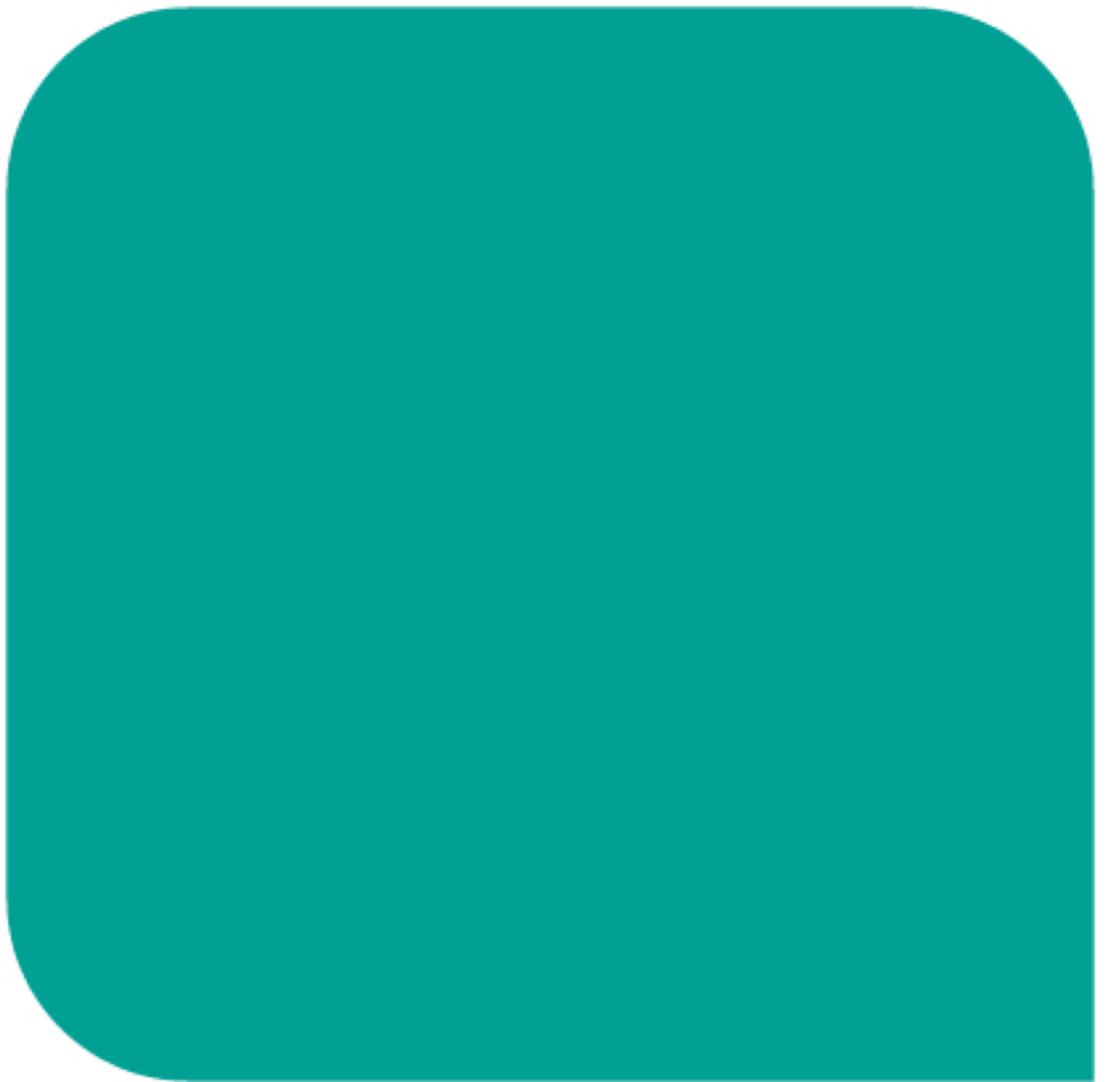




social care
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Improving mental health support for our children and young people



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Expert Working Group co-chairs foreword

There can be no keener revelation of a society's soul than the way in which it treats its children.

Nelson Mandela's statement from May 1995, spoken at the launch of the Mandela Children's Fund in Pretoria, still resonates with us more than two decades later. How we treat children, the sensitivity we show and the systems we put in place to address the needs of these children whose future is entrusted to us, is emblematic of our vision for society as a whole.

The mental health of children and young people has become a focus in our society as never before, and we welcome the commitment by government to achieve a system-wide transformation of the mental health care and support they receive by 2020. Many people have also come together, through the 'Heads Together' campaign, and talked publicly about their personal struggles in an overt effort to reduce stigma and bring mental health issues into the open.

It is our hope that as a society we will become more confident in expressing our compassion towards those with mental health needs, and that with this change the needs of children in care, who are among the most vulnerable in our society, will resonate in new ways: with government, with policymakers, and with local service commissioners and providers. However, to feel and express compassion is not enough. The feeling must act as a catalyst to galvanise those of us responsible for looked after children into making positive changes.

The Expert Working Group brought together a selection of the most committed experts in this field, who were determined and passionate to make a difference to the mental health and wellbeing of children and young people. We were fortunate to benefit from eloquent experts by experience, as well as a richness of oral testimony and evidence from local and national stakeholders. We concluded that the care system does not support the mental health and wellbeing of these vulnerable

children and young people, and can sometimes cause them unintentional harm. This needs to stop now.

We were all motivated by a strong belief that we urgently need to transform the provision and improve support for children and young people's mental health and emotional wellbeing. We see a growing mental health crisis across all groups. Trends highlight an increase in mental illness among some groups of children and young people, particularly emotional problems such as anxiety and depression.^{1, 2} Whatever the cause(s) of this increase, it is likely that the pressures on looked after children will increase with even fewer resources available to protect them.

There is also the societal cost of inaction. Given the prevalence and complexity of mental health problems among children in care, coupled with the knowledge that the best predictor of psychiatric disorders in adulthood is psychological disturbance or a psychiatric disorder in childhood or adolescence,³ intervening early and sensitively in multiple contexts across the system can generate significant benefits.

Equally, we were concerned about significant external influences that can affect the mental health and wellbeing of all young people. For example, growing up in a digital age, increased societal inequality, austerity, and political conflict and instability in the world. One of the results of this upheaval is minors arriving unaccompanied on our shores.

There can be little doubt that children and young people are experiencing new and multiple pressures in a demanding and fast-moving digitally enabled world. Online child sexual exploitation (CSE), where young people are groomed and abused online, increased by 135 per cent between 2015 and 2016.⁴ The wider use of technology can increase young people's vulnerability to abuse, bullying and exploitation. Poverty also plays a critical role in child maltreatment.⁵ During the recent period of austerity we have seen the number of children subject to child protection interventions, and who are taken into care, increase.⁶ In the last 10 years there has been a 140 per cent increase in children and young people on child protection plans.

The Expert Working Group was also greatly concerned by the considerable delays in accessing vital mental health support in the first instance. Since 2012, mean maximum waiting times for access to child and adolescent mental health services (CAMHS)⁷ have fallen.⁸ However, these are still far too high, with some children and young people waiting a long time for assessment and then again for treatment. The Care Quality Commission (CQC) identifies access to timely care and support as a key area for improvement, with CQC inspections commonly finding that CAMHS services need to take action to improve waiting times for specialist community services.⁹

In any case, there is a significant human cost associated with long waiting times, and the difficulties in getting help after assessment are now generally appreciated. We also need to tackle the problem of inadequately coordinated services at the local level and the particular difficulties in the transition from children's to adults' services. There are notable gaps in provision between community and inpatient care.

So, while we have trained and passionately caring professionals, they are too often working within a system which acts as if it lacked compassion.

The ethical imperative to intervene early is overwhelming. The needs of looked after children are complex. Diagnoses of severe disorders such as autism and attention deficit hyperactivity disorder (ADHD) can be missed in the care population and the presence of trauma can overshadow other conditions.^{10,11,12} All too often we can gain only a partial view of a child's health. By over-emphasising the distinct nature of each problem, the clinician is liable to miss important causal or situational considerations. For example, in relation to past or present attachment issues. While it is important to align symptoms with the correct diagnostic label, it is equally important that problems are viewed in the round, so that treatment can be based on a complete picture of the child's needs. This emphasis on a child-centred, needs-focused approach ran through almost all the considerations of the Expert Working Group.

In response to the need for a more flexible approach, there are useful parallels in how the needs of children and young people with special educational needs (SEN)

are met. Mirroring the Education, Health and Care Plan (EHCP) approach, the co-chairs endorse the idea of a 'graduated response' to mental health and wellbeing. We have not recommended a special emotional wellbeing plan for children in care, but feel passionately that the inclusion of this dimension in existing care plans must be significantly strengthened.

We are also concerned that children are often overlooked in decisions that directly affect them, and that this reduced agency will not only have a negative impact on their sense of self, but their trust in the systems designed to assist them, leaving them with potential long-term problems of adaptation. We see a strong case for creating a small team of professionals, including their carers, who care about and understand the child and, importantly, are perceived as caring and understanding by them. There must be key individuals who, based on in-depth knowledge of the child, will have a trusting relationship and be able to guide others in how they can best help, ensuring that the child's personal views on their care pathway are given full attention and consideration.

With significant and growing pressure on health and care budgets, there has often been no alternative to moving money out of non-statutory services (such as youth services) and into statutory child protection support. Disinvestment in one part of the system has often led to unplanned impact in another, leading to the unintended degradation of the ability of the system overall to respond well, particularly with early help.

Good commissioning and local system oversight is critical for success. Our report seeks to reinforce accountability and to emphasise the need for better professional leadership and high quality commissioning across local systems. Crucially we see this responsibility firmly within the corporate parenting role and call for better scrutiny and challenge on behalf of children in care. In our report we make specific recommendations to achieve improved collaboration and coordination of efforts at a national and local level, to move beyond organisational boundaries in a shared endeavour that is focused on the needs of children and young people. We are guided by a model of care that has the young person at its centre, recognising that if

the system does not consistently enhance the child and young person's decision-making power and sense of agency, then it falls short as a corporate parent.

