An examination of current specialist mental health projects for 'looked after' children within England

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Abstract

Evidence on outcomes for children in public care would suggest that the state does not make a good substitute parent. But it is not so easy as to correlate the outcome measures achieved by children in public care to the state's care alone as many of the histories of children looked after are incredibly complex. Professionals' current knowledge base of effective interventions to support children who carry and bear enormous emotional trauma is challenged by the complexities of these children's lives and the impact that their experiences have on them. Solutions are not quick fix and require dedication from a whole range of people involved in children's lives. Central to this is the psychological and emotional support children are given. This study examines current specialist mental health projects for looked after children within England. A variety of new projects have recently been established across England with the express purpose of working to improve the mental health of children in public care. This study examines a selection of these projects: how they were set up, funding arrangements; staffing numbers; types of professionals involved; services offered and evaluation methodology used. The study describes the areas of key learning, themes and developments that have emerged from these specialist services.

Key words: looked after children, mental health, state care, children, young people, England

Introduction

The reasons for children's entry into the public care system within each European country participating in this research are varied. An examination of contextual information shows that there are a number of different factors in individual countries that have influenced the development of services generally for children in state care in each country (for further information see Scott, Grietens & Hellinckx, and Agathonos-Georgopoulou, Sarafidou & Stavrianaki, this issue).

A decision was made by the partners early on for the English aspect of the project to have a different focus. This was due to three factors:

1. The UK already had information available on prevalence rates for looked after children and mental health (including mental illness) from a variety of studies. Nothing further would have been gained by repeating the exercise.

2. In addition, a major government study examining the prevalence rate of the mental health (including mental illness) of young people looked after by local authorities in England was in process, with the report due for publication in spring 2003.
3. Given the nature of the proposed research there would have been problems for the English partners in getting any prevalence study through an ethics committee in time for the time schedules attached to this project.

England would concentrate on examining specific projects where services were being provided to children and young people in public/state care with mental health problems, and would also take responsibility for conducting an international literature review (see Scott's article in this issue). Belgium and Greece would undertake prevalence studies.

This paper provides a summary of the results found in the English project. The paper does not include a review of the literature or a section on contextual information, as this is included elsewhere (for further information see Scott's article in this issue). First, the research objectives and the specific research questions are listed. Second, the methodology of the study is described, in particular the sample selection, the instruments, the procedures and the response rate. Third, the results are presented including descriptions of the projects, services provided and description of evaluation methodology used by the projects as well as other data. Fourth, a number of case studies are selected as good practice examples according to identifiable criteria. Fifth, the significance of the findings will be discussed, before considering practice and policy implications and overall recommendations.

Methodology

The English study had three basic *objectives*:
- To undertake a review of current specialist mental health services available to looked after children within England;
- To identify which of the available services appear to work best within the range of projects examined; and
- To identify whether evaluations of these services are routinely undertaken.

The two specific *research questions* were:
- Is there a best practice model that could be developed for services to looked after children?
- How robust are the evaluations that are completed?

Sample selection and procedures

Within England a large number of services provide mental health services to looked after children. Some of these services are generic in their referral criteria (e.g. mainstream Child and Adolescent Mental Health Services (CAMHS) that provide mental health services for looked after children), whilst others are specialist (e.g. specific projects for looked after children only, or specialist services for particular mental health difficulties which looked after children can access as well as other children who have specific difficulties). Currently there is no one publication that summarises all CAMHS services in England available for looked after children, although Richardson and Joughin (2000) listed some of the specialist services that have emerged from one Department of Health initiative.[1]

There are 150 Local Authorities in England. Recent government policy developments have placed a requirement on each Local Authority to set up specialist services for looked after children who have mental health difficulties.[2] This was the potential sample size of the study. Identifying a maximum sample size required publicity within academic, research and local authority service areas. We were particularly interested in the specialist mental health services available to looked after children, as opposed to generic services.

The following strategies were used to gather data:
- Letters were sent to the Directors of Social Services of all 150 Local Authorities in England in December 2002;
- A call for information was put on the Focus website in December 2002;
- A call for information was circulated to members of the European Scientific Association on Residantial and Foster Care (EUSARF) in December 2002.

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

The projects we have included in this study are those that responded to our requests for information. This group is not a representative or randomised sample. We were not able to identify a control group in order to compare the results of specialist services with those of more generic child mental health services.

