What Works for Children's Social Care

Mental Health of Children and Young People in care Evidence Summary

The Evidence Summaries have not been conducted or written as rapid reviews, systematic reviews or comprehensive literature reviews. Instead they were designed and written as brief notes intended to give the Independent Review of Children's Social Care a quick overview of some of the evidence on a particular topic or question. They are only being published for transparency and given their limited scope, are not intended as a resource for wider purpose.

Introduction

This Evidence Summary covers: prevalence of mental health problems among looked after children, a summary of evidence on effectiveness of interventions, and a description of some of the challenges of addressing the mental health needs of looked after children. We focus on the English or UK context, unless otherwise indicated.

Prevalence

While estimates vary across studies, the prevalence of mental health problems among looked after children and young people in England is understood to be high. According to NICE (National Institute for Health and Care Excellence) for example, in 2021, 45% of children and young people who were looked after in England had emotional and mental health problems. This compares to a rate of 10% among 5- to 15-year-old children in the general population.[1]

In 2020, data collated by the Department for Education (DfE) showed that significant numbers of children in care had social and emotional difficulties (measured by the Strengths and Difficulties Questionnaire, SDQ): 38% of young people had scores above 20 (out of 40) suggesting a psychiatric disorder.[2][3] A further 13% had 'borderline scores', which puts them at risk of developing mental health problems. This compares to 4.8% of young people in the general population who have scores above 20 and 15.5% who have 'borderline' scores.[4] Among looked after children scores varied by gender: 41% of boys had a score which was a cause for concern, compared to 34% of females.[5]

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[1] National Institute for Health and Care Excellence. (2021). Looked-After Children and Young People (update) [F] Evidence review for interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers. [online] . Available at: NICE guideline looked after children and young people: [F] Evidence review for interventions to promote physical, mental, and em. [Accessed 3 Aug. 2021].

[2] Department for Education. (2020). Children looked after in England including adoptions, Reporting Year 2020. [online] Available at: https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions [Accessed 2 Jul. 2021].

[3] Wright, H., Wellsted, D., Gratton, J., Besser, S.J. and Midgley, N. (2019). Use of the Strengths and Difficulties Questionnaire to identify treatment needs in looked-after children referred to CAMHS. Developmental Child Welfare, [online] 1(2), pp.159–176. Available at: https://journals.sagepub.com/doi/10.1177/2516103218817555 [Accessed 20 Jul. 2021].

[4] Sdqinfo.org. (2021). [online] Available at: https://www.sdqinfo.org/norms/UKSchoolNorm.html [Accessed 9 Aug. 2021].

[5] Department for Education. (2020). Children looked after in England including adoptions, Reporting Year 2020. [online] Available at:

In addition, a recent population study estimates that 83% of looked after children require special educational need support at some point during schooling, compared to 64% of children in need and 37% of children in the general population.[6]

A seminal, but older study, which included 670 looked after children found that only 9% did not have a psychiatric disorder (such as PTSD or a conduct disorder), compared to 41% (n=649) of a comparison group of disadvantaged children and 53% (n=8733) of children in the general population.[7]

The table below summarises the prevalence data for groups of children with different types of social care involvement (note: data sources, and therefore samples, vary)

	General Population	CIN	CLA	Residential Care	Foster Care
Mental Health	10%[8]	-	45%[9]	72%[10]	-
Behaviour	4.6%[11]	-	-	-	60%+[12]
Emotional	8.1%[13]	-	-	-	60%+[14]

https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions [Accessed 2 Jul. 2021].

[6] Jay, M. A., & Gilbert, R. (2021). Special educational needs, social care and health. Archives of disease in childhood, 106(1), 83–85. https://doi.org/10.1136/archdischild-2019-317985.

[7] Ford T, Vostanis P, Meltzer H, Goodman R. (2007). Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. Br J Psychiatry. 190:319-25. doi: 10.1192/bjp.bp.106.025023. PMID: 17401038.

[8] National Institute for Health and Care Excellence. (2021). Looked-After Children and Young People (update) [F] Evidence review for interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers. [online] . Available at: NICE guideline looked after children and young people: [F] Evidence review for interventions to promote physical, mental, and em. [Accessed 3 Aug. 2021].

[9] National Institute for Health and Care Excellence. (2021). Looked-After Children and Young People (update) [F] Evidence review for interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers. [online] . Available at: https://www.nice.org.uk/guidance/gid-ng10121/documents/evidence-review-6. [Accessed 8 Jul. 2021].

[10] National Institute for Health and Care Excellence. (2021). Looked-After Children and Young People (update) [F] Evidence review for interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers. [online] . Available at: https://www.nice.org.uk/guidance/gid-ng10121/documents/evidence-review-6. [Accessed 8 Jul. 2021].

[11] NHS Digital (2018) 'Mental Health of Children and Young People in England, 2017' Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

[12] O'Brien, K & Fechteer-Leggett. (2009). 'The effects of kinship care on adult mental health outcomes of alumni of foster care'. Elsevier LTD.

[13] NHS Digital (2018) 'Mental Health of Children and Young People in England, 2017' Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

[14] O'Brien, K & Fechteer-Leggett. (2009). 'The effects of kinship care on adult mental health outcomes of alumni of foster care'. Elsevier LTD.

SEND	37% [15]	64%[16]	83%[17]	-	-

International evidence from a systematic review including 25 studies indicates that rates of mental health problems vary between 30% and 82% among children in care in high-income countries.[18] In one included study for example, children in care were 3 to 4 times more likely to be diagnosed with a range of disorders, including ADHD, depression, anxiety and behavioural problems than a comparison group of disadvantaged children.[19] This evidence also suggests high comorbidity, with 34% of young people in one study meeting criteria for two disorders.

In a systematic review of prevalence studies, Hambrick et al. (2016) found that common mental health disorders among children in foster care included disruptive behaviour disorders and Attention Deficit/Hyperactivity Disorder (54%, Garland et al., 2001), Posttraumatic Stress Disorder (20%; Kolko, Hurlburt, Zhang, Barth, Leslie, & Burns, 2010), other anxiety disorders (10%; Garland et al., 2001), and mood disorders (7%, Garland et al., 2001).[20] High rates of social-emotional and developmental problems in childhood mean many care experienced adults exhibit poor functioning throughout their lives, struggling with unemployment, incarceration, substance dependence, and early pregnancy.[21]

We have written a short, and separate, note on the evidence for mental health of care leavers.

Risk & Protective Factors

Risk and protective factors for mental health outcomes in children who are not in care have been well documented and will be relevant for children who enter care. Risk factors include low socio-economic status, family conflict, and poor parental mental health.[22] Protective factors include social support, good social and emotional skills, or more specifically, emotional identification, coping skills, communication skills, resilience and self-efficacy.[23]

Children with a social worker are far more likely to have experienced significant adversity however (see figure below which lists factors identified at assessment for children in need), which places them at higher risk of developing a psychiatric disorder across the lifecourse.

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[15] Jay, M. A., & Gilbert, R. (2021). Special educational needs, social care and health. Archives of disease in childhood, 106(1), 83–85. https://doi.org/10.1136/archdischild-2019-317985.

[16] Ibid.

[17] Ibid.

[18] Engler, A.D., Sarpong, K.O., Van Horne, B.S., Greeley, C.S. and Keefe, R.J. (2020). A Systematic Review of Mental Health Disorders of Children in Foster Care. Trauma, Violence, & Abuse, [online] p.152483802094119. Available at: https://journals.sagepub.com/doi/abs/10.1177/1524838020941197 [Accessed 4 Aug. 2021].

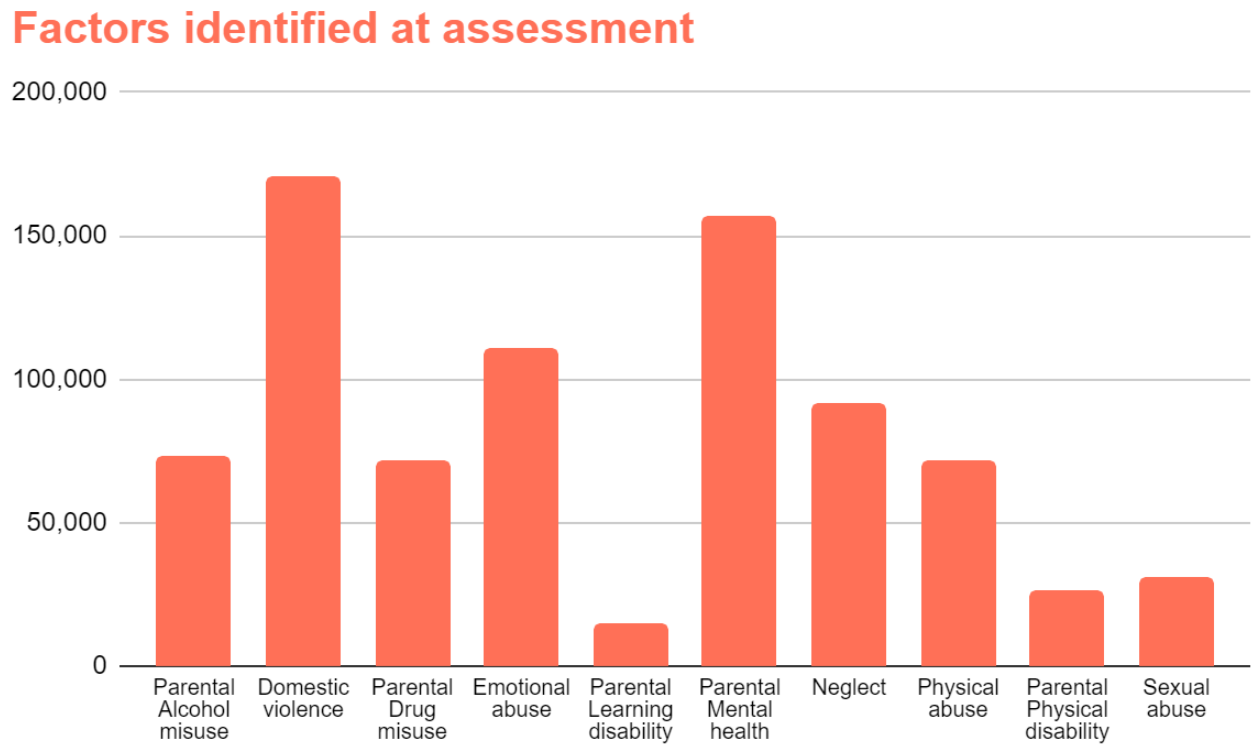
[19] Greiner, M. V., Beal, S. J. (2017). Foster care is associated with poor mental health in children. The Journal of Pediatrics, 182, 401–404.