As a society we are clear that we are not prepared to tolerate abuse and maltreatment of children and we use our laws to intervene to protect and care for them. This places us under an ethical obligation to care well for those children for whom the state has assumed parental responsibility. This is expressed through our duty to act as corporate parents to them.

We want to end by emphasising that we found excellent practice in the field and very many dedicated and impressive individuals. We heard dozens of moving personal stories about how meaningful relationships with key remarkable individuals have turned around the lives of profoundly traumatised young people. And we were inspired by the resilience and personal resources of the young people we met, who reminded us why we must make sure everything is done to enable every person to reach their full potential.

We want this report to be used now as well as to inform policy, practice and commissioning decisions going forward. We sincerely hope that the report will fulfil the declared ambition of the Expert Working Group and that it will make a difference.

Professor Peter Fonagy OBE

Dame Christine Lenehan

Alison O'Sullivan

Executive summary

In February 2016 the Department for Education (DfE) minister announced that an Expert Working Group would be created to ensure that the emotional and mental health needs of children and young people in care, adopted from care, under kinship care, under Special Guardianship Orders, as well as care leavers, would be better met. It was proposed that, by October 2017 the following would be developed:

- **care pathways:** focusing on the young person's journey
- **models of care:** how services ensure appropriate interventions
- **quality principles:** measures that set out markers of high-quality care
- **implementation products:** to support those working in the field.

The charity Social Care Institute for Excellence (SCIE) was contracted by the Department of Health (DH) and the Department for Education to establish the Expert Working Group to support this work.

We believed that it was absolutely essential that our work was co-produced with children and young people, and over 80 contributed their experience and evidence to the project. We also heard from those looking after young people and approximately 100 professionals including looked after children nurses, doctors, birth parents, social workers, residential key workers, foster carers and adoptee parents. All of these groups attended our stakeholder event in April 2017.

The Expert Working Group gathered evidence from a review of literature about what the mental health needs of looked after children were, and held a Call for Evidence of good practice. The group also considered what a good system to support the health and wellbeing of looked after children would look like, and described its key features.

One of the key issues that we recognised was that good quality ongoing assessment must be the foundation of a comprehensive strategy of support and services. The feedback from young people, stakeholders and the Expert Working Group itself was

that the Strengths and Difficulties Questionnaire (SDQ) by itself is not an effective way of measuring the mental health and emotional wellbeing of young people.

One of the strongest views of the Expert Working Group was that local areas need to be able to provide consistent care and support for a child, with an understanding that their diagnosis and therefore the type of support services they need can change. Therefore, assessment and services must be responsive and flexible. Mental health is a continuum and cannot be seen as a one-off diagnosis.

For one of our consultations we met 35 children and young people who had accessed provision from across health services including specialist in patient care ('Tier 4' provision). We asked them to create recommendations to include in our report, so that their voice was clear and strong. We present their 11 recommendations here, before our own, because their voice is the context in which our work should best be understood.

From the evidence base that we have assembled, the work of the Expert Working Group, the views of children and young people who are experts by experience, professionals and those looking after young people, we have:

- established 11 key findings, which are the drivers for change
- made recommendations that address those findings and will improve the mental health and wellbeing of looked after children
- developed seven quality statements that define the outcomes that our recommendations are intended to achieve.

Change needs to happen now, and it is our hope that this report provides a platform for that change and the necessary call for action.

We recommend that:

1. Building on the success of the virtual school head (VSH), a similar oversight role of a virtual mental health lead (VMHL) is established. This is to ensure that every child and young person in the system is getting the support they need for their mental health and emotional wellbeing.
2. The Strengths and Difficulties Questionnaire should be supported by a broader set of measures which can trigger a comprehensive mental health assessment. There are a range of tools in use that could support the assessment depending on the need of the young person.
3. Assessments should focus on understanding the individual's mental health and emotional wellbeing in the context of their current situation and past experiences, rather than solely focusing on the presenting symptoms. The young person, their caregivers, family (where appropriate) and professionals' viewpoints should be included. Young people should be able to share who they would like to accompany them to assessments, and where possible those wishes should be accommodated.
4. Caregivers should receive support for their own mental health and wellbeing.
5. Caregivers need to be informed of which statutory and non-statutory services are available when support is needed for the child or young person. This should be included in each area's local offer. It is crucial that services are funded to support caregivers' training and development.¹³
6. Everyone working directly with looked after children should receive training on children and young people's mental health so they are equipped with the appropriate skills.
7. A needs-based model is the best way to support and respond to young people. This model places the young person at the centre of decision-making and where appropriate lets them exercise choice as to how and what support they access. This allows appropriate support to be generated by need, rather than diagnosis.
8. Formal services should be more flexible in who they will allow to support the young person, acknowledging that support can come from a range of services and places. Health, education and social services need to work collaboratively to achieve this recommendation.

9. Ministers at the Department for Education and Department of Health should work together to ensure children in care and leaving care have access to services provided for their mental health and wellbeing.
10. Ofsted, the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Prisons (HMIP) should review their regulatory frameworks linked to registration to ensure that equal weight and attention is being given to mental and physical health needs.
11. The statutory review of a child's care plan by the independent reviewing officers (IROs) must include at each meeting a review of whether mental health needs have been met.
12. Every school should have a designated teacher with the training and competence in identifying and understanding the mental health needs of all their pupils who are looked-after.¹⁴
13. Existing mechanisms for capturing direct views of young people should be integral to planning and commissioning arrangements. Local Health Watch services should monitor the effectiveness of mental health care arrangements for children and young people who are looked after, and report their findings to Health and Wellbeing Boards at least annually.
14. Self-help, peer mentoring and community initiatives should be considered (if a young person expresses this is their preference) before a referral to more formal child and adolescent mental health services.
15. Clinical Commissioning Groups should ensure commissioning is informed by a Joint Strategic Needs Assessment (JSNA) which addresses the mental health and wellbeing needs of looked after children and care leavers. This should be reflected in Local Transformation Plans.
16. The Local Safeguarding Children Board, Corporate Parent Board and Health and Wellbeing Board should give appropriate priority to ensuring that the mental health needs of children and young people in care and leaving care are met.

The Expert Working Group developed a new model which places the young person at the centre. The model is based on 'I statements' supported by enablers. The model highlights what good, holistic support for mental health and wellbeing looks like from the perspective of the young person, and what needs to be in place to make it happen.¹⁵

Alongside this model, one of the major findings from our evidence is that the journeys taken to access support are often not linear. For example, a child in care may have a social worker who has the statutory responsibility of referring to child and adolescent mental health services, but their trusted relationship may be with another professional or their main caregiver. In this instance, there would be benefit to the young person being able to utilise their trusted relationship to access support together.¹⁶

To support our findings, we then developed an 'eco-map', to be used in conjunction with the accompanying decision trees. The eco-map is a representation of the choices that should be available to the young person and/or primary caregiver to access the right support and resources.

The decision trees represent our recommendations for a responsive pathway that places the child or young person at the centre, and include those that know them in the decision-making, as appropriate.

At the core of both our model and pathway is the need for:

- timely intervention and support
- a system that can be activated by anyone within the child or young person's network
- a recognition that mental health is a continuum
- support that is responsive to the young person's needs.

Our decision trees together with the eco-map create the pathways for prevention and accessing support, the core components of which are:

- the people raising a concern
- who they raise the concern to
- how that person decides what the level of concern is
- what they do in response to this concern
- ongoing monitoring and responding to need.

The roles and responsibilities presented in Appendix 3 are those that the child or young person can expect to support them as they journey through the pathways.

Introduction

As a society, we trust the state to provide the best possible care to all children who cannot be looked after by their birth families. In their journey through care, the meaning we can give to the life of the young person whose wellbeing rests in our collective hands, the speed with which we respond to the distress of children in care, and the resources we make available to support them in their time of need, all speak to our capacity as a society to safeguard the most marginalised.

The mental health of young people is a focus in our society as never before, and we welcome the government commitment that by 2020 there will be system-wide transformation of the local offer to children and young people. Work has begun with principles of service integration across health, education, justice and social care now feeding into sustainability and transformation partnerships (STPs) and Local Transformation Plans (LTPS) across the country

However, through our Expert Working Group meetings, stakeholder events and Call for Evidence we have learned that too often we are failing these children and young people. Multiple testimonies highlighted that some looked after children and young people are not accessing services when needed, or are being told that their mental health need does not meet service thresholds.

Other evidence in this report highlights that we must change our approach to children and young people's mental health and ensure that services are accessible, flexible and child-centred. The report also highlights the urgent need to transform how we commission, collaborate and work together in local areas to give children in care the same level of support, care and opportunity that we would wish for our own children. We need to build a community both around the child and those caring for them, to ensure that this group of young people are supported to reach their potential.

Background to the project

In March 2015, the Department for Education and Department of Health published new statutory guidance on promoting the health and wellbeing of looked after children. The guidance acknowledged that almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs.¹⁷

Alongside the guidance, NHS England and the Department of Health published 'Future in mind',¹⁸ which set out the need for appropriate care pathways and new models of evidence-based care to identify and meet the mental health needs of vulnerable children and young people. It was an expectation that the needs of children in care would be specifically addressed in the delivery of local services.

In September 2015, the House of Commons Education Committee announced its inquiry into the mental health and wellbeing of looked after children. In April 2016, the Committee published its report, including evidence and testimony highlighting the urgent need for action:

Looked after children who need access to mental health services often have numerous and complex issues that require specialist input across multiple agencies. We have heard evidence that CAMHS is often unable to provide this care due to high thresholds and a refusal to see children or young people without a stable placement.¹⁹

The Expert Working Group

In February 2016, Ed Timpson, Minister of State for Vulnerable Children and Families, announced in evidence to the Education Committee that an Expert Working Group would be created.¹⁹

The aim was to ensure that the emotional and mental health needs of children and young people in care, adopted from care, under kinship care, or whose placement is

formed by a Special Guardianship Orders or other formal legal orders, and those of care leavers, were better met by developing, by October 2017:

- **care pathways:** focusing on the young person's journey
- **models of care:** how services ensure appropriate interventions
- **quality principles:** measures that set out markers of high-quality care
- **implementation products:** to support those working in the field.