Instruments

The Barnardo's Research Team developed a proforma tool entitled 'The Mental Health of Children in State Care: Promising Practice Questionnaire', which was concerned with identifying:
- Information about the informant and name of project
- Aims
- Activities
- Organisation and Staffing
- Target Group
- Specialist nature of service
- Access
- Geographical Area
- History
- Evaluation
- Other information from the informant not covered in the questionnaire.

Proformas were sent out to all the Local Authorities for individual projects to record basic information about their services. This information was then collated.

In addition a further telephone interview proforma had been developed for follow-up responses with those projects where strengths in practice or evaluation had been identified by the research team from the initial data supplied by the projects. This proforma comprised 14 open ended questions, with an additional 2 questions for the interviewer to assess:
- The category of the project (a selection of 5 options given)
- The strength of the service in relation to 7 factors. The 7 factors were:
  1. Clarity of outcome objectives
  2. Evidence base
  3. Evaluation

4. Achievement of Outcomes
5. Participation of Young People
6. Participation of Carers
7. Inter-agency working

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

Results

Response rate

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

- We received a total of 59 responses. Twenty-one responses (36%) were from health services and 38 responses (64%) were from Local Authorities. The latter return rate, based on a potential sample size of 150, is just over 25% of all local authorities in England.
- Of the 59 responses, 24 'Promising Practice Questionnaires' were completed.
- A further 26 replies were received from a call for information placed on the 'Focus' website; these contacts were either from academic institutions or projects located in health services.

The 24 'Promising Practice Questionnaires' were well completed and additional information was supplied in most cases.

From the 85 responses we received from our call for information, 47 replies were valid and could be used for the purposes of the research (see Appendix for a summary list of the projects). This included information that was submitted instead of completing the promising practice questionnaire. Four of these replies were from projects based outside England, and one was from a voluntary sector project with a national remit. The following results arise from the analysis of this data.

Description of the projects

The projects included in this review are spread throughout England, with a small number of returns received from Scotland, Wales and one project in Belgium. Seventeen percent of the projects included in the study are based in London (see Table 1).

Table 1
Geographical location (frequencies)

National	1
Scotland	2
Wales	1
England (not London)	34
London	8
Belgium	1
Total	47

Strategic (and other) objectives

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

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

to objectives that were not precise or easily measurable;

> Providing safety and security to allow each individual to: 1. Grow and fulfil their potential; 2. make positive and informed life choices; 3. Establish a positive sense of self and identity; 4 have a healthy resilience to overcome life challenges.
> Lifescope: The Inter-agency Service for Children Looked After (Norfolk)

The six most common objectives are listed in Table 2 (in numerical order):

Table 2
Six most common objectives (percentages)

1	Promote the mental health of looked after children	30%
2	Training for foster carers and other staff	23%
3	Direct therapeutic work with child	19%
4	Improve access to existing CAMHS services	17%
5	• Assessments of mental health needs for looked after children • Consultation sessions • Reduce placement breakdowns • Multi-disciplinary aspect to service	14%
6	Direct therapeutic work with carers	10%

Only one project specifically mentioned research activity in its objectives.

The objectives listed by the projects generally state the broad aims of the respective services. Many services do not link their objectives to the services they provide; instead services make general statements about improving mental health without specifying how this will occur. This makes evaluation of service activity very difficult.

Activities and description of services provided

A wide variety of activities are listed in the schedule. These are broken down into 4 headings: assessments; therapy; training; and access to other services. The numbers were as follows (see Table 3).

Table 3
Activities and description of services provided by the projects

a. Assessments		
1	General mental health assessment	11
2	Non-specific assessment	6
3	Education assessment	3
4	Cognitive behavioural assessment	3
5	Attachment assessments	2
6	Health assessment	1
7	Multi-agency assessment	1
b. Therapies		
1	Non-specific clinical interventions, therapeutic treatments and other direct work	18
2	Family therapy	6
3	Play therapy	5
4	Counselling	5
5	Art, drama and music therapy	4
6	Psychotherapy	3
7	Group-work	4
8	Psychotherapy for children in transition	1
9	Attachment intervention	1
10	Adolescent counselling services	1
11	Eye movement desensitisation and reprocessing	1
12	Systemic therapy	1
13	Cognitive therapy (to child)	1
14	Psychoanalytic therapy	1
15	Social skills training	1
16	Leisure activities (e.g. scuba diving and horseriding)	1
c. Training		
1	Training and skills development for foster carers	14
2	Training for other professionals (including residential workers)	7
3	Cognitive behavioural therapy training for foster carers	1
d. Other		
1	Case consultation	16
2	Support for foster carers	11
3	CAMHS liaison	8
4	Advice and information for social workers	5
5	Consultancy to children's homes	5
6	Research and audits	2
7	Production and dissemination of information for carers and children	1
8	24 hour support	1

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

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

One project used a specific model for training foster carers (Cognitive behavioural therapy) *(Fostering changes – Southwark)*.