[20] Hambrick, E.R., Oppenheim-Weller, S., N'zi, A.M., & Taussig, H.N. (2016). Mental Health Interventions for Children in Foster Care: A systematic Review. Children and Youth Services Review, 70, 65-77

[21] Hambrick, E.R., Oppenheim-Weller, S., N'zi, A.M., & Taussig, H.N. (2016). Mental Health Interventions for Children in Foster Care: A systematic Review. Children and Youth Services Review, 70, 65-77

[22] Wille, N., Bettge, S. and Ravens-Sieberer, U. (2008). Risk and protective factors for children's and adolescents' mental health: results of the BELLA study. European Child & Adolescent Psychiatry, 17(S1), pp.133–147.

[23] Early Intervention Foundation. (2021). Adolescent mental health: A systematic review on the effectiveness of school-based interventions. [online] . Available at: https://www.eif.org.uk/report/adolescent-mental-health-a-systematic-review-on-the-effectiveness-of-school-based-interventions [Accessed 3 Aug. 2021].



[24]

For children in care, data from 2020 indicates that 64% are in care because of abuse and or neglect, with a further 8% experiencing acute family distress or dysfunction and 7% in care because they are unaccompanied refugee children.[25] These adverse childhood experiences put children in care at substantial risk of developing a psychiatric disorder in childhood or adulthood.[26]

A systematic review of mental health disorders of children in foster care identified a number of risk factors.[27] Risk factors identified in this review for suicidality included, younger age, non-Hispanic ethnicity, abuse, multiple types of maltreatment, more referrals to child welfare, more transitions, placement instability, and longer time in foster care. The most robust predictors of suicidality included physical abuse and chronicity of maltreatment. Neglected children were more likely to express internalising behaviours, depression, anxiety, and insecure attachments. Sexually abused children were more likely to experience suicidal ideation, depression, anxiety, dissociative identity disorder, PTSD, and substance abuse disorders. Emotional abuse was associated with increased suicidality.

[24] Department for Education. (2020). *Characteristics of children in need, Reporting Year 2020*. [online] Available at: https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need/2020 [Accessed 4 May 2021].

[25] Department for Education. (2020). Children looked after in England including adoptions, Reporting Year 2020. [online] Available at: https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions [Accessed 2 Jul. 2021].

[26] Early Intervention Foundation.(2020). Adverse childhood experiences: What we know, what we don't know, and what should happen next. [online] Available at: https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next [Accessed 4 Aug. 2021].

[27] Engler, A.D., Sarpong, K.O., Van Horne, B.S., Greeley, C.S. and Keefe, R.J. (2020). A Systematic Review of Mental Health Disorders of Children in Foster Care. Trauma, Violence, & Abuse, p.152483802094119.

Further, children who were physically abused were more at risk of developing a conduct disorder, oppositional defiant disorder, major depressive disorder, anxiety, and PTSD. The number of maltreatment types experienced by a child was found to be the strongest predictor of a mental health disorder, implying a potential additive effect of maltreatment.

Other factors and experiences while in care are also associated with worse mental health problems. These include placement instability and placement type, with children in kinship and foster care reporting fewer mental health problems than young people in residential care.[28][29][30][31] A review comparing the mental health of children in kinship and foster care emphasises that quality of care in each placement is likely to play a greater role than placement type (kinship or foster care) specifically.[32] However, the review found that there was support for improved psychological outcomes for children in kinship care compared to nonkinship care, implying that closer familial relationships could be protective for children in foster care.[33] There is some evidence to suggest that siblings placed apart have worse outcomes however, this was not consistent across all analytical models in one study.[34] Placement instability has been shown to be a risk factor of continued mental health problems into adulthood.[35] Attachment security appears to be a crucial factor mediating the mental health outcomes of children placed in foster care.[36]

The following diagram is drawn from an international systematic review of resilience factors in children in residential care. It outlines factors which predict resilient outcomes for children in residential care.[37]

[28] Hiller, R.M. and St. Clair, M.C. (2018). The emotional and behavioural symptom trajectories of children in long-term out-of-home care in an English local authority. Child Abuse & Neglect, [online] 81, pp.106–117. Available at: https://www.sciencedirect.com/science/article/pii/S0145213418301686 [Accessed 4 Aug. 2021].

[29] Lou, Y., Taylor, E.P. and Di Folco, S. (2018). Resilience and resilience factors in children in residential care: A systematic review. Children and Youth Services Review, [online] 89, pp.83–92. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0190740917310046 [Accessed 3 Aug. 2021].

[30] Xu, Y. and Bright, C.L. (2018). Children's mental health and its predictors in kinship and non-kinship foster care: A systematic review. Children and Youth Services Review, 89, pp.243–262.

[31] Engler, A.D., Sarpong, K.O., Van Horne, B.S., Greeley, C.S. and Keefe, R.J. (2020). A Systematic Review of Mental Health Disorders of Children in Foster Care. Trauma, Violence, & Abuse, [online] p.152483802094119. Available at: https://journals.sagepub.com/doi/abs/10.1177/1524838020941197?journalCode=tvaa [Accessed 5 Aug. 2021].

[32] Xu, Y. and Bright, C.L. (2018). Children's mental health and its predictors in kinship and non-kinship foster care: A systematic review. Children and Youth Services Review, 89, pp.243–262.

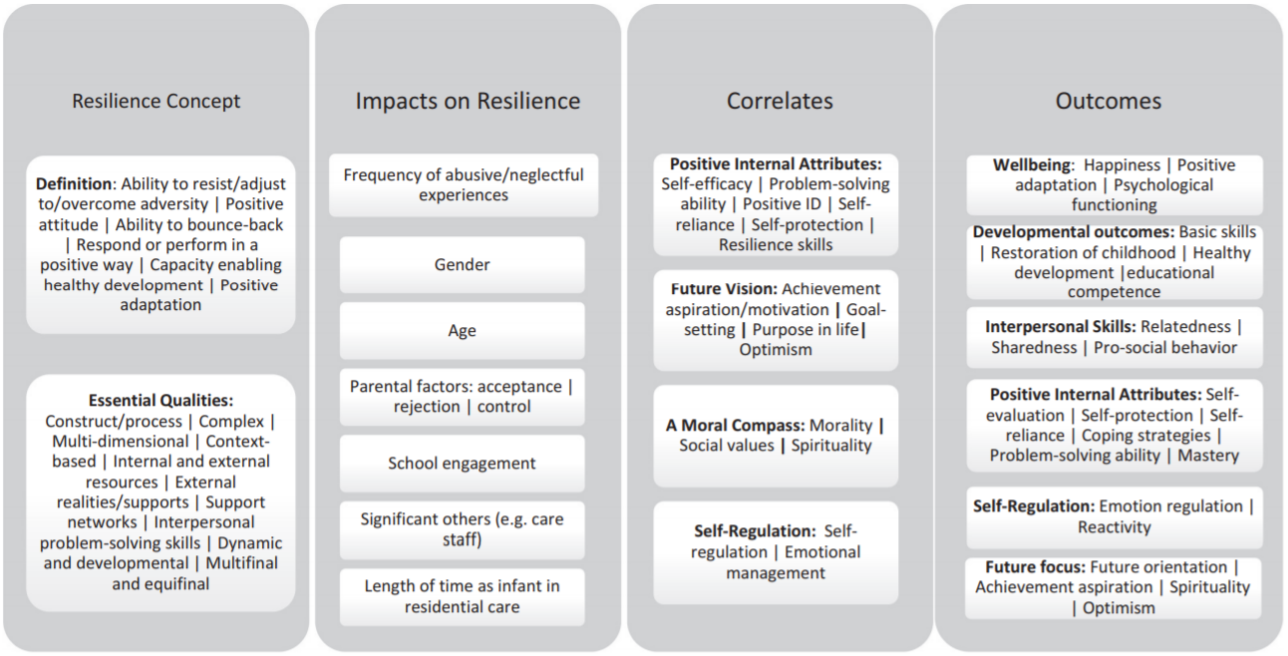
[33] Engler, A.D., Sarpong, K.O., Van Horne, B.S., Greeley, C.S. and Keefe, R.J. (2020). A Systematic Review of Mental Health Disorders of Children in Foster Care. Trauma, Violence, & Abuse, p.152483802094119.