The Expert Working Group has taken a definition of looked after children to include those living in foster homes, children's homes and residential special schools, along with those who have been adopted, are subject to Special Guardianship Orders, living within the secure care and criminal justice systems, asylum-seeking children and care leavers. Wherever we refer to 'looked after children' in this report, we mean all of these groups. We acknowledge that within this cohort, children and young people have a diverse range of needs.

Following consultation, Professor Peter Fonagy, Professor of Contemporary Psychoanalysis and Developmental Science, University College London, and Alison O'Sullivan, past President of the Association of Directors of Children's Services, were appointed by ministers as co-chairs of the Expert Working Group. In April 2017, Alison O'Sullivan handed over her role to Dame Christine Lenehan, Director of the Council for Disabled Children.

The co-chairs were appointed to bring together the perspectives of health and social care, mirroring the close relationships that are needed to improve the mental health support that looked after children need.

The Social Care Institute for Excellence has supported the work of the Expert Working Group, including leading the co-production of this report and developing resources and training to support the project.

Appendix 1 sets out further detail on the membership and work of the group.

Co-production

A fundamental principle of the project was that recommendations be based on proposals that were supported by the available research evidence, by those directly involved in looking after our most vulnerable young people, and by young people themselves. At the heart of our project were the young people who we talked to through the course of our work, to understand how they felt about mental health support and provision.

I was told that I needed to talk to a therapist because I had ‘anger problems’. Wouldn’t you be angry if someone dumped you in a family you didn’t know? All I wanted was time to think about my feelings and space to breathe – to get my head around not living with mum anymore – but I was shoved in a room and told to talk to some random person. I wasn’t ready for that and it made things worse.²⁰

As well as having young people as members of the Expert Working Group we held sessions with 80 children and young people. Young people contributed through attending the children’s reference group which met three times during the course of the project, or through a targeted group consultation.²¹ In the course of this project, we asked young people: What would help when you are having a ‘bad’ day? What type of support do you need? What needs to change? Young people were always asked the same questions, but were given a choice of response methods to ensure that they could contribute in a manner which suited their emotional literacy.

Throughout the course of the project young people expressed their anger and despair at professionals assuming they did not have the capacity to contribute to decision-making. As a result they were often not kept informed about key decisions and presented with child and adolescent mental health services as the only solution. Over 75 per cent of the young people involved in the project cited time alone and having space to breathe, or access to community resources (youth centres, drama, art, sports etc.) as helping most on a ‘bad day’.²² In order to promote young people’s

messages, we have created a new digital platform which will host all of the art, video and creative content that they created during the course of the project.

We also heard from those looking after young people, with almost 100 professionals including foster carers, looked after children nurses, doctors, birth parents, social workers, residential key workers, independent reviewing officers and adoptee parents attending our stakeholder event in April 2017. A further consultation with 20 foster carers took place in May 2017 and with Adoption Together in October 2017.²³

What do we know about the mental health needs of children in care?

There are many drivers of poor mental health, including the early and ongoing experiences of many looked after children. This is true both of their experiences leading to them being taken into care and their experiences while in care.

I used to think it was ironic, that the care system was called the 'care' system, because to me it looked like they should drop the care. The system failed to look after me well enough, which allowed my mental health and emotional wellbeing to not only be neglected, but actually directly making me unwell. Leaving me with my parents for far too long, witnessing extreme domestic violence and being diagnosed with PTSD symptoms aged 3 yet handing me straight back to my parents. To then being placed with a foster carer who never wanted me, both foster carers abusing alcohol and class A drugs, and spending 10 years bullied, controlled and hating my very existence ...²⁴

As at 31 March 2017 there were 72,670 looked after children, an increase of 3 per cent on 2016.²⁵ We know that almost half of all looked after children have a diagnosable mental health disorder.²⁶ Data collected by the Children's Commissioner in 2015 suggests that while fewer than 0.1% of children in England are in care, 4% of children referred to specialist CAMHS services are in care.²⁷ We also know that 52 per cent of children in care have low subjective wellbeing compared to around 10 per cent of children in the general population. Additionally

there is an increased risk of developmental disorders such as attention deficit hyperactivity disorder and autistic spectrum condition (ASC).¹⁰ Given that the best predictor of psychiatric disorders in adulthood is a psychiatric disorder or disturbance in childhood or adolescence,³ there is very strong obligation for early intervention with this high-risk group for their present needs and future wellbeing.

In addition to young people currently in care, every year 10,000 young people leave care. The government has acknowledged that:

Those leaving care may struggle to cope with the transition to adulthood. They may experience social exclusion, unemployment, health problems or end up in custody. Care leavers have had these problems for a long time.²⁸

Care leavers also face difficulties accessing child and adolescent mental health services, and they can face even more problems accessing support when they move from children's to adults' services.²⁸

Sometimes there is a disconnect between the social care and the health care system. Young people in care are treated as children up to 25 but for health services they are treated as adults from 18. Young people may not be able to navigate the complex pathways of the health system. They can find it difficult to access services and often have to go to the back of the queue as they don't meet adult services thresholds. Yet their health problems still remain.²⁹

NHS England has introduced a nation-wide financial incentive in place from 2017-19 to improve the experiences of young people transitioning out of Children and Young People's Mental Health Services on the basis of their age.³⁰

Call for Evidence

The Expert Working Group also held a call for evidence across the country. A total of 68 practice examples were submitted with a further 14 submissions as proposals or policy responses. Respondents included NHS trusts, third sector organisations, local authorities, private providers, national bodies, university departments, and parents and carers.³¹ The richness of oral testimony and evidence from local and national stakeholders enabled the Expert Working Group to consider what good mental health and emotional wellbeing should look like for children and young people. Each meeting looked at different functions and challenges of the system and discussions were supported with presentations by the Social Care Institute for Excellence research team.³² Our model, pathways, recommendations and quality statements are based on the evidence we collected through the Call for Evidence, from children and young people, via stakeholder events and from in-depth discussions with the Expert Working Group.

Examples from the Call for Evidence that illustrate the principles of good practice as articulated in this report include the following.

1. Enhanced screening for younger children

1a. Social-emotional Under 4's Screening and Intervention (SUSI) (Submission 9), was a clinical feasibility study based in Southwark, providing immediate access to assessment and, where indicated, intervention, for children under the age of 4 who become newly looked-after; children of parents referred to the parental mental health team; or children who are new to Child Protection Plans.

2. Multi-agency review and planning in relation to looked after children wellbeing

2a. In North East Lincolnshire specialist child and adolescent mental health service, a monthly multi-agency clinic (Submission 72) has been formed to review looked after children Strengths and Difficulties Questionnaire results. Where there are scores of concern, a multi-agency clinic decides how best to meet the

needs of the person from a health, mental health, care and educational perspective. This differs from normal practice where a Strengths and Difficulties Questionnaire would be completed but there would be no opportunity to discuss or share the results with the agencies. The clinic has also been used to identify and escalate concerns about gaps in mental health provision. All looked after children living in the area, or placed out of area, or placed in the area by other local authorities, are included in the reviews.

2b. 'ATTACH' (Submission 4) is an assessment and intervention service for all looked after children, adopted and special guardianship order children in Oxfordshire, funded by the local authority and positioned within the department of Children, Education and Families. It offers interventions for carers and young people, working with families with a high level of need who may not meet CAMHS criteria; services also include monitoring high Strengths and Difficulties Questionnaire scores for looked after children in collaboration with the looked after children health team.

3. Different models of child and adolescent mental health services to facilitate early identification of need

3a. Fast track North East London specialist child and adolescent mental health services drop-in (Submission 30) is a fortnightly drop-in service for social workers to discuss concerns they have about looked after children, receive advice on actions and make referrals to the fast track looked after children child and adolescent mental health services team as appropriate.

4. Alternatives to (child and adolescent mental health services) therapeutic services

4a. 'No Wrong Door' (Submission 7) is a multi-agency service model based in North Yorkshire. Specialist roles are brought together under one roof, and each child or young person is given a key worker and can continue to access the service up to age 25 if needed. A 'life coach' (a clinical psychologist) carries out assessments and provides interventions. The model provides for more flexibility than traditional clinical psychology services offered by child and adolescent mental health services. Life

coaches are also able to provide consultation, training and supervision to those caring for young people.

5. Child and adolescent mental health services delivered in an educational setting

5a. Lewisham virtual school child and adolescent mental health services team (Submission 25) is a joint venture between child and adolescent mental health services and the local authority's virtual school. The team is described as being embedded within the virtual school and its aim is to incorporate a child and adolescent mental health services perspective into the work of the virtual school. This is seen as way of providing a flexible and responsive service to looked after children and young people placed both in and outside the borough.

What should a good system look like?

As children and young people come into the system, and at key stages of their life, their caregivers and professionals need to demonstrate that they have a strong understanding of the child's feelings, thoughts and wishes. This community of individuals around the child needs to share its understanding of the child on a regular basis.

Understanding the lens through which the young person sees life, and having a system that communicates and works together, provides a solid platform for the young person to have the resources and support they need to flourish.

Plans drawn up to meet the needs of each individual child should always include their emotional health and mental health needs, with details on how these will be best supported. This should be reflected for every child from the very first care plan submitted to court, through every review and into plans to support leaving care or transition to adult support. An understanding of mental health needs should be through a timely assessment that takes into consideration the key principles of good assessment that we raise in our report.

There was strong evidence throughout the project that caregivers³³ often felt they could not get the support they needed for their child or young person due to high thresholds or due to being excluded from key meetings. This is reflected in the recent report from the CQC which found that local variations in eligibility criteria for CAMHS and in the availability of other services meant that in some areas of England children and young people are unable to access the care and support that they need.⁹

Both the young person and the caregiver should be confident that they can access services from health, education and social care when they are needed. They should also be confident that these agencies will respond collaboratively and flexibly to meet their needs. This includes the caregiver being able to access support and advice for their own mental wellbeing.

There are existing services and support that should promote mental health and emotional wellbeing, but these can be highly dependent on the relationship between the professionals and young people. However, we know through talking to professionals and young people that relationships (e.g. between social worker and child), can be fragile, and that young people can find it difficult to sustain a relationship with social workers because of staff changes and workloads.

