols can be unproductive and may result in a system which ‘forgets’ the young person and their needs e.g. when being placed out of area, moving from primary to secondary school, or moving between health and social care services. Whilst some attendees felt that further integration and development of a shared language around emotional health and wellbeing could address this problem, others felt that national data-sharing protocols were required.

Session 2: How can we best find out about children and young people's mental health and wellbeing, and what support they and their carers need?

Screening: A number of participants emphasised the value of regular screening as a means of identifying support needs and risks to placement stability at an early stage, suggesting key transition points as a trigger for screening (e.g. start of secondary school). However, there were some concerns that screening programmes were a 'tick-box' procedure, and members from one group questioned whether automatic screening was helpful in a needs-led model of care. There was not a consensus across the groups on screening.

Objectives of assessment: There was consensus that assessments are an opportunity to proactively identify support needs, and to enable access to appropriate and effective sources of help. Assessments should always have a clear purpose and should not be used solely to generate a diagnosis, which in some cases can 'mask' more fundamental concerns.

Involvement of young people: Participants were clear that assessments should meaningfully engage young people – they should be 'done with, and not to'. The assessment should provide an opportunity for the young person to discuss their daily life and to identify support which they feel would be helpful. Assessments should also enable young people to voice their hopes for the future. It was also suggested that assessments should be adapted to the developmental level of the young person, thereby helping them to more effectively identify and express their needs and preferences. Similarly, use of an advocate was suggested by some as a means of facilitating involvement.

Timing and frequency: There was agreement that assessments were not a one-off perfunctory exercise to be 'ticked off'. They should be regular but take place within the context of an ongoing relationship with an individual who has a good understanding of the young person. However, assessment 'fatigue' and duplication must be minimised through improved information-sharing processes.

Who should undertake assessments? There was disagreement regarding responsibilities for assessment. A small number of participants were clear that this was an activity that should be undertaken by a professional; and they suggested social workers or mental health practitioners as the most appropriate practitioners. A trained practitioner with 'professional credibility' was thought to increase trust and minimise requests for reassessment. In contrast, many attendees stated that professional status or background was not significant. For these participants, it was more important that the individual was someone who knew the young person well or was someone that they could 'open up to'. Similarly, personality traits such as being able to engage with young people, and being understanding and compassionate were identified as key characteristics that the individual should possess. One participant reported positive experiences of a peer assessment programme (implemented in a residential setting).

Content: Participants were clear that the scope of assessments should be broad enough to cover emotional health and wellbeing, and should specifically incorporate developmental history as well as histories of attachment and trauma. They should

generate an holistic understanding of 'who the young person is' rather than resulting in lists of 'presenting symptoms' that make arbitrary distinctions between mental health, emotional wellbeing, and social wellbeing. They should be personalised and focus on strengths as well as needs and should draw on multiple sources to illustrate the context of the young person's current situation whilst also retaining salient historic detail (e.g. pre-care information).

There was also agreement that the link between assessment and treatment or support should be made clearer. Ideally, the assessment should include an attempt to understand 'what has worked in the past', an explanation of why a particular treatment might be helpful, and some level of contingency planning.

Format: There was agreement that an 'assessment' did not necessarily equate to an 'interview', and a number of attendees suggested creative formats (e.g. using art materials), or highlighted the value of a 'simple' conversation in a setting in which the young person feels comfortable. Giving young people and their carers more choice in relation to the time and location of assessments was also reported to improve levels of engagement.

There was disagreement regarding the use of structured assessment tools. Whilst some found these to be a useful way of ensuring that the 'essentials' were covered, others felt that they were symptomatic of a 'tick-box' approach to care.

Over assessment: Whilst participants agreed that assessments should draw on information from multiple sources and agencies, there were some concerns regarding the tendency to 'over assess' and the significant demand this places on young people. This was also felt to make it difficult for professionals to identify the key issues that need to be addressed.

Sharing assessments: There were some concerns that even the highest quality assessments are of little use if the ability to share them effectively does not exist. An absence of effective methods to share assessments was identified as the main reason why looked after children have to repeatedly 'tell their story'. Some participants felt that this issue could only be overcome by the creation of shared databases or joint care records.

