# Reviewing the research on the mental health of looked after children: Some issues for the development of more evidence informed practice

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## Abstract

Recent prevalence research in the UK has identified up to half of all children in state care as having emotional and behavioural problems at clinical levels. While longitudinal research assures us that most children with such problems do not go on to have mental health problems in adult life, many are at high risk of criminal involvement and relationship difficulties. For a few, the combination of anti-social behaviour and interpersonal issues will lead them to forensic psychiatric services – where previously 'looked after' children are hugely over-represented.
There are major gaps in the evidence base to inform service development which must be addressed urgently if children currently in state care are to be supported in ways that might increase their chances of a bright future. The problems of 'looked after' children are multiple, but most effectiveness research focuses on time-limited interventions for single issues. While there is increasing recognition that problems of attachment underlie many presenting behaviours in this population, there is a paucity of research on attachment interventions. In addition, research incorporating looked after children and young people's perspectives on their needs, experiences, and the value of services and approaches is extremely limited.

Key words: mental health, behavioural problems, emotional problems, looked after children, prevalence

## Introduction

This article reflects upon the issues raised by a literature review undertaken for the EC funded social exclusion project *Mental health of children in state care.*[1] It considers some implications of the nature of existing research for the development of evidence-informed practice in provision for looked after children in Europe.

Prior to undertaking this review I had lead a three year research and service development initiative on gender and secure mental health services funded by the Department of Health in the UK (Scott & Parry-Crooke 2001; Williams, Scott & Waterhouse 2001; Williams & Scott, 2002). The research focused on staff attitudes and understandings of their patients' experiences and difficulties and how these related to the care they provided – particularly to women. It involved multi-disciplinary teams in a range of settings: prison healthcare services, the high secure hospitals, NHS and private sector medium secure units and adolescent secure services. In the course of this work I discovered that one a third of the women and a quarter of the men in the three high security hospitals in England (Broadmoor, Ashworth and Rampton Hospitals) had spent some part of their childhoods in residential children's homes and over 20% of the women had at least three changes of primary carer before the age of 16. Almost a quarter had attended 'special schools for children with behavioural and learning difficulties (Stafford, 1999). Between 30% and 40% of women in UK prisons have spent some part of their childhood in care (HM Chief Inspector of Prisons, 1997). Experiences of being looked after by the state which relate to less than 1% of the general population were common amongst this patient group. Yet despite vast quantities of well-funded research in forensic psychiatry and a strong commitment to evidence-based practice in the National Health Service I discovered there was almost no research on the histories and childhood experiences of the secure population. Other gaps in the research included research on the effectiveness of treatment modalities that took the secure contexts in which interventions were delivered fully into account, research into the nature and significance of relationships between mental health workers and their patients, and research which incorporated patients' perspectives on their needs and treatment. My own research into staff knowledge, perspectives and training needs revealed a wide chasm between the information and understanding they needed from research and the actual evidence-base that was readily available. For example, the majority of staff rated abuse, neglect and changes of carer in childhood as the factors impacting most significantly on adult mental health, and bio-chemical and genetic factors the least significant. However, the origins of people's difficulties in lived experience, the daily realities of their current lives, and what they themselves thought about their treatment, were almost entirely absent from the formal knowledge base of forensic psychiatry and nursing.

This previous work had alerted me to both the possible significance for adult mental health of being looked after by the state as a child, and the limitations of a research field focused narrowly on treatment interventions in relation to diagnostic categories. I approached the task of reviewing the research on children in state care and mental health optimistically; believing that I would find a far broader spectrum of investigations, properly contextualised and reflecting the complexity of issues in the lives of looked after children. I assumed that much research would be geared towards establishing the most appropriate policy and service responses to various groups within a multiply disadvantaged, heterogeneous population. I was to be disappointed in a number of respects.

## In relation to prevalence

The number of children formally identified as having 'troubled and troubling' behaviour has increased considerably in most developed countries during the last five decades. The classification of 'mental disorders' has become increasingly sophisticated during this period. The original DSM (Diagnostic and Statistical Manual of Mental Disorders) published in 1952 listed 60 types and subtypes of mental disorder, while DSM-IV, the current edition, contains well over 200. The International Statistical Classification of Diseases (ICD), has been subject to equally frequent revisions. Difficulties experienced by children and young people represent one of the areas of classificatory expansion that has both reflected and inspired research interest in the field.