[34] Hiller, R.M. and St. Clair, M.C. (2018). The emotional and behavioural symptom trajectories of children in long-term out-of-home care in an English local authority. Child Abuse & Neglect, [online] 81, pp.106–117. Available at: https://www.sciencedirect.com/science/article/pii/S0145213418301686 [Accessed 4 Aug. 2021].

[35] Engler, A.D., Sarpong, K.O., Van Horne, B.S., Greeley, C.S. and Keefe, R.J. (2020). A Systematic Review of Mental Health Disorders of Children in Foster Care. Trauma, Violence, & Abuse, p.152483802094119.

[36] Deuchar, S. and Majumder, P. (2021). Mental health services for children in care: investigation to elicit outcomes of direct and indirect interventions. BJPsych Bulletin, [online] pp.1–8. Available at: https://www.cambridge.org/core/journals/bjpsych-bulletin/article/mental-health-services-for-children-in-care-investigation-to-elicit-outcomes-of-direct-and-indirect-interventions/19E7076F1F3738F728E9CCF1A82985B8 [Accessed 11 Aug. 2021].

[37] Lou, Y., Taylor, E.P. and Di Folco, S. (2018). Resilience and resilience factors in children in residential care: A systematic review. Children and Youth Services Review, [online] 89, pp.83–92. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0190740917310046 [Accessed 3 Aug. 2021].



This evidence on risk and protective factors is correlational (though often longitudinal) and therefore not causal. We cannot therefore draw conclusions, for example that residential care or placement instability causes mental health problems (the relationship may be bidirectional), however these findings suggest that young people in residential care are likely to have disproportionate levels of mental health problems and should be targeted for intervention.

To our knowledge, there is limited data describing the prevalence of mental health in different groups of children in care, in particular children from ethnic minority backgrounds or who are LGBTQ+. Yet evidence suggests that in the general population these young people are at higher risk of developing mental health problems.

A systematic review of the experiences of children in care highlighted three key themes to improve mental health:[38]

- improve the continuity of social workers and carers to allow young people to develop trusted relationships with key adults,
- target broader concerns around stigma and trust (including in the school system) that may act as a barrier to help seeking, and
- ensure young people are receiving appropriate evidence-based psychological support in a more timely manner, before reaching crisis point.

Current Service Provision

CAMHS, Child and Adolescent Mental Health Services, is the name for the NHS services that assess and treat young people with emotional, behavioural or mental health difficulties. CAMHS services are organised by local authority around the UK, with teams made up of nurses, therapists, psychologists, child and adolescent psychiatrists support workers and social workers, as well as other professionals. The current system for accessing mental health support for children in care is complex, involving

[38] Hiller, R.M., Halligan, S.L., Meiser-Stedman, R., Elliott, E., Rutter-Eley, E. and Hutt, T. (2021). Coping and support-seeking in out-of-home care: a qualitative study of the views of young people in care in England. BMJ Open, [online] 11(2), p.e038461. Available at: https://bmjopen.bmj.com/content/11/2/e038461.info [Accessed 3 Aug. 2021].

different points of access, different services, and significant local variation within the broader regional differences.

There are four tiers of CAMHS services:[39]
Tier 1: universal services, including primary care, health visiting, early years services, and school nurses
Tier 2: targeted services, including youth offending teams, primary mental health workers, and school and youth counselling (including social care and education)
Tier 3: specialist outpatient treatment
Tier 4: highly specialised inpatient units and intensive community services

Children and young people may receive support through any tier of CAMHS. Some local authorities may also refer children and young people to third sector organisations or in some cases private provision. In some local authorities there are multi-agency or multidisciplinary services within children's social care which include CAMHS professionals. Similarly in many CAMHS teams there is specialist provision for children in care, although roles vary across local authorities. Referral points into these services are likely to vary as will type, intensity and quality of provision.

To our knowledge, there is no national data on how services are organised and provided around the country for children in care. We are aware of one study (due for publication in 2022) which has mapped service provision in three local authorities.[40] It highlights multiple referral routes, service provision type and structural arrangements which vary across authorities.

A study by Barnardo's (2019) identified two main issues with CAMHS for children in care. First, the types of therapy made available are not always suited to meet the needs of care experienced young people whose mental health problems are likely to be a result of trauma. Secondly, children in care and care leavers experience significant difficulties accessing support despite well documented mental health needs. Despite recognition that the majority of children who are in care for lengthy periods will experience mental health issues and poor wellbeing they are disproportionately affected by rejected referrals to CAMHS services (Barnardo's, 2019). This is because of a lack of stability, lack of engagement, or symptoms not being severe enough.[41] Placement moves, which are frequent for many young people in care, could exacerbate this problem as transferring care from one CAMHS in one Clinical Commissioning Group to another is often fraught with difficulties, and usually involves going through the referral process.

In 2010, NICE and SCIE published guidance on improving the mental health of looked after children. The key recommendations were:

- The need for health, education and social care professionals to collaborate more effectively to collect, monitor and share information and ensure that all of the information follows the child if they move.

[39] Crenna-Jennings, W. and Hutchinson, J. (2018). Access to children and young people's mental health services -2018. Education Policy Institute. Available at: https://epi.org.uk/wp-content/uploads/2018/10/EPI_Access-to-CAMHS-2018.pdf
[40] Clinicaltrials.gov. (2019). Relationships in Good Hands - Clinical and Cost-effectiveness of Dyadic Developmental Psychotherapy - Full Text View - ClinicalTrials.gov. [online] Available at: https://clinicaltrials.gov/ct2/show/NCT04187911 [Accessed 13 Aug. 2021].
[41] Sanders, R. (2020). Care experienced children and young people's mental health. [online] Iriss. Available at: https://www.iriss.org.uk/resources/esss-outlines/care-experienced-children-and-young-peoples-mental-health [Accessed 5 Jul. 2021].

- The need to develop and deliver services based on accurate, early assessment and intervention including referrals to specialist help.
- Universal and specialist training for professionals, primary carers (improved entry level and advanced training), social workers and independent reviewing officers (improved specialist training to support educational stability and achievement).[42]

In 2013 NICE also published this list of quality standards for the care of looked after children and young people (see Appendix 1).[43]

Referral Rates

In 2019/20, 4% of children in England accessed mental health services available on the NHS, last year in 2019/20. This is equivalent to about 1 in 3 children who needed mental health services (based on 2017 estimates of need); or 1 in 4, based on 2020 estimates of need. With regards to the 'covid effect', early data suggests that referrals to mental health services dipped early on in lockdown, but subsequently soared in early Autumn 2020. In April 2020 referrals were 34% lower than in the same month in 2019. In September they were 72% higher than in September 2019. In the year 2019/20 just 20% of children referred to services started treatment within 4 weeks, which falls far short of the government's 4-week waiting target. The average wait across England ranged from 8 days to 82 days.[44] There does appear to be a disparity between the better performing and the worse performing in terms of amount spent per child and the budget allocated to children's mental health services, suggesting that greater investment is needed to improve services and access (see Appendix 2). Unfortunately, these figures are not available for children in care, highlighting what is an important gap in knowledge for vulnerable children.

Effectiveness of interventions for children in care

This section focuses on the effectiveness of interventions for the mental health of children in care. We do not review the evidence for children in general.

There is a sizable evidence base on interventions to improve the mental health of children in care. However, much of the evidence is of low quality, and the majority of it is inconclusive. Our review of evidence below includes studies which cast a broad net in terms of children's outcomes; these include mental health problems as well as behavioural and emotional disorders. While these are distinct, many young people in care experience both. In addition, outcomes are, most frequently, carer reported.

For this evidence summary, we first identified systematic reviews to provide a summary of the evidence base as well as highlight interventions. We then did a brief search using the following search string: "mental health" + "in care" OR "foster care" OR "out-of-home care" + "impact evaluation" OR "RCT" OR "quasi-experimental design". We have included a table with all the systematic reviews we identified for this search in the appendix.

[42] Scie.org.uk. (2021). SCIE/NICE recommendations on looked after children: Home. [online] Available at: https://www.scie.org.uk/publications/guides/guide40/ [Accessed 2 Jul. 2021].

[43] Nice.org.uk. (2013). List of quality statements | Looked-after children and young people | Quality standards | NICE. [online] Available at: https://www.nice.org.uk/guidance/qs31/chapter/List-of-quality-statements [Accessed 2 Jul. 2021].

[44] Children's Commissioner. 2021. The state of children's mental health services 2020/21. [https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/cco-the-state-of-childrens-mental-health-services-2020-21.pdf]

A systematic review by Luke et al. (2014) argues that interventions need to be flexible to meet individual needs, and require a 'joined-up' approach from services, and follow-up support; this is currently not routine practice.

Direct Interventions for CYP

Direct interventions are those that target young people directly to improve their mental health.

CBT

A systematic review looking at the effectiveness of CBT for children who experienced sexual abuse found, reduced symptoms of depression, PTSD and anxiety following CBT treatment.