Session 3: The Expert Working Group's emerging recommendations *(please note these are subject to change and may or may not be included in the group's final recommendations)*

1. The creation of a 'virtual mental health lead' similar to a virtual school head
Whilst the majority of stakeholders were supportive of this recommendation, some felt that this might duplicate the work of a designated doctor or Looked after children (LAC) CAMHS teams. There was considerable discussion regarding the specifics of this recommendation:

- **Role and responsibilities:** Many participants suggested that the virtual lead should take a strategic role, providing oversight and ensuring accountability. This included ensuring completion of SDQs and PEPs, having oversight of all LAC placed out of borough, and identifying professional training needs. In contrast, other attendees felt that the role should include direct work, for example, through attendance at PEP and LAC reviews, collaboration with Independent Reviewing Officers and arranging support. It was also suggested that the lead should have powers to ensure that support is provided in individual cases where there have been difficulties accessing services.

- **Who would be suitable for the role?** There was consensus that the lead should be experienced and have a good understanding of holistic mental health and wellbeing (which should be reflected in the job title). A number of participants suggested CAMHS/mental health practitioners as the most suitable, however members from one group felt that the in-depth knowledge that virtual school team members have of looked after children could make them a suitable candidate. Having an understanding of the relationships that were important to the young person and the impact which these have on their wellbeing was thought to be especially important.

  Participants were unsure whether the duties associated with the role should be undertaken by an individual or a team. On the whole, participants felt that the volume of work and the likely variety of tasks involved required support from a multidisciplinary team.

- **Integration and funding:** Participants were unclear about where in the system the lead would be "located". Some attendees suggested that locating this within the health sector, or ensuring that the person had clinical status, would be useful in terms of the credibility of the role and facilitating referrals to other services. Attendees were also clear that, wherever the role is located, this lead must integrate and liaise closely with a wide range of practitioners including children's health, CAMHS, and social care professionals, and IROs, etc. This wide inclusion was considered essential for embedding a more holistic understanding of mental health and wellbeing. Joint funding and commissioning from health and social care was emphasised, with one group suggesting that this should be ring-fenced.

- **Implementation:** There was some discussion regarding the practicalities of implementing this recommendation. One group was concerned regarding the high numbers of looked after children and the difficulties in 'tracking' them virtually, whilst another flagged the need for the lead to be able to access

information from multiple agencies. One group suggested that embedding a mental health practitioner in a virtual school was the ‘easiest’ way of implementing this.

2. **Recommending that each young person has a nominated keyworker, who they can choose (this recommendation was generated by young people)**

   This elicited mixed views – many participants were very supportive of the idea, but a similar number had concerns.

- **Job title:** Many suggested that the title of keyworker was inappropriate given its current use. The title was also thought to signify that the role must be undertaken by a professional – some participants suggested advocate or navigator as an alternative.

- **Relationship with social worker role:** Participants from one group were particularly concerned that this work was the responsibility of social workers and they emphasised the barrier that high caseloads presented to this. In contrast, members of another group suggested that the role should be independent of social services. However they recognised that an untrained person who was ‘new’ to the system, was unlikely to have any real impact. Participants also questioned whether the role would have any powers associated with it.

- **Safeguarding and risk**: Attendees generally felt that a keyworker should support young people on a long-term basis and that this was a realistic means of reducing the number of professionals with whom they have to engage. However, many participants noted the importance of ensuring that the expectations of the young person are managed and that they understand the limits of the boundaries of the relationship. It was also suggested that keyworkers would need to be assessed and supported (e.g. as in counsellor or psychologist training), as there were concerns that those with ‘the right qualification’ might not have the necessary real-life skills and experience. A small number of participants were concerned regarding the use of a professional role to mitigate for the absence of healthy long-term relationships in the lives of LAC.

- **Status of person in this role:** Whilst participants saw the value in allowing a young person to nominate someone who supports them in a voluntary capacity there were concerns regarding accountability. It was also suggested that asking someone to advocate for a young person on a long-term basis was unrealistic unless some kind of financial remuneration was made available.

- **Availability to care leavers**: A number of participants emphasised that this support should be available to those over the age of 18 to ensure continuity and to support people into education and employment. Members of one group were concerned that this may be difficult to achieve in practice but suggested that a small team (i.e. to account for staff turnover, sickness, etc.) might be a more realistic solution.

3. Developing a ‘mental health passport’ for each young person

There were different views regarding this recommendation, and although there was some support for the idea, participants had many queries and suggested caveats. Participants from one group were particularly concerned that this undermines the statutory framework in which health information should sit.