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

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

Organisation

Projects were funded by various organisations (see Table 4).

Table 4
Funding organisations (frequencies)

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

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

Staffing

The professional disciplines are broken down in Table 5. The numbers of staff are broken down in Table 6. Numbers of staff recorded above do not reflect full-time equivalents. Many staff in health services offer a number of sessions per week only. This is certainly the case for child psychiatrists and the majority of child clinical psychologists.

Table 5
Professional disciplines (frequencies)

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

Table 6
Numbers of staff in the projects (frequencies)

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

Target group and specialism

The target group and specialisms were as follows (see Table 7).

Table 7
Target group and specialisms (frequencies)

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

Table 8
Outcomes listed by the projects (frequencies)

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

Access

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

Outcomes

The outcomes particular projects believed they have achieved are many and varied. These outcomes are listed in categories identified by the review team. It must be noted that the review

team have not had access to any additional information or evidence to support claims regarding outcomes achieved by projects. This section links closely with and should be read in conjunction with the evaluation section.

Thirty four (74%) of the 47 projects did not list any outcomes for their services. This is a poor response rate.

The remaining 26% of the projects listed the following outcomes (see Table 8).

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

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

Evaluation: Description of evaluation methodologies used by the projects

The evaluation methodologies of the projects varied considerably. A number of projects did not have an evaluation strategy. Thirty-three of the projects said that their services were evaluated (see Table 9). This does raise questions about the low response rate to the previous section – specifically the indicators against which evaluation occurs. Eight of these projects did not send any evaluations with their return. The remaining 25 projects either sent additional evaluation reports or described in detail the methodology they were using.

Table 9
Description of evaluation methodologies (frequencies)

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

Three projects mentioned using assessment tools for analysis. Other projects may well have used externally validated assessment tools such as the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999) in their work with clients but this was not specifically mentioned. Three projects had completed internal and external evaluations.

The amount of information provided by the projects was not comprehensive, so it is difficult to draw any clear conclusions from the results in this section. Many of the evaluation reports that were read as part of this review were multi-functional. These reports were linked to larger organisational service reviews and were used as evidence for the organisation meeting external (DOH) Performance Indicators (PI's) (e.g. reduce placement breakdown; improve

educational attainment of looked after children) as they were to monitoring the mental health of children and young people using the services. However as the methodology used by most projects was poor, it is difficult to see how these reports would have met the PI requirements demonstrating suitable performance outcomes. Two exceptions to this were the 'Fostering Changes' project in Southwark and the Leicester, Leicestershire and Rutland Joint Child Mental Health Strategy in Leicester.

Other information

Analysis in this section required the information obtained from the proforma completed by the project to be categorised into a range of outcome statements/measures identified by the researchers. These are as follows (Table 10).

The majority of projects featured in more than one category (76.5%). Fifteen percent of the projects could not be listed in any category. In examining the spread of scores (from 0 to 7) the median occurred in category 3. The average score was 5. The mode, or most common number of categories that each project had was 4.

Table 10
Breakdown of other information on the projects

	Categories	Number	Percentage
1	Responds to local needs	27	57%
2	Service based on evidence of effectiveness	13	28%
3	Objectives clearly identified by project	28	60%
4	Feedback questionnaires for children, carers and professionals in service review	17	36%
5	Good communication between agencies	24	51%
6	Mechanisms for the meaningful participation of children in service review/development of service	4	9%
7	Specification of intended outcomes	23	49%
8	Evidence available of some outcomes being achieved	15	32%
9	Targets set in relation to outcomes	2	4%
10	Data collected against targets	4	9%

Table 11
Specialist aspects developed by the projects (frequencies)

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

Promising practices

A number of the projects have developed specialist aspects to their services (Table 11). Many projects recognise the importance of providing support to foster carers. Some projects do this alongside offering support to the child or young person, whereas other projects specialise in providing services to foster carers only.