Differences in nomenclature, particularly the terms 'emotional and behavioural problems', 'mental health problems' and 'mental disorders', have developed out of the different medical and social welfare systems to which troubled children have been subject. More significantly in relation to reviewing research in the field are the plethora of definitions which have been operationalized under these broad headings. Along with variation in the ages of children studied and the different contexts in which research has been conducted, different definitions and thresholds for what constitutes 'problems', or constitutes them at clinical or concerning levels, have produced very different estimates of the number of children with emotional or behavioural difficulties.

There is also nothing fixed about the population of children in state care – changes in policy and practice alter who enters the care of the state, and how long they remain in such care, as well as how that care is provided. The 2,733 children in the care of the Greek state in 1999 cannot be compared in any simple way with the 55,000 in care in England in the same year. Therefore, inter-country comparisons of levels of mental health needs need to be treated with great caution.

What is comparable spacially and temporally is the special *responsibility* of the state towards their 'looked after' populations and the level of emotional and behavioural difficulties of these various groups of children relative to the *general* population. In England the research undertaken by Howard Meltzer and colleagues for the ONS puts us in the unique position of being able to compare the levels of difficulty between those children currently looked after by the state and children in the overall population.

In *The mental health of children and adolescents in Great Britain* (Meltzer et al., 2000) information was collected on an assessment of 10,000 children.

- Among 5-10 year olds 10% of boys and 6% of girls had an identified disorder.
- Among 11-15 year olds it was 13% of boys and 10% of girls.
- Conduct disorder accounted for half of all cases. Boys were twice as likely as girls to be identified as having a conduct or hyperkinetic disorder.

In *The mental health of young people looked after by local authorities in England* (Meltzer et al., 2003) information was collected on 1,039 children.

- Among 5-10 year olds 50% of boys and 33% of girls had an identified disorder.
- Among 11-15 year olds it was 55% of boys and 43% of girls.
- Conduct disorder was identified in 42% of boys and 31% of girls.

Research such as this exposes the fact that 1 in 10 of all children display behaviours of the same magnitude as those currently being accepted and treated by Child and Adolescent Mental Health Services (CAMHS). This rises to almost half of all looked after children. It *can* therefore be read as identifying a large constituency of children in need of mental health services. Indeed it has been estimated that only 1 in 5 children in need of such services in the UK actually receive them (HAS, 1995). The answer to this need is sometimes conceived in terms of more child psychiatrists, psychologists, in-patient beds and primary mental health care workers. But we need to be cautious about rushing to apparently obvious conclusions. My review of the research suggests that in relation to the mental health needs of children in state care such provision, even if it were forthcoming, is unlikely to provide a complete solution. The reasons for this lie in the origins and causes of most emotional and behavioural difficulties in children, the position of children within the family and the inaccessibility and stigma of traditional mental health services.

The ONS population survey places the mental health problems of all children firmly within their social context. Prevalence rates for mental health problems are considerably higher among children from disadvantaged families:

- Where neither parent was employed children were twice as likely as other children to have an identified disorder.

- Children from families in Social Class V were three times as likely as those in Social Class I to have an identified disorder.
- Children with three or more siblings were twice as likely as other children to have an identified disorder.
- Children with a parent who had no qualifications were twice as likely as children with a parent educated to degree level to have an identified disorder.
- Children in single parent families were twice as likely as children in two parent families to have an identified disorder.
- Thirty-one per cent of children who had experienced three or more stressful life events had an identified mental health problem compared to 10% of children overall.

Meltzer et al. (2000)

These factors are identical to some of the risk factors for entering public care identified in research by Bebbington and Miles (1989). These were, in descending order: living with one adult; living in overcrowded housing; being part of a family in receipt of benefits; being of mixed race; having a mother under 21; coming from a large family and being from a poor neighbourhood.

Given the synchronisity of the risk factors for both becoming 'looked after' and having emotional and behavioural difficulties it is hardly surprising that all the prevalence studies reviewed showed high rates of problems in LAC samples. Studies conducted since 1980 have reported mental health difficulties to be present in between 41% and 96% of their samples. The disparity in findings results from differences in national policy and practice, samples and methods: particularly in terms of the definitions of 'mental health difficulties' used, the range of difficulties considered, and the source of information/identity of informants.