There was no evidence that CBT helped to reduce child behaviour problems. Only a small number of studies with small sample sizes were available for review. Larger, more robust studies are needed to provide evidence of the effectiveness of CBT in aiding children's recovery from sexual abuse. The evidence in this review was from the USA and Australia, therefore it may have limited applicability to the UK. The particular review did not focus on children in care specifically.[45]

A further systematic review found that Trauma Focussed CBT (TF-CBT) could reduce symptoms of posttraumatic stress for school-aged children in foster care.[46] Another study supplemented TF-CBT with an engagement intervention, and found that children and caregivers who received the engagement intervention were more likely to complete at least four sessions, and were more likely to be retained until treatment completion.[47][48]

Mentoring

Take Charge, a so-called self-determination intervention, using coaching and group mentoring for adolescents (14-17), found improvements in self-determination scores, quality of life, hopelessness and mental health recovery scores in the intervention group.[49] The treatment group had lower carer-reported anxiety/depression than controls at follow-up; the same was true for withdrawn/depressed.[50] A NICE review of this intervention suggests that mentoring interventions may be more effective for older children, they also noted that the evidence base for these types of interventions is not strong.

Animal Therapy

Another intervention that could offer support for the mental health of looked after children is animal therapy. The use of animals as part of group or individual therapy sessions is designed to enhance

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[45] What Works for Children's Social Care. (2020). Sexual abuse recovery using CBT - What Works for Children's Social Care. [online] Available at: https://whatworks-csc.org.uk/evidence/evidence-store/intervention/sexual-abuse-recovery-using-cbt/ [Accessed 4 Aug. 2021].

[46] Hambrick, Erin & Oppenheim-Weller, Shani & N'zi, Amanda & Taussig, Heather. (2016). Mental Health Interventions for Children in Foster Care: A Systematic Review. Children and Youth Services Review. 70. 10.1016/j.childyouth.2016.09.002.

[47] Dorsey S, Pullman MD, Berliner L, Koschmann E, McKay M, Deblinger E. (2014). Engaging foster parents in treatment: A randomized trial of supplementing trauma-focused cognitive behavioral therapy with evidence-based engagement strategies. Child Abuse & Neglect. 38:1508–1520. [PubMed: 24791605]

[48] Hambrick, Erin & Oppenheim-Weller, Shani & N'zi, Amanda & Taussig, Heather. (2016). Mental Health Interventions for Children in Foster Care: A Systematic Review. Children and Youth Services Review. 70. 10.1016/j.childyouth.2016.09.002..

[49] National Institute for Health and Care Excellence. (2021). Looked-After Children and Young People (update) [F] Evidence review for interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers. [online] . Available at: https://www.nice.org.uk/guidance/gid-ng10121/documents/evidence-review-6. [Accessed 8 Jul. 2021].

[50] Luke, N., Sinclair, I., Woolgar, M. and Sebba, J., 2014. What works in preventing and treating poor mental health in looked after children. London: NSPCC.

the therapeutic process and can help to create trust and acceptance. The ways in which animals are used is flexible: generally, children are encouraged to bond with the animals, sometimes by providing care, and in some cases, stories about the animals are related to the children's experiences. For children in care, work with dogs and horses in particular has shown links to decreases in trauma symptoms and an increase in felt attachment security. This evidence comes from the USA, with moderate but poorly matched samples and no long term follow up has been undertaken.[51]

DDP

Dyadic Developmental Psychotherapy (DDP) is a relationship-focused therapy characterised by a strong therapeutic alliance, empathy and unconditional positive regard. It seeks to treat the complex psychological problems of looked after and adopted children.[52] There is a limited but growing evidence base for DDP. It forms part of Dyadic Developmental Practice, which refers to both DDP and DDP informed work with parents. One of the main principles of DDP is that therapy with the child is supported by the parents/caregivers' active presence.

Wingfield and Gurney-Smith reported that 12 adoptive parents receiving DDP gained increased curiosity, understanding and empathy for their children, while the children reported fewer behavioural problems, improved control over emotions, better relationships with peers and improved sleep.[53] On the other hand, in spite of progress, a number of parents described the sessions as emotionally exhausting, uncomfortable and upsetting. Feedback from therapists delivering DDP has, however, been very positive. Turner-Halliday et al. (2014) reached out to child and adolescent mental health services (CAMHS) in the UK delivering the treatment. DDP was seen as an effective tool for directly tackling complex profiles of mental illness alongside the root causes of both internalising and externalising problems. The inclusion of parents and carers on such an emotionally stimulating journey was seen to indirectly facilitate secure attachment through an improved mutual understanding.[54] There is current research underway in this area with a registered trial: 'Relationships in Good Hands Trial: clinical and cost-effectiveness of Dyadic Developmental Psychotherapy for abused and neglected young children with maltreatment-associated problems and their parents', an RCT led by Professor Helen Minnis. To answer this research question, within three contrasting service contexts (NHS, Social Care, Private Practice), what is the clinical and cost-effectiveness of an intensive therapy (DDP) for improving mental health in abused and neglected children?[55]

Social Prescribing

Social prescribing is a way of linking patients in primary care with sources of support within the community to help improve their health and wellbeing. Social prescribing programmes are being widely promoted and adopted in the NHS.[56] One systematic review described the limitations of the evidence base, stating, most of the evaluations of social prescribing activity are small scale and

[51] Luke, N., Sinclair, I., Woolgar, M. and Sebba, J., 2014. What works in preventing and treating poor mental health in looked after children. London: NSPCC.

[52] Hughes, D., Golding, K.S. and Hudson, J. (2015). Dyadic Developmental Psychotherapy (DDP): the development of the theory, practice and research base. Adoption & Fostering, [online] 39(4), pp.356–365. Available at: https://journals.sagepub.com/doi/abs/10.1177/0308575915610943 [Accessed 11 Aug. 2021].

[53] Wingfield, M. and Gurney-Smith, B. (2019). Adoptive parents' experiences of dyadic developmental psychotherapy. Clinical child psychology and psychiatry, 24(4), pp.661-679.

[54] Turner-Halliday, F., Watson, N., Boyer, N.R., Boyd, K.A. and Minnis, H.. (2014). The feasibility of a randomised controlled trial of Dyadic Developmental Psychotherapy. BMC psychiatry, 14(1), pp.1-11.

[55] https://fundingawards.nihr.ac.uk/award/NIHR127801

[56] Bickerdike, L., Booth, A., Wilson, P.M., Farley, K. and Wright, K. (2017). Social prescribing: less rhetoric and more reality. A systematic review of the evidence. BMJ Open, [online] 7(4), p.e013384. Available at: https://bmjopen.bmj.com/content/7/4/e013384 [Accessed 11 Aug. 2021].

limited by poor design and reporting.[57] There is a small evidence base on social prescribing for children and we have not been able to identify evidence as it relates to children in care.

Life Story Work

Life Story Work (LSW) is the process of helping people to remember and make sense of their early lives. It can help children who have been separated from their birth family to understand their past, and come to terms with the present circumstances and what has happened to them along the way. LSW aims to give children a structured and understandable way of talking about themselves and helps them build a sense of self-worth and to develop a record about themselves they can refer to and carry with them through life. The work allows children to record facts about themselves, their birth families and the families they live with now, where they came from and where they live now.

Luke et al. (2014) report that the majority of the evidence base on LSW comprises qualitative work. It suggests that children and their caregivers can value life story work as an opportunity to work through emotions and explore identity, and to improve their relationships. One study linked life story intervention to decreases in children's externalising behaviours.[58] The evidence cited comes from the US and the UK, using very small sample sizes and measures of changes in children's behaviour were rated by carers.[59] A quick search suggests that the nature of the evidence base has not changed in this time.

A systematic review of the facilitators and barriers to refugee children disclosing their life stories found the main barriers to disclosure were feelings of mistrust and self-protection from the side of the child and disrespect from the side of the host community. While the facilitators included, a positive and respectful attitude of the interviewer, taking time to build trust, using nonverbal methods, providing agency to the children, and involving trained interpreters.[60]

Non Violent Resistance

Non-violent Resistance (NVR) is a method to manage child and adolescent aggressive behaviour and to decrease parental helplessness. It's described as a systematic approach for helping parents, teachers, and other caregivers cope with violent and self-harmful behaviours by strictly non-violent and non-escalating means.[61] It has its root in the sociopolitical field but has now been adapted for parents of youth with challenging behaviour, foster parents, teachers, and caregivers of psychiatric inpatients. We could only identify a small number of studies relating to the effectiveness of NVR. One of these is an RCT of NVR training with foster parents in Belgium which found only small effects in favour of the intervention for improvement of child behaviours from the total problems scale at treatment completion and on internalising, externalising, and total problems at the follow-up.[62] These

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[57] Ibid.

[58] Haight, W., Black, J., and Sheridan, K. (2010) A mental health intervention for rural, foster children from methamphetamine involved families: Experimental assessment with qualitative elaboration. Children and Youth Services Review, 32(10), 1,446–1,457.

[59] Luke, N., Sinclair, I., Woolgar, M. and Sebba, J., 2014. What works in preventing and treating poor mental health in looked after children. London: NSPCC.