Comments

Comments made by project workers/managers when completing the proforma indicate that there is insight into the range of difficulties many of the projects face with regard to lack of suitably qualified staff available to work in these specialist projects, under-resourcing and lack of funding available in some areas (not all), and poor evaluations undertaken (in some cases no evaluations had been completed). A number of the proformas described new services in their first year of operation, which illustrates the increase of services in this area. One service had been commended by the Government Social Services Inspectorate (SSI) and Children First commission (Psychology team attached to the LOCATE service in Bath and North East Somerset) and one project was located in a Beacon Council (the Leicester, Leicestershire and Rutland Joint Child Mental Health Strategy in Leicester).

Good practice project examples

A number of projects included in this study describe practice that met the 'promising practice' criteria that the researchers had identified. The main elements of these criteria are listed below. This list of projects is not exhaustive, and should not be interpreted as the only projects within the study where 'promising practice' was identified by the research team. Projects identified include one that works solely with foster carers; one that works with hard-to-reach young people; and one of the 24 CAMHS innovation projects.

- Does the service/initiative respond to identified local needs?
- Is the service/initiative based on the best available evidence of effectiveness?
- Are its objectives clear?
- Do these include the specification of intended outcomes for looked after children?
- Are targets set in relation to outcomes?
- Is data collected against targets?
- Is there evidence available of outcomes being achieved?
- Are there mechanisms for the meaningful participation of children and young people in service review/development (where appropriate)?
- Is there evidence of good communication between agencies to the benefit of looked after children?

1. 'The Fostering Changes Programme' in Southwark (London)

Background

This project has links with the National Specialist Adoption and Fostering Team at Maudsley Hospital, London. This team is a multi-disciplinary clinical CAMHS team that provides assessment of children in foster placements and adoptive placements where difficulties have emerged. Over the years feedback from foster carers indicated a gap in practical skills and advice available to foster carers managing difficult behaviour.

Project description (service provision, philosophy, evaluation and staffing)
The aim of the project is to provide foster carers with practical skills in the management of child behaviour via training.

A training course based on cognitive behavioural theory is provided. There are 2 different courses:
- One for carers of under 12's.
- One for carers of teenagers.

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

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

The course has been developed by drawing from various parent training programmes that have proved to be effective:
- Webster-Stratton, 1992;
- Neville et al., 1998;
- Sanders, 1999;
- Sutton, 1999.

The staffing consists of:
- one part-time project worker
- one part-time co-ordinator
- support from other professionals associated with the Maudsley adoption and fostering team (social work, clinical psychology, child psychiatry).

Evaluation of project

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

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

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

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

The project is aware that current resources, placement availability, recruitment and retention issues and current policy changes are all factors which have enormous implications for placement choice for looked after children and consequently have an impact on the future development of this service. For further information, please see Pallett et al. (2002).

2. *The Leicester, Leicestershire and Rutland Joint Child Young People's Team*

Background

This Service has NHS Beacon Status. The Leicestershire Partnership Trust's young people's team was set up in 2002 to provide a service to hard-to-reach young people who were homeless, young offenders and/or looked after.

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

The aim of the service is 'to empower frontline staff and carers with basic mental health skills' so they are better able to identify those at risk of difficulties and can 'build resilience'. Project staff work directly with young people who don't 'meet the threshold' for seeing a psych-professional.

The staffing consists of:

- four primary mental health workers for homeless children and families
- four primary mental health workers for two youth offending teams (YOTs)
- two primary mental health workers for the looked after population
- two psychologists
- one psychiatrist

In addition to this project, the local CAMHS already has a specialist therapeutic social work team covering the same area and providing long-term psychotherapy. This team includes two psychologists and a psychiatrist. The two primary mental health workers focus on consultation to carers and joint work with social work staff (each residential unit has a designated PMHW as their link to CAMHS services).

Evaluation

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

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

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

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

Amongst the 12 young people interviewed at follow-up three quarters felt they had been helped. For further information, see Hopkins (2002).

3. *SSLAC – Sheffield support service for looked after children*

Background

This service was one of the 24 CAMHS Innovation Grant projects. The team was established through the partnership of several agencies: NSPCC, Sheffield Social Services, Community Health Sheffield and Sheffield Education Authority. The service is managed by the NSPCC.

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

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

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

The approach of the service has been informed by the need for coherent *networking* throughout the looked after system. Staff begin all work by hosting multi-agency meetings.