This view is supported by the Ofsted 'Annual social care report 2016' and the All Party Parliamentary Group for Children Inquiry into Social Care 2017:

Stability is consistently undermined by staff shortages, high turnover of social workers and multiple care placements, with consequences for the quality of care. In some areas agency staff account for more than 40 per cent of social workers.³⁴

Commissioning and multi-agency collaboration

Good services need good commissioning. Every local authority has a Health and Wellbeing Board which is responsible for the Joint Strategic Needs Assessment;

clinical commissioning groups with responsibility for the sustainability and transformation partnerships; corporate parent committees who lead local arrangements and quality assure service delivery to looked-after young people and care leavers. However, we know that these systems are variable, and there is not consistent learning from the best practice of those who are delivering good care. There needs to be more transparency and accountability in each local area about how services are commissioned and quality assured for looked after children and young people.

The Expert Working Group were very concerned about the number of individuals and organisations that can be involved in a child's care, poor multi-agency collaboration and the capacity of the system to support young people with the most complex needs. There were several testimonies provided by Expert Working Group members of young people who needed inpatient care who could not access a bed and as an alternative were placed in a secure unit or children's home, or who had several placements before they accessed the right support.

The Expert Working Group's concern about insufficient capacity in the system was reflected in the comment made by Judge Munby, the president of the High Court's family division, in August this year. In his judgement on the case of a 17-year-old-girl who could not be provided with an appropriate mental health bed he stated

If ... we, the system, society, the State, are unable to provide X with the supportive and safe placement she so desperately needs, and if, in consequence, she is enabled to make another attempt on her life, then I can only say, with bleak emphasis: we will have blood on our hands.³⁵

This supports evidence on the ground and information shared by Expert Working Group members that at the moment the system is not meeting the needs of all our young people with high-level needs who require specialist inpatient care ('Tier 4' provision). The CQC has also identified the availability of suitable inpatient services for children and young people in their local area as a key area for improvement.⁹ There is a NHS England program across the country to improve crisis care and community services with an intended £1.4bn further investment.³⁶ We hope to see

this translated into practice and suitably resourced to meet the needs of looked after children and young people

We know that there are some groups of looked after children who are particularly vulnerable to mental health problems. Critically, this includes children and young people with disabilities, who are over-represented in the care system and who can struggle to get mental health support which is tailored to their needs. When commissioning services, local areas must ensure that the needs of all looked after children and young people are met, including those who need more bespoke services.

Virtual mental health lead

The Expert Working Group's concern that children and young people with complex mental health needs are not getting the mental health support they need led to one of our primary recommendations: the creation of a virtual mental health lead. This reflects the success of the creation of a virtual school head for looked after children, with the same principles of championing the needs of young people, monitoring progress in local areas (including young people out of borough), intervening where needed and promoting best practice, all with a focus on mental health and wellbeing. We see the two roles working closely together.

The virtual mental health lead would have responsibility for:

- system leadership; monitoring mental health and wellbeing plans that local areas have in place for looked after children
- collecting local data to help embed best practice nationally
- providing support and challenge where needed for individual young people
- developing strong multi-agency relationships in particular health, education and social care services

The Expert Working Group discussed at length where this post should be located and the overall consensus was that it should be a health role with the virtual mental

health lead having sufficient mental health expertise and professional credibility to communicate with (and, where needed, challenge) other health professionals. However, to effectively deliver improvements, the post-holder must have the skills, credibility and authority to work across all local organisations.

The corporate parent

The Expert Working Group discussed in detail the role of corporate parenting, which operates at many levels: through those carers who care for children on a day-to-day basis, through local authorities who carry the statutory responsibility to ensure children are well cared for on behalf of the state, and also through national and local agencies. The Expert Working Group were clear that the quality of support and placement stability that a child receives as they enter the system should not depend on where they have been placed.

Equally Expert Working Group members agreed that effective multi-agency collaboration is crucial in meeting the responsibility and duty of the corporate parent. The corporate parent has a dual responsibility, both as the 'parent' and as the provider of services for looked after children. The Expert Working Group is concerned that the latter role is too often given priority and wants to see the corporate parent putting their duty as parent first:

The corporate parent should enhance a child's quality of life as well as simply keeping them safe. In order to raise ambition for looked after children, elected members and senior leaders must act like 'pushy parents', working hard to ensure the best for looked after children through asking the question, 'is this good enough for my child?'³⁷

One of the key principles in the Children and Social Work Act 2017 is that corporate parents must act 'in the best interests of and promote the health and wellbeing of children and young people in care'.³⁸ It is our hope that when the Act comes into effect in 2018 this increases local areas' commitment to children and young people's mental health and the consistency with which services are delivered.

Child and adolescent mental health services provision

Improvements to mental health provision for our children and young people must be actioned on both a local and national level, building on existing guidance and reports, and on good practice already in place across the country, to deliver more responsive services.

While the government announcement of additional funding for child and adolescent mental health services is welcome, it is too soon to say whether this investment will deliver the significant improvements to services that we all want to see, with shorter waiting times and better, more tailored services. The imminent Green Paper on children and young people's mental health gives an opportunity for the government to set out how it plans to make further improvements for the mental health of all children and young people, including through prevention and access to services.

Increasing funding for child and adolescent mental health services will not deliver improvements to services if the new funding merely replaces funding which has been withdrawn. All parts of the system need to prioritise looked after children and support their mental health and wellbeing through a more coherent and properly funded response to their needs. It is also important to highlight that there is significant pressure on local authority budgets, and a huge knock-on effect on the quality of services available for children outside formal child and adolescent mental health services support – with councils facing a £2 billion funding gap by 2020.

Stable placements and relationships

Young people themselves say that stability is the most important aspect of their experience of care. In the children's commissioner's latest report on vulnerable children and the stability index she says:

When children in care have to change their placement, it can lead to relationships with trusted adults being broken. When children in care have to move schools, they can lose ties with friendship groups. Staff turnover in

residential units and changes of allocated social worker can further unsettle children and young people. We estimate that around 50,000 children in care on the 31st March 2016 (71% of all children in care in England) experienced a change in their placement, school, or their social worker over a 12-month period ... across England as a whole around 220 children experienced high instability ... That means they experienced multiple placement moves, a mid-year school move and multiple social worker changes, all within in the same 12-month period.³⁹

Placement instability should be seen as both a cause of mental health conditions and an effect of the placement itself. A number of the children and young people we spoke to had experienced multiple placements. One young person said that this can make children in care feel unloved or too damaged to be cared for.

Another factor in placement instability is when carers are not properly supported to help the child or young person in their home. Examples were provided both by the Expert Working Group and through stakeholder consultations where caregivers received no support when living with young people with complex needs.

Caregivers need a supportive environment where their wellbeing is promoted and looked after, so in turn they are better equipped to support the complex needs of the young people they are caring for. Examples submitted through the Call for Evidence that promoted the caregivers' wellbeing included the following.

- **AdOpt Parenting programme (Submission 44)**⁴¹ is a group-based parenting programme, developed from the KEEP fostering programme, and specifically designed for adoptive parents to help facilitate parenting techniques. It address specific difficulties which adopted children may experience. AdOpt includes an adoptive parent as facilitator, and the programme targets parents and children post-legal order, a time when parents have historically received limited support and which is critical for future family cohesion, child development and wellbeing. The overall programme has been designed for adoptive parents to help facilitate parenting techniques and

support that address specific difficulties which adopted children may experience.

- **Fostering Changes Programme National Adoption and Fostering Clinic (Submission 82)**⁴⁰ was developed at the Maudsley Hospital, South London, in conjunction with King's College London, in order to provide the practical support and training for foster carers. The approach seeks to train foster carers to maintain children and placements, address behavioural challenges and also to skill them up to thinking about how to collaborate and engage with young people about their mental health wellbeing and concerns.

Assessment

Children and young people's needs and the support services they require evolve and change over time. The Expert Working Group was adamant that local areas need to be able to provide consistent care and support for the child, with the understanding that any diagnosis, if made, as well as specific needs, will change and adapt over time. Assessment and supporting services must therefore be responsive and flexible. Mental health need is a continuum and cannot be described by a one-off diagnosis. This echoes the findings of 'Future in mind':

The provision of mental health support should not be based solely on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.¹⁸

Strengths and Difficulties Questionnaire

Done correctly, assessment can be the foundation for providing a comprehensive strategy of support and services, developed in partnership with children and young people and their caregivers.

It was the view of the Expert Working Group, supported by feedback from young people and stakeholders, that the Strengths and Difficulties Questionnaire (SDQ)

alone is not an effective way to measure the mental health and emotional wellbeing of young people. Additionally, members advised that it is unable to detect post-traumatic stress disorder (PTSD), attachment disorganisation⁴² and developmental issues such as autistic spectrum condition. The Expert Working Group therefore recommend that the SDQ is used in conjunction with other assessment methods.

NSPCC research found that in four local areas surveyed, there was no routine assessment of mental health.⁴³ Similarly, although the completion of the SDQ for all looked after children has been a statutory requirement since 2009, there is a huge variation in completion rates across local authorities. Between 2014 and 2016 there was only a 75 per cent completion rate in England as a whole, with 15 local authorities completing SDQ for less than 50 per cent of their looked after children and young people, and three authorities failing to report a single use of the tool.²⁶

The Expert Working Group spent considerable time discussing the way that need should be formally assessed. Our discussions recognised that looked after children have a range of needs beyond any diagnosis, and assessment should recognise their strengths as well as their challenges.⁴⁴

Assessments should not be done once and then forgotten: they are inevitably a snapshot and as such need to be updated at regular intervals. Assessments should focus on the overall mental health and emotional wellbeing of a looked-after young person and lead to action. Their own, their caregivers', families' (where appropriate) and professionals' viewpoints should all be included.

Young people should be asked who they would like to accompany them to assessments and where possible those wishes should be met. At the end of an assessment, the young person should have an understanding of why the assessment took place, know that they were listened to and understood, and understand what will happen next. Effective assessments must see the young person in the context of the situation they are in, the support they need, the key people in their life and their own perspective on their life and situation. Assessments must also be kept under continuous review.