More recent research has tended to use standardised measurement tools such as the Child Behaviour Checklist (Achenbach, 1991; Achenbach & Edelbrock, 1983). Although useful in a number of ways few such tools have been specifically tested upon 'looked after' populations or normed for use with children in crisis. Random or stratified samples are extremely rare so variations resulting from the length of time children have been in foster care at the point of data collection, their age at the time of first placement, their age at the time of study, whether they are from urban or rural areas and the type of placements they have been in previously are rarely taken into account. Such information, suggestive of the considerable heterogeneity of the care population, is seldom reported in adequate detail when findings are published.

Findings from the survey by Meltzer et al. highlight some of the difficulties which arise from the methods utilised in less sophisticated research in the field. For example, Meltzer et al. found that 43% of children who were clinically assessed as *not* having a disorder were viewed by their carers as doing so. Of course not reaching 'clinical levels' does not mean a child does not have difficulties, but the finding draws attention to the importance of the source of information in studies of this type as well as indicating the importance of non-clinical interventions and support.

This survey is particularly helpful because it includes information about looked after young people's physical health, use of services, placement type, educational achievement, social networks and lifestyle issues alongside the prevalence of mental disorders. Two-thirds of all looked after children were reported to have at least one physical complaint. The most common being eyesight, speech and language problems, co-ordination difficulties and asthma. Forty-four per cent of those identified as having a mental disorder were in touch with child mental health services.

About 60% of all looked after children had difficulties with reading, spelling or maths. Children identified as having a 'mental disorder' were more than twice as likely as other looked after children to have marked difficulties, and a third were considered to be three or more years behind in their intellectual development. These children were four times more likely than their looked after peers to report not spending any time with their friends. Such correlations remind us that emotional and behavioural difficulties are inseparable from numerous other aspects of life. However, they also raise numerous questions. Professionals and carers need to know precisely *how* such difficulties are inter-related, what is the direction of cause and effect (where such exists), what are the priorities for intervention, and how are interventions in one domain likely to impact in another.

The overriding message of prevalence studies is the high prevalence of emotional and behavioural difficulties of children in state care. This is hardly news – but it should focus our enquiries on strategies to address the needs of all looked after children in ways that are accessible and acceptable to them, their carers and families. Unfortunately there is little research or evaluation of services that tackles these issues (for an exception see Callaghan et al., 2003).

## Taking the long view

Longitudinal studies provide us with an important perspective on the interpretation of prevalence data. Research focussed on outcomes has assessed adult functioning at a variety of ages and life stages. In relation to children who have had difficult early experiences it may be particularly important to 'take the long view'. Their social and emotional development may be slower than that of their more advantaged peers and the transition to adulthood more problematic than for young people with a secure base upon which to build their lives. Certainly much adult distress and difficulty has its roots in childhood problems. However, Ann Buchanan's secondary analysis of NCDS data in the UK tells us that three out of four young people (75%) who had been 'looked after' did not have psychological problems at 16, and four out of five (80%) did not experience such problems at 33 (Buchanan, 1999). Continuities seem strong looking backwards (as we discover through research with adults in prison or secure psychiatric services), but looking forwards the picture is much less deterministic and the connections between earlier and later problems are not always straightforward. There is no simply narrative to be told about behavioural problems in childhood increasing the risk of adult mental health problems. It is rather that such problems are associated with a range of psycho-social outcomes including poorer educational attainment, higher unemployment, relationship difficulties, early parenthood and involvement in crime. This being so, is it helpful to use the language of psychiatry or 'mental health' at all when discussing the emotional and behavioural problems of children and teenagers?

Research clearly indicates that adults who have been 'looked after' as children are significantly disadvantaged compared to the general population. How such disadvantage is affected by their experience of being 'looked after' is much more difficult to assess. In many respects these adults may be very similar to their peers when matched on childhood factors other than experience of the care system. The most recent study confirming such a picture (Buehler et al., 2000) uses data from the US National Survey of Families and Households (NSFH) to compare adults with experience of foster care, a matched control group, and a random sample of the general population. The foster care group were similar to the matched group on almost all indicators including self-esteem, depression and life-satisfaction:

> Adults who experienced foster care had similar levels of adult adjustment as those with similar background characteristics... It may be that by studying individuals whose life circumstances have been so extreme as to warrant state intervention, we are, in reality, only examining social and economic circumstances that are mirrored by many families in our country. (Buehler et al., 2000, p. 623)

So, in relation to at least some adult outcomes, a period of childhood spent in care ensures life chances *no worse* than those that might have transpired had there been no time spent in care. However, in relation to *some* children and *some* outcomes there is evidence that a period in care may have made things worse – the high malaise scores in Buchanan's analysis of NCDS data (Buchanan et al., 2000) or Newton et al.'s research (2000) on placement change increasing behaviour problems suggests this – but we need to know more. In particular, professionals and carers need to know 'what has worked'. Research focused on young adults who have achieved outcomes which are better than would have been predicted by their early life circumstances would be particularly informative.