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

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

The staffing consists of:

- two art therapists (PT)
- one team manager (FT)
- one social worker (FT)
- one team administrator (FT)
- one clinical psychologist (FT)
- one play therapist (PT)
- one team secretary (PT)
- one educational psychologist (PT)

Evaluation

An evaluation officer has been with the team for much of the project. The national children's mental health charity 'Young Minds' are responsible for guidance and co-ordination of all CAMHS innovation funded projects in relation to monitoring and evaluation.

An annual report for 2002 is available which contains the findings of the evaluation. Data has been collected through monitoring information from referral forms, a Strengths and Difficulties Questionnaire (Goodman, 1999) for children and young people, 'user' feedback (children and young people, carers and parents and professionals). SSLAC stresses the importance of research, evaluation and reflective practice and uses this to inform its work. For example, a survey of foster carers identified training needs and subsequently, a training pack was designed and delivered by the service. For further information, see Kurtz and James (2003).

Discussion of findings

These findings show a mixed picture: this is an area of service provision currently expanding and developing, with new money from central government fuelling this expansion. The majority of specialist services are provided by multi-professional teams. Joint funding arrangements exist and a low number of service evaluations are routinely undertaken. What has become clear from undertaking this research is that many more areas for development exist, especially if the Department of Health interest in this area (including an increase of resources) is going to be used to full advantage.

Service evaluations

Many of the projects' descriptions of their aims and objectives do not link to service user outcomes listed by the projects or methods of project evaluation used to comment on efficiency or effectiveness. Frequently the relationship between objectives and measurable quantitative outcomes was poor. Additionally very little qualitative outcomes were also used. Where outcomes and evaluations did occur (and there are some good examples of this), there was no consistent methodology used between projects to enable any easy comparison across projects. This is a lost opportunity, but also reflects the results of an earlier study commissioned by the Department of Health evaluating the Department of Health funded 24 CAMHS innovation projects (Kurtz & James, 2003).

Multi-disciplinary funding and working together

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

In 2003 the Department of Health (DOH) published a consultation document on the proposed Children's National Service Framework (NSF) for children. The NSF is set to develop new national standards across the NHS and Social Services for all children. In this report the mental

health of looked after children is identified as an area where improvements in multi-agency partnerships within CAMHS is seen as essential (DOH, 2003). As a part of this process, the DOH has established an external working group whose remit is to define standards to support the delivery of services that will improve the mental health and well being of children and adolescents. The 'Outcomes Subgroup' of the Child and Adolescent Mental Health External Working Group has issued a report examining possible standards for inclusion in the Children's NSF (Outcomes Subgroup, 2003). This contains useful information on outcome indicators.

This research also examined which professionals were involved in providing mental health services to looked after children. Overwhelmingly in the projects canvassed for this study, the most common professional employed in these specialist projects was a social worker. Given that Meltzer et al. (2003) reports a very high rate of psychiatric disorder amongst this population of children, questions are raised concerning whether social workers for looked after children currently have the necessary skills and knowledge base to effectively work with these vulnerable children in a prime capacity, given the type of behaviours and difficulties that children are presenting with. There is discussion about the introduction of 'Primary Mental Health Workers' whose role is described as, 'to act as an interface between universal first contact services for children and families and Specialist CAMHS' (Foster, 2004). These workers are seen as one way of improving access to CAMHS services at an earlier stage for vulnerable children, including looked after children. Further research will be required to monitor the impact of this development on services for looked after children.

Ascertaining the views of children

There is still more to be done to ensure that the views and wishes of children and young people are heard and shared with service providers as well as policy makers. Some services made no attempt to take on board the views of children and young people either in the development or ongoing evaluation of their service. This also includes representation or input into the steering group. Other services did take this into account. Additionally, as a part of this research, a group of looked after young people were consulted about their experiences of mental health services. We intend to publish the results of this consultation process as a separate paper.

Evidence based practice

One of the other points emerging from this study is individual project's limited use of the 'evidence base' in respect of 'what works' with this client group to support provision of and development of services to children in public care. Very few projects were able to be specific about the type of interventions they offered to children and young people with mental health problems. Most services offered generalised assessments and interventions. More research opportunities exist for examining how projects use the research evidence base in this area to inform interventions and how they in-turn contribute to the knowledge base in this area through evaluations and outcome indicator material produced. Not all changes in behaviour and emotional health shown by children and young people during the course of referral, assessment and therapy/intervention can be solely attributed to the mental heath practitioner. For looked after children complex factors are often at play and it is difficult to isolate variables to prove the link between change and behaviour and successful intervention. It would be very difficult to demonstrate a causal link between the outcomes identified by the projects and the cause of the positive change for the child being achieved directly because of the intervention of the project.