One of our sessions saw 35 young people from across the country who had accessed provision from early help to specialist inpatient care. In the session, the children and young people were unanimous in their belief that it did not matter who was completing the assessment, but rather how the assessment was done. One young person proposed (and others agreed) that anyone who asked you about your mental health should meet you first 'just to talk and get to know you'. One young person (unsurprisingly) added 'we need to know they care before we share our deepest and darkest feelings'.⁴⁵

Contemporary challenges

The number of people asking for help with mental health issues is increasing. The voluntary sector and health services report increasing demand for children and young people's mental health care and support.⁹ Although increased awareness, improved screening and greater clinical recognition are factors, secular trend studies highlight a general increase in mental illness among children and young people, particularly emotional problems such as anxiety and depression.^{2, 46} Whatever the cause(s) of this increase, it suggests that mental health challenges have become more complex and prevalent for all children and young people in recent years. The Expert Working Group was concerned about a number of external influences which can affect the mental health and wellbeing of all young people, including:

- growing up in a digital age
- increased societal inequality
- failure to develop coherent support for children's mental health.

Children and young people's recommendations

We asked the 35 children and young people who had accessed provision from early help to specialist inpatient care to create recommendations to include in our report so that their voice is clear and strong. It is right that these are presented before the key findings of the Expert Working Group's work.

- **Young people need love and kindness**, and interventions should be tailored to this.
- **Not everything is an issue or problem** – sometimes a young person just needs help to take stock and to speak about things.
- **Don't judge us.**
- **Don't leave us waiting** for help or without information on decisions that affect us. We want to be involved in what's happening in our lives.
- If someone gets told they have mental health problems, give them time and space to think about this alone, or process it with a friend/carer. **We need time.**
- Remember **we are still young people.**
- **Don't treat us differently** because we are in care.
- **Remove barriers** to accessing mental health services. This includes access, location, waiting times and information about how the service can help.
- Let young people be **involved** in deciding what they want or how they receive help.
- **Social workers should be trained** in life story work, talking therapies and anger management.
- If a young person has more complex needs, they should have **access to more advanced therapy**, but if social workers were trained in (above) a lot of issues would be resolved.

Summary of key findings

1. There was strong testimony from front-line professionals that a needs-based model is the best way to support and respond to young people. A needs-based model allows the child to be placed at the centre of decision-making and where appropriate to exercise choice as to what support they need.
2. Both young people and front-line professionals expressed a frustration at the conventional linear approach to describing care pathways, which over-emphasises reliance on a statutory relationship that may not be the most trusted relationship. A linear pathway also frequently fails to utilise the relationships that may be central to the child or young person. Young people's journeys are not linear and neither are their needs, so effective solutions cannot be solely linear either.
3. Initial and continuing assessment of mental health status is essential for monitoring and meeting needs. There are a range of tools in use that could support the assessment depending on the need of the child or young person. Strengths and Difficulties Questionnaires by themselves are not sufficient. Examples of different methods of assessment can be found in our Call for Evidence.
4. When we asked our young person's reference group who should complete the assessment, they consistently reported that **how** it was completed was more important than by whom. The group were eager to recommend that there is an initial meeting between the chosen professional and the young person before any assessment is done as 'trust and getting to know each other first before you share deep stuff' is crucial for young people. The Expert Working Group supports this recommendation.
5. Statutory services must ensure they allow those who have key relationships with the young person to **contribute** to decision-making. There was evidence offered during the course of the project that people with central current relationships with the child or young person, most commonly the main caregiver,⁴⁷ were excluded from decision-making.
6. Caregivers need to be fully aware and informed of what statutory and non-statutory services are available. Additionally, in order to properly support the

young people they care for, caregivers need support for their own mental health and wellbeing.⁴⁸

7. Children and young people want choices outside of child and adolescent mental health services. The most commonly cited examples by children and young people when asked what helps on a bad day were having time out and space to breathe, followed by recreational activity. Self-help (including peer mentoring) and resources within the community should be seen as viable choices for supporting the young person.
8. The Expert Working Group strongly advocates the reframing of accountability for looked after children and young people's mental health and emotional wellbeing. We believe that there need to be stronger mechanisms of accountability within existing systems which we highlight in our recommendations.
9. Building on the success of the virtual school head, the Expert Working Group believes that a similar oversight role of a virtual mental health lead is needed.
10. Statutory services are becoming much better at consulting children and young people. While this is a welcome step forward, it is only by **collaborating** with young people that we can move beyond services 'done to' to services 'done with'. If young people are not involved effectively from the start, they will disengage with professionals and services and the commissioning of services will not be informed by those using the service.
11. In relation to mental health assessment, the Expert Working Group made key process recommendations that shift control back to the child and young person, including, where possible, a strengths-based approach focusing on enhancing resilience. This is detailed in our pathways and decision trees.

Recommendations and quality statements

Quality statement	Key risk	Recommendation
<p>Quality statement 1: Commissioning and accountability Young people’s needs are met because there are systems and procedures in place to hold commissioners and providers to account. All those jointly responsible for commissioning have the knowledge and information to work together to make informed decisions that are responsive to children and young people’s needs.</p>	<p>There is insufficient accountability in the current system.</p>	<ol style="list-style-type: none"> 1. Clinical Commissioning Groups should ensure commissioning is informed by a Joint Strategic Needs Assessment (JSNA) which addresses the mental health and wellbeing needs of looked after children and care leavers. This should be reflected in Local Transformation Plans. 2. The Local Safeguarding Children Board, Corporate Parent Board and Health and Wellbeing Board should give appropriate priority to ensuring that the mental health needs of children and young people in care and leaving care are met. 3. Ofsted, the Care Quality Commission and Her Majesty’s Inspectorate of Prisons should review their regulatory frameworks linked to registration to ensure that equal weight and attention is being given to mental and physical health needs. 4. The statutory review of the child’s care plan by the independent reviewing officers must include at each meeting a review of whether mental health needs have been met.

Quality statement	Key risk	Recommendation
<p>Quality statement 2: Leadership Each locality has an accountable, independent virtual mental health lead whose primary responsibility is the mental health and emotional wellbeing of looked after children and young people.</p> <p>This person provides leadership and oversight of the local system and ensures a holistic approach to care is in place, including ensuring that appropriate information is shared with everyone who is involved in the child or young person's care.</p>	<p>There is no consistent leadership for supporting, monitoring and championing young people's mental health.</p>	<ol style="list-style-type: none"> 5. Building on the success of the virtual school head (VSH), a similar oversight role of a virtual mental health lead (VMHL) is established. This is to ensure that every child and young person in the system is getting the support they needed for their emotional wellbeing and health. 6. Every school should have a designated teacher with the training and competence in identifying and understanding the mental health needs of all their pupils who are looked-after.⁴⁹ 7. Ministers at the Department for Education and Department of Health should work together to ensure children in care and leaving care have access to services provided for their mental health and wellbeing.
<p>Quality statement 3: Workforce Everyone working directly with the children and young people, including those who are transitioning into adulthood, will have the knowledge, skills and competencies to recognise and respond to their mental health needs. This includes knowing when and how to access support from more specialist services if needed.</p>	<p>Caregivers are not sufficiently supported by the current system, either to access services for the young person they care for or to support their own mental health and wellbeing.</p>	<ol style="list-style-type: none"> 8. Caregivers need to be informed of which statutory and non-statutory services are available when support is needed for the child or young person. This should be included in each area's local offer. It is crucial that services are funded to support caregivers' training and development.⁵⁰

Quality statement	Key risk	Recommendation
<p>Quality statement 4: Workforce Foster carers, special guardians, kinship carers, adoptive parents and those providing first-line support in children’s homes are recognised and valued as members of the workforce. They are provided with opportunities for training and development and are included in decision-making. They have access to support and advice from specialist mental health services for their own mental health and that of the child for whom they are caring.</p>	<p>Those working directly with young people do not always receive sufficient training to support complex mental health needs.</p>	<p>9. Caregivers should receive support for their own mental health and wellbeing.</p> <p>10. Everyone working directly with looked after children should receive training on children and young people’s mental health so they are equipped with the appropriate skills.</p>
<p>Quality statement 5: Voice Children and young people’s right to be involved in decision-making that affects their lives is recognised and supported. They are listened to as experts in their own experience by being given opportunities to work with professionals in planning and reviewing their support, including involvement in their care plan and pathway plan. This should be consistent with their individual development, preferences and needs.</p>	<p>The current model of delivering care relies too much on diagnosis and not enough on need.</p> <p>Children and young people are not consistently being offered the platform to contribute to decision-making that affects their lives.</p>	<p>11. A needs-based model is the best way to support and respond to young people. This model places the young person at the centre of decision-making and where appropriate lets them exercise choice as to how and what support they access. This allows appropriate support to be generated by need, rather than diagnosis.</p> <p>12. Existing mechanisms for capturing direct views of young people should be integral to planning and commissioning arrangements. Local Health Watch services should monitor the effectiveness of mental health care arrangements for children and young people who are looked after, and report their findings to Health and Wellbeing Boards at least annually.</p>

Quality statement	Key risk	Recommendation
<p>Quality statement 5: Voice (cont)</p>	<p>Children and young people want choices outside of child and adolescent mental health services. Their views must be listened to and responded to appropriately. Our consultations with children and young people highlighted that children often feel they are not given choices as to how to manage their own mental health and wellbeing.</p>	<p>13. Self-help, peer mentoring and community initiatives should be considered (if a young person expresses this is their preference) before a referral to more formal child and adolescent mental health services.</p>
<p>Quality statement 6: Pathway Children and young people know what services and support they are entitled to, and what those services provide. An informed and accountable workforce ensures that children and young people can access support that meets their individual needs and preferences, whatever their first point of contact.</p>	<p>A linear pathway can prevent a child or young person from sharing information essential for decision-making, as it places accountability on a statutory relationship that may not be their trusted relationship.</p>	<p>14. Formal services should be more flexible in who they will allow to support the young person, acknowledging that support can come from a range of services and places. Health, education and social services need to work collaboratively to achieve this recommendation.</p>