- **Potential connotations:** Many attendees felt that ‘passport’ was likely to hold negative connotations for some people, particularly asylum seekers. There were also concerns that this may lead to further ‘labelling’ and increased stigma. Some participants felt that the name needed to reflect a wider focus on emotional health and wellbeing.

- **Rationale:** It was noted that much of the information that could realistically be included was already available – and the question was raised as to whether this was the right solution as to why this was not effectively occurring at the moment. However, other participants supported the concept as a means of reducing the need for young people to repeatedly ‘tell their story’.

- **Ownership:** There was consensus that the young person should be able to choose whether to use a ‘passport’ and that they may not be appropriate for all LAC, particularly those of a younger age.

  All participants emphasised that the passport must be owned by the young person who should have the final say on what is and isn’t included. Whilst there was recognition that the ‘passport’ should be useful to practitioners, attendees were clear that young people may not want their entire history to be shared – the wishes of the young person should override professional needs. It was therefore suggested that young people could also be in charge of updating their ‘passport’.

- **Content:** Participants were unsure about what information should be included in a ‘passport’. Whilst some felt that the emphasis should be on ‘what’s important now’, others felt that it needed to include the detail and chronologies. However, there were some concerns that this may overlap with life story work.

- **Storage and confidentiality:** Security and confidentiality were a key concern for many and a physical document or card was thought likely to be lost. Participants also suggested that carrying this could make some looked after children feel even more ‘different’. Digital storage options were discussed as a solution to some of these issues and it was noted that Leeds LAC CAMHS uses a virtual passport. Other suggestions included an app, however, there were concerns that this type of technology may not be accessible to all. A small number of participants suggested that digital tools offered an opportunity for young people to express their strengths and needs creatively (e.g. using music and images).

Appendix 1: Agenda for professional stakeholder event 13 March 2017

Item no.	Time	Topic
1.	10:30–11	Registration and Refreshments
2.	11–11:30	Introduction to conference from Peter Fonagy and Alison O Sullivan (Co-chairs)
3.	11:30–12:30	Group Session 1: What should be the key features of a model supporting emotional wellbeing of children in care, leaving care and those who are adopted? *By model, we mean the overall system, including different services and how they are organised.* *Questions:* *1) In your experience, what **works well** in supporting the mental health and emotional wellbeing of looked after children?* *2) Are there places or parts of the system where this is **happening already?** What does this look like?* *3) In your experience **what is less helpful** in supporting the mental health and emotional wellbeing of looked after children?*
	12:30–1:30	Lunch
4	1:30–2:30	Group Session 2: Screening and assessment* – how can we best find out about children and young people's mental health and wellbeing, and what support they and their carers need? * The terms 'assessment' and 'mental health assessment' describes a range of outputs. The Expert Working Group defines assessment in the broadest sense of **finding out about children and young people's mental health and wellbeing, and what support they and their carers might need**. The process of assessment, including within CAMHS, is not necessarily linked to diagnosis. *Questions (these are the same as we used in the ERG)* 1. What are the key objectives of mental health assessment(s) for looked after children? *Prompts for facilitators:* • *When we say 'mental health assessment' what do we mean?*

		• *What should the focus of the assessment be – diagnosis of mental health problems? A more holistic exploration of mental health and wellbeing?* • *What kinds of help would we want to be made available to children and young people on the basis of the assessment?* 2. Based on these, what form(s) should assessment take? What is working well already that this could build on? *Prompts for facilitators:* • *When? At what point(s) in child's journey?* • *In what setting(s)?* 3. What else would need to be in place to support people to conduct a good assessment? *Prompts for facilitators:* • *What skills would be needed to undertake a good assessment? Would this require training?(could lead to **who** this is depending on time)* • *What would happen post assessment?*
6.	2:30–2:45	Break
7.	2:45–3:45	Group Session 3 – Your views on emerging recommendations on ways of working from the Expert Working Group *The expert working group is considering the following recommendations – what are your thoughts on these (discuss each in turn). How easy/difficult would these be to put in to place? How similar or different are they from what is happening at the moment? How could they be put in to practice?* *1. The creation of a 'virtual mental health lead' similar to a virtual school head* *2. Developing a 'mental health passport' for each young person* *3. Recommending that each young person has a nominated keyworker, who they can choose*
8.	3:45–4:30	Q and A with Co-chairs