Macdonald (2001, p. xviii) observes that, '... having good intentions is not enough; the helping professions have an immense capacity to do harm as well as good, and there is ample evidence

that we tend to overestimate the latter and underestimate the former.' This research has resulted in more questions for the researchers concerning the evaluation methodology adopted by many of the projects and how outcome measures are identified and agreed.

Future themes and recommendations

This study has several practice and policy implications. There is a distinction made between the micro-level (practice) and macro level (policy and strategy).

Micro level

1. All specialist projects should be strongly encouraged to undertake regular evaluations and reviews of their services. It would be useful if the evaluations followed a similar methodology, as then results could be disseminated across the projects. The overview of the 24 projects funded by the DOH is a useful starting point in this area, but their evaluation points to many of the same difficulties (Kurtz & James, 2003). One of the recommendations arising from the study is that guidance should be given on a reasonably rigorous methodology for evaluation that could be applied across CAMHS work with looked after children that could take into account the different interventions and form of service offered to these children. This may well be picked up in the Children's NSF, due for publication later in 2004.
2. There should be a central information service register of all mental health projects specifically for looked after children, either an extension of the FOCUS publication, or via a voluntary organisation such as 'Young Minds'. This occurs already within informal channels but information exchange does not routinely occur across the country. For those local authorities, PCT's and mental health trusts (soon to be Children's Trusts) still in the process of setting up specialist services, information on evaluation and learning regarding process would save time and many mistakes being repeated.
3. In a related point, links between multi-agency stakeholders should be debated at an early stage, including how services are provided, how to consult with users of services and the professional skills of staff necessary for working with children (Audit Commission 1999; Mental Health Foundation, 1999). Working in partnership across organisational boundaries is the aim; the provision of a seamless service is the objective, but both are difficult to achieve in reality without willingness, co-operation, skill and negotiation throughout the different hierarchical levels within the partner organisations. Managing the multi-agency aspects of the projects has had mixed success and presents stakeholders with challenges. Invariably these projects have a range of stakeholders, including health and social care. Depending on local partnerships and arrangements for working across agency boundaries, including line management responsibilities for projects and individual staff working in the projects, sources of tension can dramatically affect the success/failure of projects.
4. Some funding should be preserved for prevention and early intervention, despite high demand for acute services.
5. There should be better systems in place to undertake earlier detection of mental health issues within the looked after system. Children coming in to care should be routinely screened for mental health issues by qualified staff as this could lead to earlier access to services and better support being provided to foster carers and residential staff on issues to do with managing difficult or challenging behaviour. We came across one project in Glasgow that had a model based on this type of intervention. All other direct service projects worked with the child or young person following a referral from a professional once

they were in care. The Glasgow approach builds on an earlier Scottish study (Dimigen et al., 1999) and would be able to provide information for service planning based on specific local need.

6. Professional conflicts have emerged regarding whether it is appropriate to undertake therapeutic work with children 'in transition'. Further debate is needed as many of the children who require mental health services are children 'in transition', where decisions still have to be made about permanency plans.
7. There is a need to develop a holistic service that does not just provide services to the child but also to the network of people involved caring for the child and providing services to the child (e.g. social workers, teachers, residential social workers and foster carers).
8. Involving service users in the development of services in a non-tokenistic way remains a challenge.
9. There is a need for more flexibility in service provision. Engaging young people is challenging. The experience of some of the projects (e.g. 'Connexions' in Dorset; SSLAC in Sheffield) is that this can be done, however there are resource implications. Often this means working outside of the traditional CAMHS model of service delivery (i.e. from 9-5, for 50 minute sessions held at a hospital outpatients clinic that the young person travels to each week for a series of sessions), and managing an appointment system that fits with school and home life commitment of the child or young person. This is especially relevant for looked after children who may have missed long periods of school at some stage in their academic history.
10. Short term interventions are not necessarily evidenced as effective, yet they are the favoured model of service delivery by agency stakeholders. Further research is required in this area.