Quality statement	Key risk	Recommendation
<p>Quality statement 7: Assessment Universal health and wellbeing screening of all looked after children and young people are of a quality to act as an early warning system to identify support needs and prevent problems escalating. Young people and those supporting them meet to assess what the young person wants to achieve, and the help they need to achieve it. Assessments are not a 'one-off' exercise, but are ongoing, with flexibility in format and delivery, according to the individual needs and preferences of the young person.</p>	<p>Strengths and Difficulties Questionnaires (SDQ) by themselves do not capture the full range of emotional and wellbeing needs of a child or young person. Initial and continuing assessment of mental health status is essential for monitoring and meeting needs.</p>	<p>15. The Strengths and Difficulties Questionnaire should be supported by a broader set of measures which can trigger a comprehensive mental health assessment. There are a range of tools in use that could support the assessment depending on the need of the young person.</p> <p>16. Assessments should focus on understanding the individual's mental health and emotional wellbeing in the context of their current situation and past experiences, rather than solely focusing on the presenting symptoms. The young person, their caregivers, family (where appropriate) and professionals' viewpoints should be included. Young people should be able to share who they would like to accompany them to assessments, and where possible those wishes should be accommodated.</p>

Model

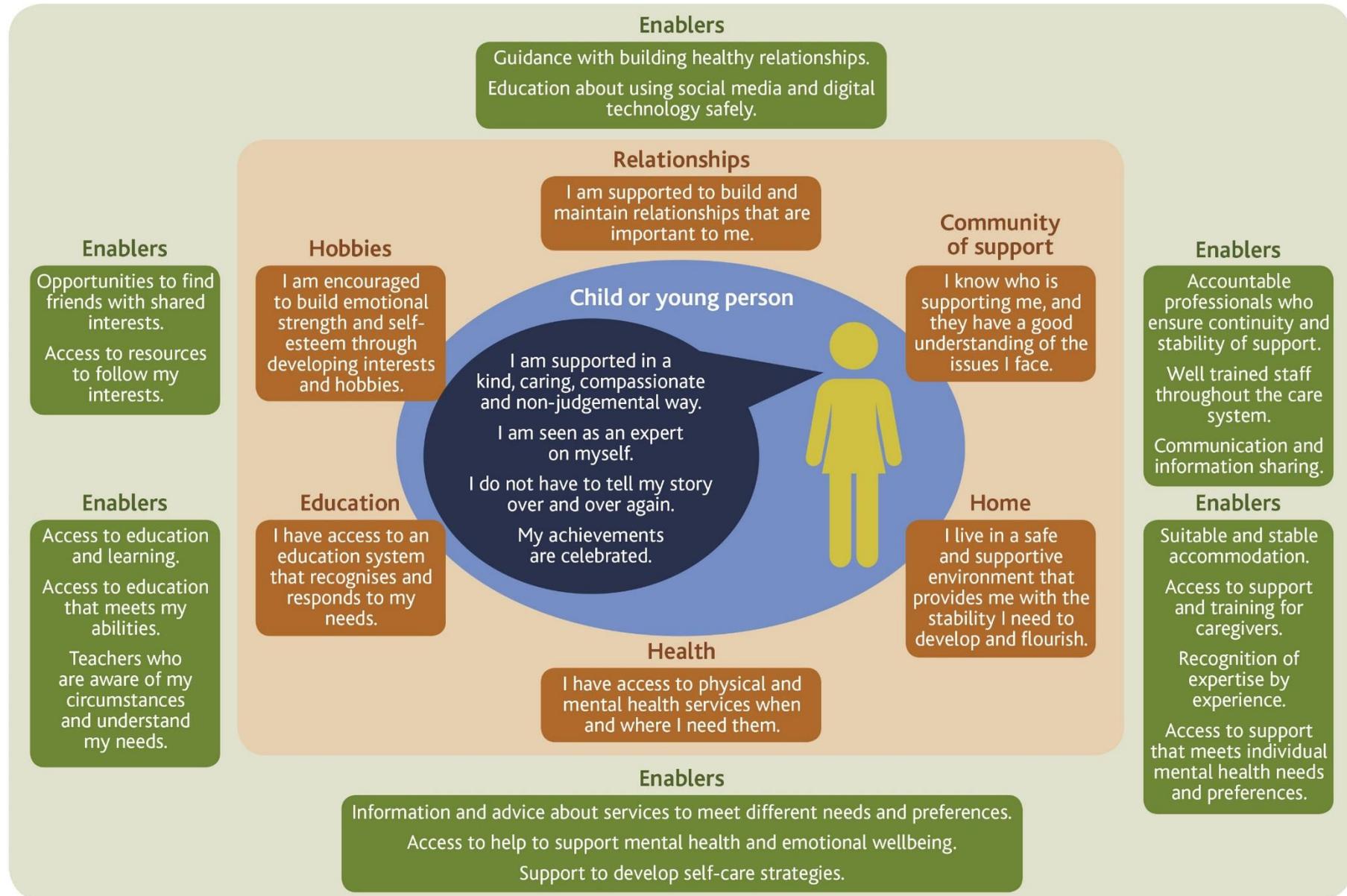
The development of a model that champions the mental health needs of the young person was a key task of the project. The Expert Working Group spent a considerable proportion of its meetings debating and evaluating what relationships and support were critical for a young person.

A lot of my clinical work is with young people who are sick of being told what they are like, that they are traumatised or [have] attachment disorder or whatever the fashion is in local services, when their own priorities and self-understanding is very different from that of the professional system or carers who claim to know better than them. What is needed is open mindedness, truly collaborative practice and shared formulations.⁵¹

The group developed a model which places the young person at the centre. The model is based on 'I statements' supported by enablers: that is, what good, holistic support for mental health and wellbeing looks like from the perspective of the young person. The principles of the model were supported by evidence presented at the Expert Working Group, the Expert Working Group's group work, the professionals' stakeholder event and consultations with children and young people.

In conjunction with the model, a whole system framework of training that prepares and supports carers and professionals, respecting their roles in supporting young people, is crucial. This collaborative approach would both provide those at the front-line of supporting our young people with the resources to respond to and contain a range of behaviours and mental health needs, and ensure that everyone involved in their care is coming from the same understanding and knowledge base. There was a consistent request from stakeholders to have training that focused on how to manage behaviours and individual wellbeing.

Expert Working Group model



Pathways

One of the major findings from our evidence is that the journeys taken to access support are often not linear. For example, a child in care may have a social worker who has the statutory responsibility of referring to child and adolescent mental health services, but their trusted relationship may be with another professional or their main caregiver. In this instance, there would be benefit to the young person being able to utilise their trusted relationship to access support together.⁵²

To support our finding, the Expert Working Group developed an eco-map, to be used in conjunction with the accompanying decision trees. The eco-map is a representation of the choices that should be available to the young person and/or primary caregiver to access the right support and resources. The decision trees represent our recommendations for a responsive pathway that places the young person at the centre, and includes those that know them in the decision-making, as appropriate.

At the core of both our model and pathway is the need for:

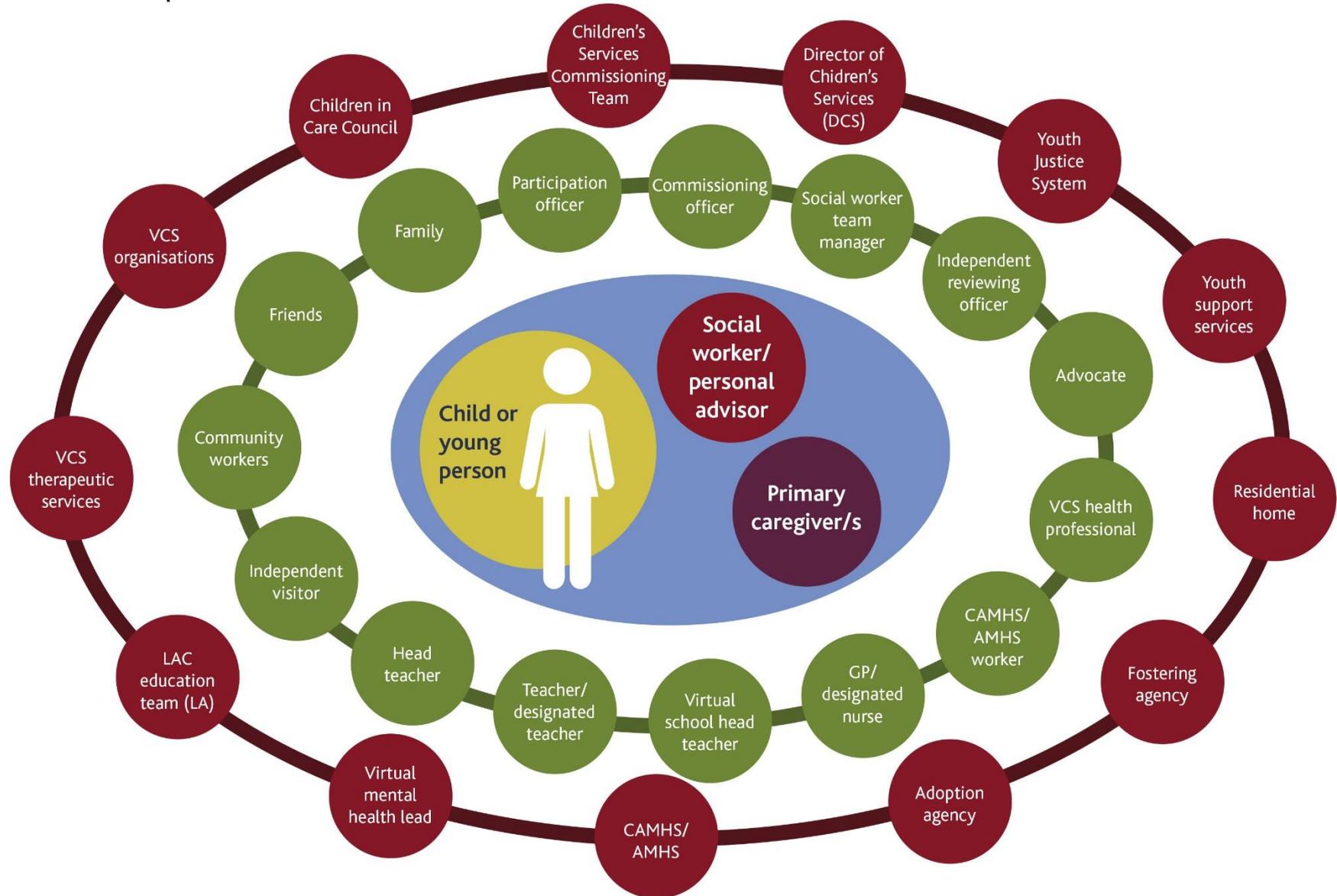
- timely intervention and support
- a system that can be activated by anyone within the child or young person's network
- a recognition that mental health is a continuum
- support that is responsive to the young person's needs.