Of course we know that a whole train of disadvantageous consequences may be set in motion by the effects of early risk, but this is not so much a direct cause and effect relationship but what Rutter calls an 'indirect chain mechanism' (Rutter, 2001): a pathway along which marginalisation and disadvantage are likely to be cumulative.

This metaphor of 'pathways' also suggests the importance of cross-roads and turning points; factors which the evidence suggests are an important aspect of the non-inevitability of continuous or recurrent mental health difficulties (Rutter, 2001). The metaphor reminds us that interventions for the most vulnerable young people, who are likely to be exposed to continuing and potentially cumulative risks, may need to take a long term approach. Effective interventions for behavioural problems are time-limited and it has been argued that good mental health care could be more helpfully compared to dental health care so that regular check-ups, repair-work and daily self-care need to be built into service provision.

## Limitations of longitudinal research

A recognised problem with longitudinal studies is that the most disadvantaged individuals are over-represented in those who 'drop out' between data collection sweeps. The NCDS in the UK and NSFH in the USA, whilst maintaining population representativeness, share this problem with the purposive samples collected for smaller scale studies, each being liable to lose subjects who are hospitalised, imprisoned, highly mobile, homeless, substance dependent or extremely disturbed or distressed. It is therefore probable that such studies underestimate the poorest outcomes.

This serves to remind us that 'drop out' rates are not merely a methodological inconvenience, but an indicator of the chaos and social marginality which excludes some adults previously in state care from studies conducted in their name.
It also alerts us to the fact that we need to know considerably more about the 20% or more 'looked after' children for whom childhood adversity has lead to particularly poor mental health in adulthood.

## The research participation of looked after children and young people

In 2001 Barnardo's research unit interviewed 100 young service users aged 12 to 18 with the aim of highlighting the policy and practice priorities of young people themselves. Their views on the looked after system and how it should operate to make a positive difference in their lives were clear:

- Provide accessible, informal services.
- Address the stigma of care.
- Recognise the importance of education.
- Ensure access to social spaces and activities.
- Provide health (including mental health) education.
- Support care leavers.

As individuals workers and carers need to:
- Be reliable and trustworthy.
- Give information.
- Really listen to, and be prepared to act on, what young people say.

Social workers, foster carers and teachers came in for some damning criticism but young people were equally clear about the relationships with adults that made a positive difference to their lives. The factors which they identified as being of vital importance were:
- Not seeing you as a job or a source of income.
- Being fair.
- Demonstrating commitment: 'going the extra mile'.
- Believing in you.

The views of these young people about 'what matters' are well supported by a variety of research on factors that make a difference to the life chances of children looked after by the state. For example, in research on the stability of adoptive and foster placements the strongest predictor of success is the commitment of carers (Fanshel et al., 1990). In resilience research educational and social opportunities are very important and a supportive, reliable, mutually trusting relationship with at least one significant adult is crucial (Newman, 2002). The things that matter to looked after young people, matter, period. And a great many of them are about relationships – they are about the 'how' and the 'who' of what the state may call 'service delivery' but which to children in care is everyday life. The issues that they believe make a difference are those of relationship and process rather than structure and content – yet little research in the mental health field focuses on such matters.

Research incorporating young people's views on mental health services is extremely limited. There are a couple of small scale studies focussing on such views but very little 'effectiveness' research in this area incorporates a user perspective. In one UK sample of care leavers 31% had been referred to mental health services since turning 15 and most of them had been under impressed with the services they had received, describing them variously as 'crap', 'stupid', 'a waste of time', and complaining that they had been 'treated like a child' by mental health professionals (Saunders & Broad, 1997). Teenagers views of mental health services are also addressed in Triseliotis et al.'s study *Teenagers and the Social Work Services:*