Macro level

11. The NHS, Social Care and Health modernisation agenda assumes that there is a core of skills amongst professionals. There is such a recruitment and retention problem within social care and health currently that this cannot fail to impact on staffing of specialist projects, and this is likely to be the reality for quite some time. Invariably these specialist teams are not fully staffed, and this has implications for service capacity and throughput.
12. The development of the National Service Framework for children by the Department of Health (due out in Autumn 2004) will assist in the drive to continue mainstreaming specialist services (including mental health) for looked after children in England. We would recommend better systems in place to undertake earlier detection of mental health issues for children looked after. Assessing the mental health of looked after children and providing services should be routinely monitored.

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

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Notes

1. In 1999 The Department of Health allocated Mental Illness Specific Grant Funding to 24 projects, and a number of these projects deal directly with looked after children. A summary of these projects can be found on the 'Young Minds' website or in the Richardson and Joughin (2000) publication. These 24 projects were subject to an overall evaluation, (Kurtz & James, 2003) which is also available from Young Minds.
2. The Government announcements and initiatives regarding specialist CAMHS services are:
   - On 17/1/03 The Department of Health issued a Local Authority Circular (LAC) outlining the Child and Adolescent Mental Health Service (CAHMS) grant guidance 2003/04. This announced a substantial increase in funding to Local Councils in England, with the total CAMHS grant in 2003/04 set at £51M. £44.1M is allocated directly to councils, and is an increase of £28M on the grant available during 2002/03. The remaining money is to be used for funding specific projects for looked after children.
   - This links with a vision for CAMHS improvements set out in 'Improvement, expansion and reform: The next three years priorities and planning framework 2003-2006' published in October 2002.
   - During the last 5 years there were a number of reports published that highlighted the need for service review in this area Richardson and Joughin (2000), Audit Commission (1999) and Mental Health Foundation (1999).
   - The National Service Framework for Children is due to be published in Autumn 2004. The draft consultation document, published in 2003, makes reference to CAMHS services for looked after children.

References

ABIDIN, R. (1995). *Parenting Stress Index – Short Form*. Odessa, Florida: Psychological Assessment Resources Inc.

AUDIT COMMISSION (1999). *Children in mind: Child and adolescent mental health services*. Audit Commission/NHS, London UK.

DEPARTMENT OF HEALTH, HOME OFFICE AND DEPARTMENT FOR EDUCATION AND EMPLOYMENT (1999). *Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children*. The Stationery Office, London UK.

DEPARTMENT OF HEALTH (2002). *Improvement, expansion and reform – the next 3 years: Priorities and planning framework 2003-2006*. The Stationery Office, London UK.

DEPARTMENT OF HEALTH (2003). *Getting the right start: The National Service framework for children, young people and maternity services – Emerging findings*. London: www.doh.gov.uk/nsf/children/gettingtherightstart.

DIMIGEN, et al. (1999). Psychiatric disorder among children at time of entering local authority care: Questionnaire survey. *British Medical Journal*, Vol. 319, 675.

FOSTER, B. (2004). Into the future. *Professional Social Work*, June.

GOODMAN, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 40, 791-799.

HOPKINS, G. (2002). Beacon of hope. *Community Care*, 11 December.

KURTZ, Z., & JAMES, C. (2003). *What's new: Learning from the CAMHS Innovation Projects – Executive summary*. Department of Health: London.

McCANN, J., et al. (1996). Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal*, 313, 1529-1530.

MACDONALD, G. (2001). *Effective interventions for child abuse and neglect*. Chichester: Wiley.

MELTZER, H. et al. (1999). *The mental health of children and adolescents in Great Britain.* Office National Statistics – The Stationery Office, London, UK.

MELTZER, H. et al. (2003). *The mental health of young people looked after by local authorities in England.* ONS – TSO: UK.

MENTAL HEALTH FOUNDATION (1999). *Bright futures: Promoting children and young people's mental health.* London: Mental Health Foundation.

NEVILLE, D., KING, L., & BEAK, D. (1998). *Promoting positive parenting of teenagers.* Aldershot: Arena.

OUTCOMES SUBGROUP (2003). *Supporting documentation: Emerging findings of outcomes subgroup of child and adolescent mental health external working group contributing to the development of the Children's National Service Framework (NSF).* London www.dh.gov.uk/assetroot/04/03/28/07/04032807.pdf.

PALLETT, C., SCOTT, S., BLACKEBY, K., YULE, W., & WEISSMAN, R. (2002). Fostering changes: A cognitive-behavioural approach to help foster carers manage children. *Adoption and Fostering, 26,* 39-48.