Our decision trees together with the eco-map create the pathways for prevention and accessing support, the core components of which are:

- the people raising a concern
- who they raise the concern to
- how that person decides what the level of concern is
- what they do in response to this concern
- ongoing monitoring and responding to need.

The roles and responsibilities presented in Appendix 3 are those that the child or young person can expect to support them as they journey through the pathways.

General eco map



PREVENTION DECISION TREE

At each stage consider:

Relationships

Community of support

Home

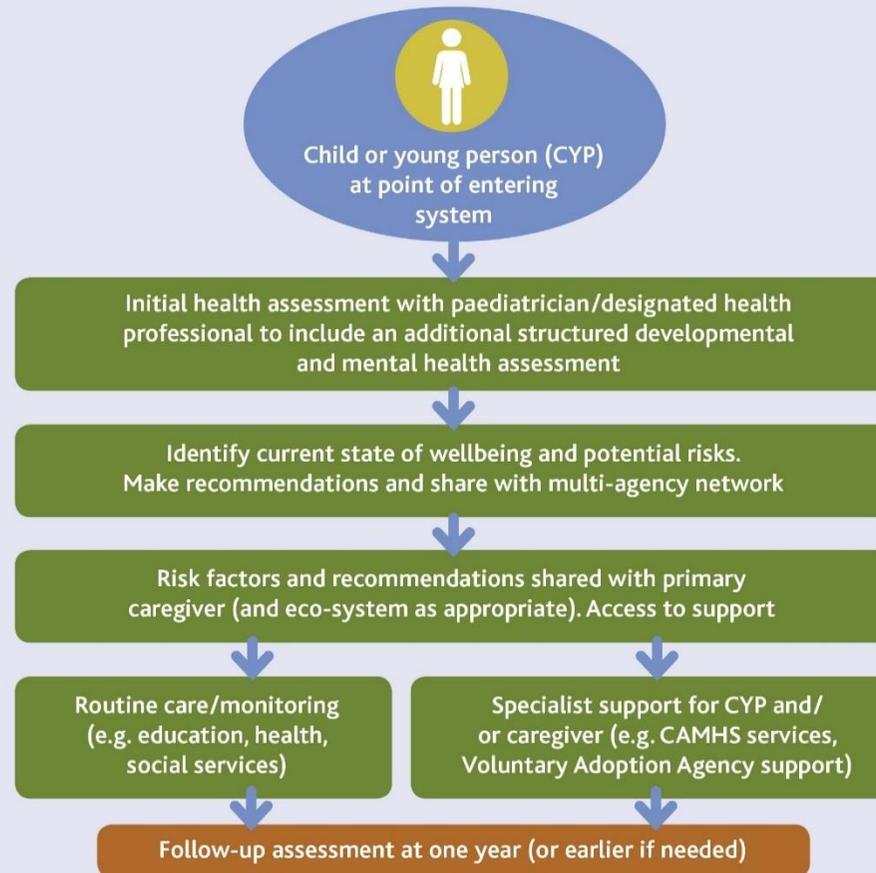
Health

Education

Hobbies

Enablers

- Training for designated health professionals to carry out a mental health assessment
- Recording and sharing of risks and recommendations with multi-agency networks
- Consistent, timely and appropriate information sharing with professionals in child or young person's ecosystem
- Communication with foster carer/adoptive parent/primary caregiver/ecosystem
- Access to support for child or young person
- Access to support for primary caregivers



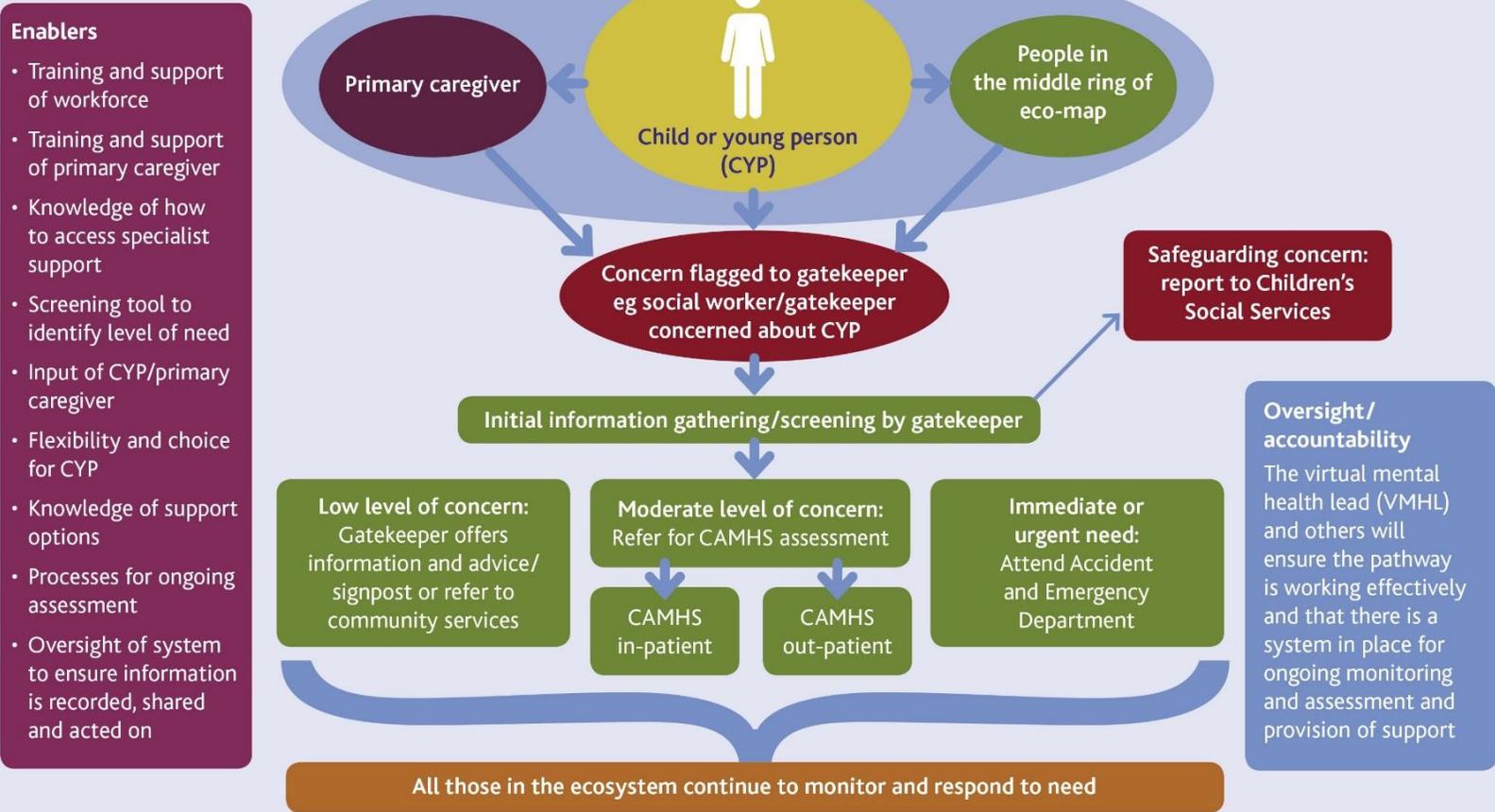
Oversight/ accountability

The virtual mental health lead (VMHL) and others will ensure the pathway is working effectively and that there is a system in place for ongoing monitoring and assessment and provision of support

ACCESSING SUPPORT DECISION TREE

At each stage consider:

- Relationship
- Community of support
- Home
- Health
- Education
- Hobbies



Conclusion

The Expert Working Group's strength was the wide range of skills and experiences of its individual members. Drawn from across the health, education and social care sectors, its members were committed to transforming the care that looked after children receive. All Group members unanimously agreed that the current system is failing these young people – and at its worst is causing unintentional harm.

Our Call for Evidence found pockets of excellence across the country, however there is not a consistently good offer for the mental health support and provision of looked after children in all local areas. Too many young people are not receiving the support they need, which in turn is having a detrimental effect on their wellbeing. Equally, we are not sufficiently supporting those that are caring for young people, some of whom can have very complex mental health needs.

There has been a consistent message from front-line staff, caregivers, local and national stakeholders and young people themselves that there is an urgent need to transform current service provision and provide a systematic approach across local areas that meets the needs of all children and young people.

Both provision and policy need to be developed alongside the young people that need the service, in a genuinely collaborative way. Local areas cannot develop services for young people without ensuring they are at the heart of informing how those services are commissioned and developed. Likewise, care plans should robustly demonstrate how they are supporting the mental health and wellbeing of individuals while ensuring the young people themselves have been given an appropriate platform to contribute to the decision-making that affects their lives and wellbeing. There are still too many young people who feel they are watching from the side lines rather than being active participants in their own care.

We strongly believe services that view mental health and physical health equally, a coordinated mental health offer from local areas, and a virtual mental health lead to champion quality services, could transform the current system. Our

recommendations not only provide a route to change in local areas and commissioning services, but provide a model and pathways to help individuals and service providers navigate through the system.

We have the choice of whether we want our young people to become active citizens that contribute to society or ones that continue to need the support of the state. The system at present creates the latter, with a significant financial burden at a local and national level and the wasted potential of some remarkable young people. Change needs to happen now, and it is our hope that this report provides a platform for the change needed and the necessary call for action.