> [N]early all those who saw psychologists or psychiatrists said they did not confide in them and nearly half were actively disliked. This probably had as much to do with the nature of the contact (divorced from the teenagers' everyday lives and focusing on their personal problems) as the communication skills of the professionals. Nevertheless it casts some doubt on the value of referrals to these particular specialists to deal with 'deeper' issues, if young people are much more likely to confide in carers and teachers. (Triseliotis et al., 1995, p. 165)

Judging by the quotations from some of the young people, professional communication skills were more of an issue than the authors suggest. Confusion and alienation are apparent in comments such as: 'He doesn't make much sense'; 'She makes me feel weird'; 'He kept interrupting', or '... He didn't talk straight, came out with words I'd never heard of.' (Triseliotis et al., 1995, p. 165). There is currently no research that provides access to younger children's feelings about or perspectives on mental health services. Within traditional medical research 'patient compliance' (their willingness to follow a course of treatment) or 'consumer acceptability' are the terms within which such matters tend to be considered. This fails to do justice to the complexity of interventions in relation to mental health, where relationships between professional and client *are* the core component of the 'treatment'.

## Prevention

In relation to children in state care prevention is usually discussed in terms of 'primary prevention'. By the time a child comes into care it is assumed that 'the damage has been done' – and problem-focussed treatment or damage limitation is all that is possible. However, if we think in terms of pathways and those 'indirect chain mechanisms' then 'prevention' of further harm through the promotion of resilience throughout childhood and adolescence is both possible and necessary.

A recent Barnardo's review undertaken for the Centre of Evidence-Based Social Services, University of Exeter included a summary of the general factors that promote resilience in childhood (Newman, 2002). These include:

*Individual factors*
- The development of skills, opportunities for independence, and mastery of tasks.
- Structured routines and a perception by the child that praise and sanctions are being administered fairly.
- Help to resolve minor but chronic stressors as well as acute adversities.[2]
- Encouragement to develop or adopt positive styles of thinking.

*School/community factors*
- Positive school experiences: academic, sports or friendship related.
- Good and mutually trusting relationships with teachers.
- Good home-school liaison.
- Community based initiatives that help to build social capital.
- Active support from external sources, including mentors, where children are at risk of developing anti-social behaviour.

Children within the care system face particular challenges, and may often have many of the key resilience promoting factors weakened, notably capacity to exert agency, parental support and positive educational experiences (Gilligan, 1997; Schofield, 2001). However, the message from resilience studies is an optimistic one. Well designed, accurately targeted and efficiently delivered educational, recreational and social care services may make a real difference to children who have experienced adversity. By attempting to replicate the factors that enable some children to resist or recover from early adversity, we can extend this protection to a wider population of children. There is some evidence that children's resilience can be stimulated by interventions aimed at promoting 'learned optimism' (Seligman, 1998). The messages drawn from research in relation to the resilience facilitated by strong social networks and education are particularly pertinent to looked after children. They point to a much more wholistic, whole population approach to their difficulties.

When it comes to examining the evidence base for interventions targeting specific difficulties common amongst looked after children there are some surprising gaps. For example, despite the numerous forms of therapy developed to help children who have been abused, evaluations of interventions aimed specifically at abused children are somewhat scarce. Finkelhor and Berliner (1995) found only 29 studies of treatment outcomes for sexually abused children, many were poorly designed and the results were mostly non-conclusive. There is some emerging research support for brief, structured CBT treatments which involve children and their carers (Berliner, 1997). However, considerably more evidence is needed and research which disaggregates data in relation to children's ongoing family circumstances (e.g. living with a natural parent, with foster carers, etc.) is vital.

Of course there is good experimental and clinical evidence for the effectiveness of CBT in relation to specific behavioural problems – particularly where parents or carers are involved (Buchanan, 1999). However, what is likely to make a difference to long-term outcomes is how these interventions are reinforced and built on in the context of family life. There is little or no research that goes beyond short-term 'customer satisfaction' into understanding the ability of some families to integrate new behaviours into parenting and personal narratives. In terms of the assessment and preparation of residential, foster or adoptive carers, to deliver effective care, such knowledge is crucial.