[60] van Os, E. C. C., Zijlstra, A. E., Knorth, E. J., Post, W. J., & Kalverboer, M. E. (2020). Finding Keys: A Systematic Review of Barriers and Facilitators for Refugee Children's Disclosure of Their Life Stories. Trauma, Violence, & Abuse, 21(2), 242–260. https://doi.org/10.1177/152483801875774

[61] Omer, H. and Lebowitz, E.R. (2016). Nonviolent Resistance: Helping Caregivers Reduce Problematic Behaviors in Children and Adolescents. Journal of Marital and Family Therapy, [online] 42(4), pp.688–700. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5575919/ [Accessed 12 Aug. 2021].

[62] Van Holen, F., Vanderfaeillie, J., Omer, H. and Vanschoonlandt, F. (2016). Training in Nonviolent Resistance for Foster Parents. Research on Social Work Practice, [online] 28(8), pp.931–942. Available at: https://journals.sagepub.com/doi/abs/10.1177/1049731516662915 [Accessed 16 Aug. 2021].

small effects on behavioural problems are comparable with the effects achieved by other training programs for parents.
For parenting stress, small positive effects were found at treatment conclusion in 3 out of 4 parenting stress scales, increasing to medium-sized effects at follow-up. Foster mothers in the NVR group felt more able to cope, reported less severe problems, and were more satisfied with the parenting situation. This study is limited by a small sample and restricted randomisation.[63]

Interventions for carers

Parenting interventions are commonly used to enhance children's outcome, including behavioural and mental health outcomes.

A systematic review by Shoemaker et al. (2020) examined the effectiveness of parenting interventions (e.g. Incredible Years, MTFC-A, KEEP) for foster and/or adoptive families in a series of meta-analyses regarding four parent outcomes, three child outcomes, and placement disruption. The meta-analyses for child outcomes showed that parenting interventions are only effective in decreasing child behaviour problems and not effective in improving attachment security. In addition, analyses also found no significant overall effect on diurnal cortisol levels of foster and/or adopted children. Intervention programs were most effective for older children with regard to sensitive parenting, dysfunctional discipline (only for children up to 5 years old), and parenting stress. For this meta-analysis, any effects on child outcomes are indirect (as they are mediated through parenting behaviour) and may take some time to be revealed because they are dependent on the development and interaction of parent and child behaviours over time. However, the strongest overall effect was found for sensitive parenting, and previous research has suggested that increasing parents' sensitive behaviour may result in improvements in attachment security, stress regulation, and placement disruption of children. Results showed that parenting interventions are positively effective (with small to large overall effect sizes) in improving sensitive parenting, dysfunctional discipline, parenting knowledge and attitudes, and parenting stress of foster and adoptive parents. The largest overall effect size was found for sensitive parenting, indicating that the evidence base for existing parenting interventions that are aimed at improving sensitive behaviours in foster and adoptive parents is strong.[64]
Please see Appendix 3 for a table of characteristics of intervention studies included in the meta-analysis.

Fostering Changes
Fostering Changes is a 12-week course for foster carers, which aims to help carers build positive relationships with children in their care. Carers are taught to encourage desirable behaviours through the use of positive reinforcement and the setting of clear limits and consequences for behaviour. One RCT found showed a significantly greater reduction in the intervention group's reports of children's problem behaviours, and a greater improvement in the carer-reported quality of attachment between

[63] Ibid,
[64] Schoemaker, N.K., Wentholt, W.G.M., Goemans, A., Vermeer, H.J., Juffer, F. and Alink, L.R.A. (2019). A meta-analytic review of parenting interventions in foster care and adoption. Development and Psychopathology, [online] 32(3), pp.1149–1172. Available at: https://www.cambridge.org/core/journals/development-and-psychopathology/article/metaanalytic-review-of-parenting-interventions-in-foster-care-and-adoption/3FC41F78B9B1B4582CBD9E37BA1DB6EF [Accessed 4 Aug. 2021].

the child and carer, in comparison to the control group.[65] However, outcomes were measured using the Carer Efficacy Questionnaire (CEQ), which is not a standardised measure. Long-term follow-up was not included in the research. A further RCT has since been conducted in Wales in which 312 foster carers from 19 sites were assigned to treatment. At 12 months they found no difference between trial groups for the primary outcome of carer efficacy. There were small statistically significant differences between trial groups on carer-reported child behavioural problems and carer-reported use of coping strategies. These differences reduced over time. Carers reported that the content of the course encouraged taking a more understanding, less confrontational approach and many of the foster carers described having learned new ways of dealing with behaviours and situations, including praise and distraction.[66]

MTFC-A

Multidimensional Treatment Foster Care for Adolescents, is a specialised form of treatment foster care, based on theories of social learning and behavioural reinforcement, and provides specially trained foster carers and the children they look after with a wraparound team of social workers, therapists, skills workers and managers. Reviewing the evidence on MTFC, Luke et al. (2014) conclude that MTFC has failed to consistently demonstrate lasting effects. They propose that MTFC and treatment residential care may be effective for those who are expected to return home or move to a long-stay placement.

KEEP

Keeping Foster Parents Trained and Supported (KEEP) developed as an offshoot of MTFC for a wider group of foster and kinship carers. This 16-session programme aims to strengthen the behaviour management skills of carers. Carers are taught how to use behavioural contingencies; set effective limits; and balance encouragement with limits. Currently all of the evidence comes from the USA, which shows that children had fewer carer reported behavioural issues compared with those in control groups, mediated by greater positive reinforcement behaviour by the KEEP carers. However, comparison groups do not receive a placebo intervention. This is problematic, as the outcome measures are carer-reported, and follow ups have also been short (maximum 2 months).[67]

Incredible Years

Developed from the Incredible Years parenting programme, Incredible Years Carer Training, aims to improve parenting skills, in order to prevent or reduce children's problem behaviours and to improve their social skills. Overall findings have been mixed with limited evidence for children in care. Foster carers in Wales who received Incredible Years training reported a greater reduction in problem behaviours in the children they looked after (aged 2–17 years) at a follow-up six months after the start of the intervention, when compared with controls. They also reported a greater reduction in hyperkinetic behaviours.[68] Luke et al. (2014) also note that measures are reported by carers; it is debatable whether a carer-reported measure of children's behaviour after training is a reflection of

[65] Luke, N., Sinclair, I., Woolgar, M. and Sebba, J., 2014. What works in preventing and treating poor mental health in looked after children. London: NSPCC.

[66] National Institute for Health and Care Excellence. (2021). Looked-After Children and Young People (update) [F] Evidence review for interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers. [online] . Available at: https://www.nice.org.uk/guidance/gid-ng10121/documents/evidence-review-6. [Accessed 8 Jul. 2021].

[67] Ibid.

[68] Luke, N., Sinclair, I., Woolgar, M. and Sebba, J., 2014. What works in preventing and treating poor mental health in looked after children. London: NSPCC.

reductions in the behaviour itself or rather in the carers' increased confidence in dealing with them.[69] Linares et al. (2006) in a US based study found increased use of positive praise at the end of the intervention and at three months follow-up with a sample of 64 foster children, compared with services as usual. This intervention also found improved co-parenting between biological parents and foster carers on completion of the intervention.[70]

Triple-P

The Triple-P Parenting Programme is a system involving five different levels of intervention, ranging from very low intensity to high intensity. An RCT has been conducted in Germany using Triple-P with foster carers.[71] Eighty-one families with 87 children in foster care aged 2 to 7 years participated in the trial. Intervention and control group families were reassessed three times over a period of 1 year. The study found no advantages of the intervention group compared with the usual care control group on any outcome measure, and concluded the present intervention is likely associated with a low risk of harm but also with a high likelihood of a lack of significant benefits for foster parents and their young children going beyond feeling satisfied about the delivered services. The authors hypothesised that as entrance to foster care is already associated with some favourable outcomes, additional support did not add significant benefit, as well as this, participating foster families showed favorable baseline results on parenting measures which may have impeded intervention effects to unfold on these proximal variables.

Luke et al. (2014) offer a succinct summary of the evidence base as it stands, that the interventions that target behavioural or emotional difficulties are sometimes costly, particularly intensive ones such as MTFC, and "limitations with the research make it difficult to say a particular intervention or factor has been shown to 'work', leaving us with a set of common principles that require more rigorous testing. Behavioural interventions are largely delivered through caregivers, consistent with the evidence base for the disorders. The programmes reviewed that appear to have some 'success' have in common a structured programme of core components with some flexibility to meet individual needs; a 'joined-up' approach from services; and follow-up support.[72]

System Level Interventions

We are aware of a number of new system level interventions which may be promising, however there is little or no evidence to support their effectiveness as of yet. We outline these briefly below.

Trauma Informed Care

According to the EIF, Trauma Informed Care (TIC) is underpinned by the principle that experiences of trauma are prevalent and may interfere with service users' ability to form a trusting relationship with their providers. The EIF emphasise the limitations of the existing evidence base for TIC, but state that findings from less rigorous studies are positive, observing improvements in practitioners' knowledge

[69] Ibid.

[70] Hambrick, E.R., Oppenheim-Weller, S., N'zi, A.M., & Taussig, H.N. (2016). Mental Health Interventions for Children in Foster Care: A systematic Review. Children and Youth Services Review, 70, 65-77

[71] Job, A.-K., Ehrenberg, D., Hilpert, P., Reindl, V., Lohaus, A., Konrad, K., & Heinrichs, N. (2020). Taking Care Triple P for Foster Parents With Young Children in Foster Care: Results of a 1-Year Randomized Trial. Journal of Interpersonal Violence. https://doi.org/10.1177/0886260520909196.