RICHARDSON, J., & JOUGHIN, C. (2000). *The mental health needs of looked after children.* FOCUS: Royal College of Psychiatrists.

SANDERS, M. (1999). *Triple P: Positive Parenting Program.* Milton, Queensland: Families International Publishing.

SCOTT, S., SPENDER, S., DOOLAN, M., JACOBS, B., & AASPLAND, H. (2001). Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. *British Medical Journal, 323,* 194-197.

SUTTON, C. (1999). *Helping families with troubled children: A preventive approach* Chichester: John Wiley and Sons.

WEBSTER-STRATTON, C. (1989). Systematic comparison of consumer satisfaction of three cost-effective parent training programs for conduct problem children. *Behaviour Therapy, 20,* 103-115.

WEBSTER-STRATTON, C. (1992). *The Incredible Years.* Toronto: Umbrella Press.

WEBSTER-STRATTON, C., & HERBERT, M. (1994). *Troubled Families – Problem Children.* Chichester: John Wiley and Sons.

WEBSTER-STRATTON, C., & HANCOCK, L. (1998). Training for parents of young children with conduct problems: Content, methods and therapeutic processes. In C.E. SCHAEFER, & J.M. BRIESMEISTER (Eds.), *Handbook of parent training.* New York: John Wiley and Sons.

Appendix

List of 47 projects included in the study

	Name of Project	Location of Project
1.	Locate	Bath and North East Somerset
2.	Mental Health Service for Looked After Children	Bolton
3.	DAYPIN – Rainbow	Bolton
4.	CAMHS Consultation services to residential homes and foster carers	Bradford
5.	Multi-professional support teams for Looked After Children	Cheshire
6.	Steps Therapeutic Services Team	County Durham
7.	CLASP-CAMHS Looked After Systems Project	Darlington
8.	Connections	Dorset
9.	CAMHS/CAMHISS Looked After Children – Consultation Service	Dudley
10.	Unified Adolescent Team	East Hampshire and Portsmouth Unitary Authority
11.	Multi-disciplinary CAMHS Team	Essex
12.	Orthopedagogical Treatment Centre	Ghent, Belgium
13.	Specialist Mental Health Service for Looked After Children	Glasgow
14.	LACES	Glasgow
15.	Looked after children clinical psychologist and attachment worker	Greenwich
16.	ASSIST	Hammersmith and Fulham
17.	Community Therapist	Havant and Gosport
18.	Specialist Psychologist Posts	Herefordshire
19.	Looked After Children Project	Hillingdon
20.	CLAMHS	Lambeth
21.	Leicester Young People's Team	Leicester, Leicestershire and Rutland
22.	The Wickham Project	Lewisham
23.	CAMHS Tier 1 Support to Children's Homes and LEA Boarding Schools	Lincolnshire
24.	CAMHS Tier 1 Support to Foster Carers	Lincolnshire
25.	Blueprint	National Service run by 2 voluntary sector organisations: Voice for the Child in Care and National Children's Bureau
26.	Lifescope: The Interagency Service for Looked After Children	Norfolk
27.	Children Looked After Mental Health Service	Nottingham
28.	Primary Mental Health Worker: Looked After Children	Peterborough
29.	Looked after children's project	Redbridge
30.	Psychology Team	Response from FOCUS website – location of service unknown

	Name of Project	Location of Project
31.	Child Psychologist	Response from FOCUS website – location of service unknown
32.	Child Psychologist	Response from FOCUS website – location of service unknown
33.	Clinical Psychologist providing Specialist Placements	Response from FOCUS website – location of service unknown
34.	STARLAC	Salford
35.	Sheffield Support Service for Looked After Children	Sheffield
36.	Looked After Children's Service	Southampton
37.	Southend Child and Family Consultation Service	Southend
38.	Fostering Changes Programme	Southwark
39.	Clinical Psychology Service to Looked After Children	Sunderland
40.	Storm Project	Swansea
41.	Senior Mental Health Worker for Looked After Children	Tameside
42.	Intensive Placement and Support Initiative	Wandsworth
43.	Shared post between CAMHS and the Wandsworth Independent Living Scheme	Wandsworth
44.	The Young Options Institute	Warwickshire
45.	Connect	West Berkshire
46.	Child Psychologists	West Sussex
47.	Primary Care and Support Project	Worcestershire

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