The appropriate training, involvement and support of foster carers is accumulating evidence of effectiveness first, in terms of placement stability. Securing and reinforcing a relationship with a main carer represents current best wisdom in relation to attachment problems, and placement stability and permanence are important proxy indicators (Howe & Fearnley, 1999). And second, in terms of reducing emotional and behavioural difficulties:

> The only interventions with demonstrated effectiveness in reducing the emotional and behavioural problems of looked after children are those delivered either in close liaison with foster carers, or directly through foster carers. (Rushton & Minnis, 2001, p. 35)

Evaluation of Barnardo's Family Placement Services in Scotland showed that a combination of skilled recruitment and matching, with training and intensive support for foster carers, can reduce disruption rates. These were as low as 12% for children placed with foster carers between 1996 and 2001 (Barnardo's Scotland, 2001). However, a major difficulty is that despite the recognition of the importance of attachment we lack an evidence base supporting interventions in relation to older children with attachment difficulties.

There is as yet no research that effectively *unpacks* the different elements which make a difference to stability of placement and improved outcomes in specialist foster care. In addition, the available research studies are very mixed in the adequacy of the descriptions they supply in relation to children's history or treatment, carer characteristics, training, support or other interventions provided. They often conclude that research providing much better descriptions of both interventions and populations is required in order to draw conclusions about exactly what works for whom (see Minnis & Del Priore, 2001). Research needs to develop alongside specialist fostering programmes to enable the various elements of training, salary, support, multi-professional input and monitoring to be unpacked.

In considering some of the new initiatives intended to increase placement stability and improve outcomes for children with emotional and behavioural problems it is important not to lose sight of some of the evidence from 'ordinary' placement experience. Some of the older studies of adoption and long-term family placement concluded that therapeutic intervention in the early years of an 'ordinary' placement is not usually appropriate (Argent, 1988; Reich & Lewis, 1986; Thoburn, 1990; Yates, 1985) and that for children who require therapy in later childhood or adolescence careful consideration needs to be taken as to whether this should involve the foster/adoptive parents or the child alone. This is not the same as suggesting that 'new families' should be left to get on with it, but rather that the relationship with the new carers is paramount and anything therapeutic that occurs is likely to be through the relationship they establish. Even more reason that we should be doing – what increasingly services are doing – regarding training and support of carers as preventative mental health provision and raising the competence and confidence of all carers to manage children's difficulties appropriately, teach cognitive skills and promote resilience.

## Conclusion

While there is some extremely useful research in relation to the mental health of children in state care, there are major gaps in terms of an adequate evidence base to inform the development of services, or to enable carers and professionals to make confident choices about issues such as training or prioritising interventions. Policy and practice in relation to children in the care of the state is increasingly multi-professional and inter-agency. However, there continues to be a lack of cross-over between traditional 'medical model' research dealing in diagnostic categories and treatment modalities with educational and social research into the care context, the development of resilience, or academic achievement.

Conducting research in the context of the changing boundaries between children's services in the UK is challenging. Part of the success of programmes being developed specifically to address the mental health needs of looked after children may be based on how well they are able to work across the multiple agencies involved in their lives: evaluation of programmes must be able to do the same. In England and Wales The Children Bill (2004) introduces 'extended schools' as 'hubs' for services to children. If these are to serve the needs of children in state care extended schools must prioritise genuinely inclusive school policies and practices. Otherwise those who are already excluded and marginalised may suffer doubly as a result, because their exclusion from (or marginalisation within) the school system may be mirrored by poor or non-existent access to the support services that are located there. Research must follow and investigate these changes. Evaluating effective interventions at the level of the individual child is not the only kind of evidence needed to inform practice. Understanding the influence of the systems through which services are delivered, and the context in which they are received, is equally important.

The Children Bill emphasises that early intervention with children at risk is essential to preventing children from being developing anti-social and criminal behaviour in later life, and ensures wider access to sensitive personal information among professionals working with such children. While few would oppose 'joined-up' approaches to service provision, there has been so little research into the views of looked after young people on their needs (including for confidentiality), and their views on the 'mental health' services they receive, that we do not know the implications of these changes. Many such young people feel old enough to 'vote with their feet' by disengaging from services if they do not get the responses they require. It would be tragic if at the very point we are able to identify the prevalence, long-term implications, and some indications of effective intervention and support for looked after children, we did not effectively address issues of the appropriateness and accessibility of services.

### Notes

1. Partners in the project were Barnardo's (UK), Belgium (Katholieke Universiteit Leuven) and Greece (Institute of Child Health) co-ordinated by NCH – The Bridge Child Care Development Service.

2. One of the biggest risks to children's mental health is the persistent presence of minor irritants rather than infrequent major stressors (Compas, 1987).

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