[72] Luke, N., Sinclair, I., Woolgar, M. and Sebba, J., 2014. What works in preventing and treating poor mental health in looked after children. London: NSPCC.

of ACEs, screening and referral procedures, potential reductions in cases of child maltreatment (although it has been difficult to disambiguate these from reporting practices), increased placement stability, and reductions in reports of depression, family difficulties and child behaviour problems.[73] However, one US based RCT of a TIC service found a very small significant difference in practice outcomes within any of the measured domains of improvements in trauma screening practices, case planning, mental health and family involvement, progress monitoring, collaboration, and perceptions of the state's overall system performance.[74]

Mental Health Assessments

The Anna Freud Centre, funded by the DfE, are running a series of pilots to improve mental health assessments for children entering care. The project aims to ensure that the approach used for mental health assessments is appropriate for Looked After Children's needs, such that it would increase the likelihood of accessing the right support, at the right time and by responding to each child's individual needs. According to a press release on the pilots, up to 10 pilots across the country will work with the Anna Freud Centre over a period of two years to trial a new approach to mental health assessments, benefiting from additional funding and a bespoke package of support, including training and dedicated implementation consultants.[75]

Virtual Mental Health Leads

Modelled on the successful implementation of Virtual School Heads who have a statutory responsibility towards children in care in each LA. Those appointed as Virtual Mental Health Leads (VMHL) would have a similar oversight role. With the aim to ensure that all young people with a social worker receive the support they need for their mental health and emotional wellbeing.[76]

The development and implementation of such a role, or similar, is an idea that has been circulating for some time. However, it is yet to be implemented.

Challenges

There are a number of challenges in addressing the mental health of children and young people with care experience. These range from issues with access and funding to potential limitations of diagnostic tools.

A significant challenge is engaging young people in therapeutic interventions that are acceptable and attractive to them. If young people do not engage with services provided, this limits the usefulness of the evidence that is able to be produced.[77] An intervention or service can only be fully implemented

[73] Asmussen, K., Fischer, F., Drayton, E. and Mcbride, T. (2020). Adverse childhood experiences: What we know, what we don't know, and what should happen next. Early Intervention Foundation.

[74] Asmussen, K., Fischer, F., Drayton, E. and Mcbride, T. (2020). Adverse childhood experiences: What we know, what we don't know, and what should happen next. Early Intervention Foundation.

[75] Annafreud.org. (2018). Improving mental health assessments for children entering care – pilot project. [online] Available at: https://www.annafreud.org/insights/news/2018/10/improving-mental-health-assessments-for-children-entering-care-pilot-project/ [Accessed 12 Aug. 2021].

[76] Social Care Institute for Excellence (SCIE). (2017). Transforming mental health support for our children and young people. [online] Available at: https://www.scie.org.uk/news/mediareleases/looked-after-wellbeing [Accessed 16 Aug. 2021].

[77] Dixon, J., Biehal, N., Green, J., Sinclair, I., Kay, C. and Parry, E. (2013). Trials and Tribulations: Challenges and Prospects for Randomised Controlled Trials of Social Work with Children. British Journal of Social Work, [online] 44(6), pp.1563–1581. Available at: https://academic.oup.com/bjsw/article-abstract/44/6/1563/1738632 [Accessed 6 Aug. 2021].

and evaluated if children and young people are willing to engage with it. For example, a recent pilot feasibility study for a substance misuse intervention for children in care concluded that due to low recruitment and retention of participants, an RCT was not feasible.[78] Engagement with adults, services and other young people can be a real challenge for children in care, often due to past trauma and a mistrust of adults. This should be considered during intervention or service development.

Recent reporting on joint targeted area inspections (JTAIs), stated that for some vulnerable young people, including those in care, there is a legacy of drift and delay in agencies identifying and responding to their mental health needs.[79]

There are also inevitable issues around funding of services. These can often arise when a young person is moving house or placement for example, causing a change in Clinical Commissioning Group (CCG)/GP and requiring different funding streams to fund existing treatment. Furthermore, there are well reported delays and difficulties in gaining access to appropriate mental health support for young people in care.

A note on measurement of outcomes

Another factor to be considered is the potential limitations of measurement, screening and diagnostic tools. For example, the SDQ is an extremely widely used screening tool, both by professionals and for research purposes. Luke et al. (2014) state, the SDQ provides an easy way of monitoring children's wellbeing over time; it could give a broad indication of those who are having significant difficulties and may need further assessment, though the data collected could be much more extensively used.[80] The SDQ is most commonly used in it's singular format, where only the carer report is collected. This is also often used to set thresholds for access to CAMHS services. Used in this way, it may lead to young people being excluded from desperately needed services, especially given the high levels of complexity involved.[81] As an example, for some specific sub-groups such as UASC, the SDQ has been found to be insufficient in recognising PTSD symptoms.[82] The SDQ is a narrow screening tool and is more effective at 'screening' for some disorders, e.g conduct issues, than others e.g, depression.

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[78] Alderson, H., Kaner, E., McColl, E., Howel, D., Fouweather, T., McGovern, R., Copello, A., Brown, H., McArdle, P., Smart, D., Brown, R. and Lingam, R. (2020). A pilot feasibility randomised controlled trial of two behaviour change interventions compared to usual care to reduce substance misuse in looked after children and care leavers aged 12-20 years: The SOLID study. PLOS ONE, [online] 15(9), p.e0238286. Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0238286#sec035 [Accessed 9 Aug. 2021].

[79] 'Feeling heard': partner agencies working together to make a difference for children with mental ill health. (2020). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942529/JTAI_-_partner_agencies_and_children_with_mental_ill_health.pdf

[80] Luke, N., Sinclair, I., Woolgar, M. and Sebba, J., 2014. What works in preventing and treating poor mental health in looked after children. London: NSPCC.

[81] Wright, H., Wellsted, D., Gratton, J., Besser, S.J. and Midgley, N. (2019). Use of the Strengths and Difficulties Questionnaire to identify treatment needs in looked-after children referred to CAMHS. Developmental Child Welfare, [online] 1(2), pp.159–176. Available at: https://journals.sagepub.com/doi/10.1177/2516103218817555 [Accessed 20 Jul. 2021].

[82] National Institute for Health and Care Excellence. (2021). Looked-After Children and Young People (update) [F] Evidence review for interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers. [online] . Available at: https://www.nice.org.uk/guidance/gid-ng10121/documents/evidence-review-6. [Accessed 8 Jul. 2021].

For diagnosis, Luke et al. (2014) suggest the SDQ, Child Behaviour Checklist (CBCL) and Children's Global Assessment Scale (CGAS) may be more useful as broad measures of well-being than for assessing specific conditions, and that teacher and carer reports are more useful than the self-report.

The Child Outcomes Research Consortium (CORC) is a useful resource for finding the most appropriate outcome measure. There has also been suggestion that data from tools like the SDQ that are used so widely in CSC should be made more readily available, and local and national level CAMHS data should be accessible to researchers and professionals. Further to this, while this data is not always available, LAs and CCGs or CAMHS also do not consistently collect this level of data on all young people, for example, for young people who identify as LGBTQ+, and on ethnicity. It is also difficult to use the data to compare outcomes or prevalence of mental health difficulties amongst children of different ethnic backgrounds. Limitations in the data collected make it harder to accurately determine 'what works'.

Conclusion

This paper has summarised the evidence base on the mental health of looked after children. The lack of available data on the prevalence of mental health conditions for children within the children's social care system is an issue, particularly at LA level for children in care. Further, the lack of data is a particular issue in understanding prevalence for underrepresented groups, such as those who identify as LGBTQ+, where the evidence suggests that in the general population these young people are at higher risk of developing mental health problems. However, this data is not collected for these groups when in care. At present, the DfE publishes statistics on emotional and behavioural health (through SDQ scores) for looked after children, yet this is insufficient for determining the extent of mental health conditions of looked after children. It therefore is recommended that data on the prevalence of mental health conditions for children in care be gathered and collated, with health, education and social care collaborating to collect and share this information. Where possible, this data should be broken down by groups such as gender, ethnicity and sexuality, in order to track whether particular cohorts of looked after children have disproportionate rates of mental health conditions.

Further, there is a lack of data on assessment, quality of care, support and interventions. Data on how CAMHS services are organised and provided around the country, including for looked after children should be collected and made publicly available.

The significant limitations to the evidence base for interventions, with many not (yet) having robust evidence to say that they work for looked after children, calls for further high quality research to determine which interventions are evidence-led.

There are also system wide challenges to contend with such as issues around funding for mental health services. Research on those interventions which show promise is being undertaken, for example on DDP.

Mental health and Care Leavers (August 2021) Evidence Summary

The Evidence Summaries have not been conducted or written as rapid reviews, systematic reviews or comprehensive literature reviews. Instead they were designed and written as brief notes intended to give the Independent Review of Children's Social Care a quick overview of some of the evidence on a particular topic or question. They are only being published for transparency and given their very limited scope, are not intended as a resource for wider purposes.

Prevalence

Currently, there is no national data collected concerning the mental health and wellbeing of care leavers in the UK. However, Coram Voice has developed 'Bright Spots Indicators' which is a survey that measures the subjective well-being of care leavers. This tool was co-produced with care-experienced young people to reflect their conceptual understanding of well-being. Their 2020 report 'What Makes Life Good'[83] analyses the responses of 1,804 care leavers collected in 21 local authorities between 2017 and 2019. These responses were compared with the general population by asking care leavers the same four questions that the Office of National Statistics uses to measure subjective wellbeing. They found that a larger proportion of care leavers reported low well-being in all four questions in comparison to their non care-experienced counterparts.

	Data source	**Low scores (0 to 4)** **%**	**Very high scores (9 to 10)** **%**
Life Satisfaction	Your Life Beyond Care	26%	16%
	Annual Population Survey	3%	27%
Happiness	Your Life Beyond Care	26%	21%
	Annual Population Survey	8%	32%
Things I do in life are worthwhile	Your Life Beyond Care	23%	22%
	Annual Population Survey	4%	32%
Anxiety	Your Life Beyond Care	34%	29%
	Annual Population Survey	20%	38%

[83] Briheim-Crookall, L., Michelmore, O., Baker, C., Oni, O., Taylor, S., & Selwyn, J. (2020). What makes life good? Care leavers' views on their well-being. [online]. Coram Voice. Available at: https://coramvoice.org.uk/wp-content/uploads/2020/11/1883-CV-What-Makes-Life-Good-Report-final.pdf [Accessed 25 Jul. 2021].

In comparison to responses from children looked after aged 11 to 18, care leavers reported lower levels of wellbeing. There also appears to be significant variation in care leaver wellbeing between local authorities, with rates ranging from 14% - 44%.

There is little data on the lifelong impact of care experience upon mental wellbeing, although we know from studies such as Felitti et al's (1998)[84] that the impact of trauma and adverse childhood experiences on lifelong wellbeing is pervasive. The Care Leavers Association conducted a mixed-methods study[85] on the physical and mental health needs of care-experienced people of all ages. They collected survey responses from 418 care leavers and 215 health professionals working with care leavers. They found high numbers of mental health needs experienced during and after care:

	During Care	After Care
Anxiety	80%	79%
Depression	78%	75%
Low self-esteem	87%	83%
Self harm	40%	29%
Difficulty managing anger	60%	49%
Substance misuse	33%	44%

Current service provisions

The transition from CAMHS to Adult Mental Health Services (AMHS) typically begins between the age of 16 - 18. Some local authorities may have a dedicated LAC CAMHS service that extends support to care leavers up to 25[86], however, this is uncommon. For most CAMHS services, the cut off remains at 18, which has created a 'cliff edge' in service provision where many care leavers are left with decreased access to mental health services[87]. This is compounded by a reduction in statutory service support from the local authority which often coincides with instability and significant life changes (e.g leaving care placements) as care leavers are accelerated into independence at 18.

Most adults with mental health disorders receive provision through primary care services, whilst a small minority of adults diagnosed with severe mental illness will meet the threshold for secondary care AMHS[88]. Practitioners in Barnardo's (2017)[89] study reported that care leavers they worked with

[84] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of t he leading causes of death in adults. The Adverse Childhood Experiences (ACE) study. Am J Prev Med. 14(4), pp.245-258.

[85] Braden, J., Goddard, J., & Graham, D., 2017. Caring for Better Health: An investigation into the health needs of care leavers. [Online]. The Care Leavers Association. Available at: https://careleaverpp.org/wp-content/uploads/2018/04/Caring-for-better-health.pdf [Accessed 25 Jul 2021].

[86] SABP. (2021). CAMHS Care Leavers.[Online] Available at: https://www.sabp.nhs.uk/CYPFwellbeing/services/MH-LD/camhs-care-leavers [Accessed 26 Jul. 2021].

[87] Smith, N. (2017). Neglected Minds: A report on mental health support for young people leaving care. [online]. Barnardos. Available at: https://www.barnardos.org.uk/sites/default/files/uploads/neglected-minds.pdf [Accessed 25 Jul. 2021].

[88] Lamb, C., & Murphy, M. (2013). The divide between child and adult mental health services: points for discussion. British Journal of Psychiatry. 202(54), pp.41-44. https://doi.org/10.1192/bjp.bp.112.119206

[89] Smith, N. (2017). Neglected Minds: A report on mental health support for young people leaving care. [online]. Barnardos. Available at: https://www.barnardos.org.uk/sites/default/files/uploads/neglected-minds.pdf [Accessed 25 Jul. 2021].

were rarely diagnosed with severe mental illnesses and therefore frequently do not reach the criteria for AMHS. Instead, mental health needs are often related to pre-care experiences such as attachment disorders, emotional or conduct disorders and PTSD. Additionally, they found that 65% of care leavers experiencing mental health problems were not currently receiving mental health support from statutory services. Care leavers who did receive support often received time-limited interventions such as CBT which practitioners reported being unsuitable for many care leavers. Similarly, Braden, Goddard and Graham (2017)[90] reported almost a third of care leavers in their study experienced challenges in accessing mental health services. Key barriers identified were: thresholds, assessments, waiting times and available interventions. Participants expressed that a greater understanding of the issues that care leavers experience throughout adulthood is needed in AMHS. Further, assessments and eligibility criteria should reflect the additional needs of care-experienced adults.

Evidence of Effectiveness

There is a dearth of high-quality evidence in the UK that seeks to explore the effectiveness of interventions aimed to improve the mental wellbeing of care leavers.

Alderson et al's (2020)[91] pilot feasibility RCT explored the effectiveness of two evidence-based behavioural change interventions to reduce risky substance use and improve mental health for young people in or leaving care; Motivational Enhancement Therapy (MET) and Social Behaviour and Network Therapy (SBNT). MET is a client-centred approach to counselling which acknowledges the therapist's role in enabling change but centres on the young person as the facilitator of change. SBNT utilises cognitive and behavioural strategies to support the development of positive social networks which can support behaviour change and goal attainment. However, the results of this study were inconclusive due to challenges in recruitment, retention of participants and challenges in data collection[92]. Nevertheless, the study found that young people often perceived their substance use as a symptom of other issues that were affecting their lives. The authors suggest that interventions need to be delivered more horizontally, where several interrelated factors can be explored at the same time, and situated within a wider context of adverse childhood experiences and the challenges of experiencing the statutory care system. A broader tiered approach such as the 'Thrive' model[93] adopted by CAMHS was suggested by Alderson et al (2020) as a potential way to deliver this intervention to young people with care experience. They suggest that this would foster a person-centred approach that could be delivered in a way that recognises the wider determinants of risk within the context of the care system, in addition to accommodating both preventative interventions or intensive therapeutic work.

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[90] Braden, J., Goddard, J., & Graham, D., 2017. Caring for Better Health: An investigation into the health needs of care leavers. [Online]. The Care Leavers Association. Available at: https://careleaverpp.org/wp-content/uploads/2018/04/Caring-for-better-health.pdf [Accessed 25 Jul 2021].

[91] Alderson, H., Kaner, E., McCool, E., Howel, D., Fouweather, T., McGovern, R., Copello, A., Brown, H., McArdle, P., Smart, D., Brown, R., & Lingam, R. (2020). A pilot feasibility randomised controlled trial of two behaviour change interventions compared to usual care to reduce substance misused in looked after children and care leavers aged 12-20 years: The SOLID study. PLoS ONE, 15(9) https://doi.org/10.1371/journal.pone.0238286

[92] ibid

[93] Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M., Fonagy, P., Fleming, I., & Munk, S. (2019). THRIVE Framework for system change. [online] CAMHS Press. Available at: http://implementingthrive.org/wp-content/uploads/2019/03/THRIVE-Framework-for-system-change-2019.pdf [Accessed 3 Aug 2021].

Taylor et al's (2021)[94] systematic review and meta-analysis on interventions to improve outcomes for young people leaving care found that independent living programmes are unlikely to have a significant impact on the mental wellbeing of care leavers, however, they may be beneficial in conjunction with other support services. It found limited evidence that extended care policies can improve psychosocial outcomes for young people leaving care, and certainty in the evidence is low. It is important to note that almost all of the studies included in this review were from the United States, which may reduce its applicability to the UK. Listed below are the findings from this review that relate to mental health outcomes:

Miller et al (2020)[95] study on extended care programmes in Washington State observed a statistically significant impact on mental health outcomes for young people leaving care. Extended foster care enables fostered youth to remain in foster care until 21 if enrolled in an education program. Extended foster care can include other services such as supervised independent living. In this QED analysis, reductions in inpatient and outpatient substance abuse treatment and inpatient and outpatient mental health treatment were observed. However, there were no statistically significant reductions in the prevalence of diagnosed mental health conditions between those who received extended care and those who did not, although there was some reduction in diagnosed drug-related substance use disorder. There are moderate concerns relating to risk of bias within these results, and caution should be taken when interpreting these findings.

The RCT of YVLifeSet reported statistically significant reductions in depression and anxiety symptoms[96]. LifeSet is an intensive in-home support programme that provides support to young people leaving care for up to twelve months. It aims to facilitate successful transitions into independence. LifeSet provides highly individualised and high-intensity support, generally with weekly hour-long face-to-face sessions and the availability of 24/7 crisis intervention. It is a clearly defined programme that includes a range of interventions tailored to focus on the individual's needs, such as emotional regulation, psychoeducation on trauma and client-centred counselling. Practitioners hold low caseloads and receive structured supervision to encourage adherence to the programme. Whilst there are some concerns of bias within the relatively small improvements in depression and anxiety symptoms observed in those who received this intervention, it could be considered clinically meaningfully[97].

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[94] Taylor, D., Albers, B., Mann, G., Chakraborty, S., Lewis, J., Mendes, P., Macdonald, G., Williams, K., & Shlonsky, A. (2021). Systematic review and meta-analysis of policies, programmes and interventions that improve outcomes for young people leaving the out-of-home care system. [Online]. CEI. Available at: https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_-Systematic_Review_YP_Leaving_OOH_Care_July2021_FINAL.pdf [Accessed 28 Jul. 2021]

[95] Miller, M., Bales, D., & Hirsch, M. (2020a). Extended Foster Care in Washington State: Final Report. [online]. Available at: https://www.wsipp.wa.gov/ReportFile/1721/Wsipp_ExtendedFoster-Care-in-Washington-State-Final-Report_Report.pdf [Accessed 26 Jul. 2021].

[96] Courtney, M.E., Valentine, E.J., & Skemer, M. (2019). Experimental evaluation of transitional living services for system-involved youth: Implications for policy and practice. Children and Youth Services Review. 96, pp.396-408. https://doi.org/10.1016/j.childyouth.2018.11.031

[97] Taylor, D., Albers, B., Mann, G., Chakraborty, S., Lewis, J., Mendes, P., Macdonald, G., Williams, K., & Shlonsky, A. (2021). Systematic review and meta-analysis of policies, programmes and interventions that improve outcomes for young people leaving the out-of-home care system. [Online]. CEI. Available at: https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_-Systematic_Review_YP_Leaving_OOH_Care_July2021_FINAL.pdf [Accessed 28 Jul. 2021]

The RCT of the Better Futures intervention reported a large statistically significant improvements in young people's mental health empowerment[98]. Better Futures is a coaching and peer support programme for care-experienced young people who experience mental health challenges, and endeavours to increase entry to post-secondary education and support development of self-determination skills. The programme is delivered by 'peer coaches' who have lived experience of the care system and/or mental health challenges. The programme provides a 4 day residential that focuses on preparing young people for entry into higher education, one-to-one peer coaching sessions (over nine months) and four group mentoring workshops. However, Taylor et al (2021) highlighted concerns around risk of bias and the clinical meaningfulness of the large improvements found in this study.

[98] Geenen, S., Powers, L.E., Phillips, L.A., McKenna, J., Winges-Yanez, N., Croskey, A., Nelson, M., Blachette, L., Dalton, L.D., Salazar, A., & Swank, P. (2014). Better Futures: a Randomized Field Test of a Model for Supporting Young People in Foster Care with Mental Health Challenges to Participate in Higher Education. Journal of Behavioral Health Services & Research. 42, pp.150-171.

Appendices

Appendix 1: NICE quality standards for the care of looked after children and young people

Statement 1. Looked-after children and young people experience warm, nurturing care.
Statement 2. Looked-after children and young people receive care from services and professionals that work collaboratively.
Statement 3. Looked-after children and young people live in stable placements that take account of their needs and preferences.
Statement 4. Looked-after children and young people have ongoing opportunities to explore and make sense of their identity and relationships.
Statement 5. Looked-after children and young people receive specialist and dedicated services within agreed timescales.
Statement 6. Looked-after children and young people who move across local authority or health boundaries continue to receive the services they need.
Statement 7. Looked-after children and young people are supported to fulfil their potential.
Statement 8. Care leavers move to independence at their own pace.

Appendix 2: The tables below show the three 'best' and 'worst' CCGs for mental health service spending and waiting times for children in England for 2019/20.[99]

The 3 CCGs with the highest performance on mental health service spending and waiting times for children in England for 2019/20.

Clinical Commissioning Group (CCG)	% CCG budget spent on children's mental services	2019/20 spend per child on children's mental services	% of children (under 18) receiving CAMHS treatment during 2019/20	Average Waiting Time for People with Two Contacts (Days)	% Referral s Closed Before Treatment	CCG overall score (Min: 5 Max: 25)
NHS South Tees CCG	1.35%	£104	7.2%	30	19%	25
NHS Darlington CCG	1.12%	£79	7.8%	30	14%	23
NHS Durham Dales, Easington and Sedgefield CCG	0.98%	£88	7.1%	32	21%	23

The 3 CCGs with the lowest performance on mental health service spending and waiting times for children in England for 2019/20.

Clinical Commissioning Group (CCG)	% CCG budget spent on children's mental services	2019/20 spend per child on children's mental services	% of children (under 18) receiving CAMHS treatment during 2019/20	Average Waiting Time for People with Two Contacts (Days)	% Referral s Closed Before Treatment	CCG overall score (Min: 5 Max: 25)
NHS Greater Preston CCG	0.70%	£45	3.6%	69	40%	6
NHS Crawley CCG	0.56%	£37	3.6%	66	33%	7
NHS Horsham and Mid Sussex CCG	0.79%	£44	2.9%	65	34%	7

[99] Children's Commissioner. 2021. The state of children's mental health services 2020/21. [https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/cco-the-state-of-childrens-mental-health-services-2020-21.pdf]

Appendix 3: Shoemaker et al. (2019) - Characteristics of intervention studies included in the meta-analysis

Author(s)	Intervention program	Delivery	Setting	Sessions	Duration (months)	Focus	Treatment control group
Akin et al. (2015)	PMTO	I	H	*NR*	Max. 6	*NR*	CAU
Baker et al. (2015)	EA2 Tele-intervention	I, G	H	*NR**	1.5	PE, VM, VF, O	Waitlist
Benjamin (2010)	BIMP	G	*NR*	7	2	PE, O	Waitlist
	LLP	G	*NR*	7	2	PE	Waitlist
Bick & Dozier (2013)	ABC	I	H	10	2.5	PE, VF	Dummy
Bondy (1997)	Family Psychotherapy	I	CC	16	4	PE, O	CAU
Bywater et al. (2010)	IY	G	CC	12	3	PE, VM, O	Waitlist
Carnes-Holt (2010)	CPRT	G	CC	10	2.5	PE, VF	Waitlist
Carnes-Holt & Bratton (2014)	CPRT	G	CC	10	2.5	PE, VF	Waitlist
Chamberlain et al. (1992)	ES&T	I, G	H, CC	*NR*	*NR*	PE, VM	CAU (+ monthly additional stipend)
Chamberlain et al. (2008)	KEEP	G	CC	16	4	PE, O	CAU
Ciff et al. (2015)	REBT	G	CC	5	1	PE	CAU
Dozier et al. (2006)	ABC	I	H	10	2.5	PE, VF	Dummy
Dozier et al. (2009)	ABC	I	H	10	2.5	PE, VF	Dummy
Farmer et al. (2010)	Enhanced TFC	I	H	6	1.5	PE, MF, O	CAU
Fisher & Kim (2007)	MTFC-P	I, G	H,CC, O	*NR*	9 to 12	PE, O	RFC
Gaviţa et al. (2012)	CEBPT	G	*NR*	5	4	PE, O	Waitlist
Greeno et al. (2016)	KEEP	I, G	O	32	4	PE, O	CAU

Hampson & Tavormina (1980)	Behavioural group training	G	CC	8	2	PE, O	Waitlist
	Reflective group training	G	CC	8	2	PE, O	Waitlist
Jonkman et al. (2017)	MTFC-P	I, G	H, CC	36	9	PE, O	TAU, RFC
Juffer et al. (1997)	Video-feedback & Book	I	H	3	3	PE, VF	Dummy
	Book only	I	H	2	3	PE	Dummy
Juffer et al. (2005)	Video-feedback & Book	I	H	3	3	PE, VF	Dummy
	Book only	I	H	2	3	PE	Dummy
Juffer et al. (2008)	Video-feedback & Book	I	H	3	3	PE, VF	Dummy
	Book only	I	H	2	3	PE	Dummy
Leathers et al. (2012)	Adapted KEEP	I, G	H, CC	Max. 32[T]	4	PE, O	CAU
Lee & Holland (1991)	MAPP	G	CC	10	2.5	PE, O	CAU
Lee & Lee (2016)	Head Start	I, G	H, CC	2 to 54	*NR*	PE	CAU
Linares et al. (2012)	Adapted IY	G	CC	3	3	PE	CAU
Lind et al. (2017)	ABC-T	I	H	10	2.5	PE, VF, O	Dummy
Maaskant et al. (2016)	PMTO	I	H	*M* = 21.42	*M* = 5.36	O	CAU
Maaskant et al. (2017)	PMTO	I	H	*M* = 21.42	*M* = 5.36	O	CAU
Macdonald & Turner (2005)	No name	G	*NR*	5	1.25	PE, O	Waitlist
Mersky et al. (2015)	Brief PCIT	I, G	H, CC	8	2	PE, MF	Waitlist

	Extended PCIT	I, G	H, CC	12	3.5	PE, MF	Waitlist
Mersky et al. (2016)	Brief PCIT	I, G	H, CC	8	2	PE, MF	Waitlist