Appendix 1: Members of the Expert Working Group

Expert Working Group co-chairs

Professor Peter Fonagy OBE

Dame Christine Lenehan (April 2017 –
November 2017)

Alison O’Sullivan (April 2016 – April
2017)

Expert Working Group members

Polly Ashmore

Eamon McCrory

Linda Briheim-Crookall

Phillip McGill

Tony Clifford

Steve Miley

Saffron Cuts

Gwyneth Nightingale

Sally Donovan OBE

Dr Sheila Redfern

Richard Field

Filmon Russom

Councillor Gillian Ford

Dr Miriam Silver

Sharon Goldman

Doug Simkiss

David Graham

Dr Oliver Sindall

Professor Jonathan Green

Jan Slater

Dr Renu Jainer

Billy Smallwood

Cathy James

Jack Smith

Chloe Juliette

Sue Sylvester

Matt Langsford

Kevin Williams

Glynis Marsh

Dr Matt Woolgar

Carol McCauley

Linda Wright

Representatives from the Department for Education

Andrew Baxter

Akosua Wireko

Helen White

Representatives from the Department of Health

Ellie Isaacs

Shain Wells

Members of SCIE staff

Beth Anderson

Ted Barker

Dr Susanne Gibson

Stephen Goulder

Michaela Gray

Florence Lindsay-Walters

Lucy Milich

Hannah Roscoe

Appendix 2: The Expert Working Group process

Establishing the Expert Working Group

The overall aims agreed with the Social Care Institute for Excellence as the contracted social care charity supporting the Expert Working Group, was to ensure that the emotional and mental health needs of children and young people in care, adopted from care, in kinship care, those with Special Guardianship Orders and care leavers were better met. That in the future, children and young people who are looked after would have access to high quality services, from a range of informed professionals and based on a clear assessment of need. To do this the project would develop, by October 2017:

- care pathways – focusing on the journey that a child or young person in need of support might make
- models of care – the organisation and configuration of services to ensure the provision of appropriate evidence-based interventions
- quality principles – clear statements and measures that set out an achievable marker of high-quality and effective care
- implementation plans and products to support the use of the care pathways, models of care and quality principles.

Membership of the Expert Working Group

The Social Care Institute for Excellence led a nationwide recruitment process for the membership of the Group, who met eight times over the course of the project and provided feedback between meetings. Members of the Group included directors of children's services, foster carers, social workers, designated doctors and nurses, children's home managers, consultant clinical psychologists and psychiatrists, local councillors, adoptee parents and care leavers.⁵³

I joined because we all hold a responsibility to continue improving our looked after children's services and I wanted to learn, think and contribute to the development of joined up services. Change can only happen when we all work together.⁵⁴

As a care leaver I joined the Expert Working Group, because I know it's not just me that has been let down by the care system. I am fed up of hearing speech after speech, announcement after announcement about how things need to change and they don't, by getting involved, I can feel like we're making a difference, hold the top dogs to account and to contribute to improving the care system so that it focuses on what matters most – care.⁵⁵

Our members played a crucial part in our hearing professionals' and young people's voices and considering the best available evidence to assist us in developing a new model of care, pathways and quality statements.

Project scope

The Expert Working Group's aim was to include the mental health and emotional wellbeing support for looked after children and young people, those adopted, living in kinship arrangements and under Special Guardianship Orders, and for care leavers.

The Group acknowledge that there are both parallels and key differences for each cohort within the population of children and young people described above. For example, there are the children and young people who are living in kinship arrangements with relatives or family friends who are not (or are no longer) looked-after, and whose placement is not formed by a special guardianship or other formal legal order. These children are placed with their relatives and friends often as a result of hardship or trauma, and social services may have been involved with the family.

Within this cohort of young people are asylum-seeking children who have a unique set of challenges that come about from the nature of how they entered the country, what they may have witnessed in their life before this point, and because their support networks of family and friends have been left behind.

Another example is care leavers who can leave care as young as 16, with the expectation of being prepared to live independently, while statistics show that within the general

population there are now 3.3 million 20–34-year-olds still living with parents and this number is expected to increase.⁵⁶

There are now 26,340 care leavers aged 19–21. Unfortunately, on average, these young people are far less likely than others to achieve positive outcomes as they reach adulthood. They are far more likely not to be in education, employment or training (NEET), to have poor physical and mental health, to experience abuse and neglect, and to be involved in the criminal justice system.⁴⁰

We fully acknowledge the diverse nature of this cohort of young people. For the purpose of the report, we have referred to the population within scope as looked after children or young people, unless referencing a specific group within that population.

Stakeholder events and consultations

Title	Date	Location
Expert Working Group	11 July 2016	Kinnaird House, London
Expert Working Group	12 October 2016	Kinnaird House, London
Expert Working Group	15 November 2016	Kinnaird House, London
Call for Evidence	1 January-1 April 2017	Online
Expert Working Group	26 January 2017	Kinnaird House, London
Children & Young People's Steering Group	15 February 2017	Kinnaird House, London
Expert Working Group	7 March 2017	Kinnaird House, London
Professionals' stakeholder event	13 March 2017	Friends House, London
Children & Young People stakeholder event	11 April 2017	St Luke's Community Centre, London
Expert Working Group	26 April 2017	Kinnaird House, London
SCIE Mental Health Support Focus Group – Foster Carers	24 May 2017	St Luke's Community Centre, London
Expert Working Group	12 June 2017	Kinnaird House, London
Children & Young People stakeholder event	14 June 2017	Location withheld
Expert Working Group	13 July 2017	Kinnaird House, London
Children & Young People's Steering Group	7 August 2017	Kinnaird House, London
SCIE Focus Group – Adoption Together	4 October 2017	Kinnaird House, London

Appendix 3: Roles and responsibilities

Children's Services

Children's Services are ultimately accountable to the Director of Children Services who will be accountable to the Chief Executive and the Lead Member for Children and Young People. These are the only statutory accountable roles aimed at improving outcomes for our children and young people.

Care Leaver Personal Advisor: They take over care planning from social worker when the young person is over 16 or a care leaver. They should help with education, training and employment opportunities, as well as advice on housing, money, and health and wellbeing. Accountable to the Team Manager, who is in turn accountable to Director of Children's Services.

Child Participation Development Officer: This role can vary but they predominantly sit in the Quality Assurance team and try to encourage children and young people to have a voice and/or hold children's services to account. They will also work with the Children in Care Council and children and young people to ascertain views on services are represented. They are accountable to Quality Assurance Unit.

Commissioning Officer: Commissioners in local authorities are responsible for making decisions about which services to buy in, and assure the quality of the service. For children's social care, this would involve decisions about which independent fostering agencies, children's homes, and specialist services to support looked after children, Children's Services should use. Commissioners would also be responsible for negotiating favourable deals and rates with particular providers, in return for using their service a particular amount of time. They are accountable to the Children's Service Commissioning Team. Commissioning of some services may be undertaken jointly with the NHS Clinical Commissioning Group.

Independent Advocate: This is a statutory role to ensure that the child or young person is able to express their views, including making a complaint. Local Authorities should provide information about children's rights and arrangements for advocacy services to every child or young person in their care. The Independent Advocate is also responsible for providing information about advocacy services. They are accountable to their Advocacy service.

Independent Reviewing Officer: Chairs the Looked After Children Review meetings. This role ensures children and young people's views, wishes and feelings are heard at the meeting. They have oversight of the care plan and can act on behalf of the child in challenging the local authority. They are employed by and accountable to the Local Authority. However the nature of their responsibilities means that they also hold the local authority to account and they must be independent from the immediate line-management of the professionals working with the child or young person.

Independent Visitor: This is a voluntary role, independent of the local authority, who visits the child or young person regularly in a befriending and listening role, and will provide a consistency of support. Accountable to the relevant Independent Visitor service that abides by Department for Education guidance.

Social Worker: Each looked after child and young person must have a named social worker who is responsible for their care. The social worker will manage the care plan, make decisions about placements, and may make or approve referrals to other agencies. They are accountable to the Social Worker Team Manager, Service Directors and Director of Children's Services.

Social Worker Team Manager: They manage a team of social workers and allocate cases to the social worker/personal advisor, and monitor outcome of decisions, whilst giving advice, support and supervision to the team. Accountable to the Director of Children's Services.

Health Services

Designated Doctor and Nurse for looked after children: The Designated Doctor/Nurse has specific roles and responsibilities for safeguarding children and young people. They are a source of expertise for partner agencies and provide strategic advice and guidance to service planners and commissioning organisations. They ensure that a timely and appropriate holistic assessment and health care plan identifies needs of looked after children. Children over five years will receive an annual health review by a Designated Nurse. GPs and primary health staff will also be involved in supporting children and young people with their mental health: as primary care they are often the first point of contact for children and young people having problems with their mental health, after which they may make a referral to local Mental Health services and will be a steady point of contact for young people in their area. They are accountable to their NHS Trust.

Health Visitor: Children under five years will receive a six monthly review health assessment by a Health Visitor. They are accountable to the Nursing and Midwifery Council and their NHS Trust.

Mental Health Worker (children and young people's and adults'): Children and young people's mental health services (CYPMHS) cover a range of different support offers and professionals. Examples of services could be drop-in centres or self-help support, or more targeted support provided by multi-disciplinary teams that work with children and young people and those who care for them, to support their emotional or behavioural wellbeing (commonly known as 'CAMHS'). Similarly, Adult Mental Health Services (AMHS) will provide support for care leavers with a mental health problem. Some areas offer services for young people between the ages of 16 and 25, or from 0-25, as part of an alternative service model that bridges a number of life transitions such as starting work or going into higher education. There may be a wide range of professionals involved, but service workers often include psychiatrists, clinical psychologists, psychotherapists, social workers, family therapists and mental health nurses and support workers. Children and young people and adult service workers are accountable to their service manager and to their professional bodies; service providers are accountable to commissioners (be it the Clinical Commissioning Group (CCG), NHS England or other commissioners like local authorities) and to NHS Improvement; CCGs are responsible for commissioning services in their area and are accountable to the Health Secretary through NHS England; finally NHS England is responsible for commissioning some specialist services such as inpatient beds and is also accountable to the Health Secretary.

School Nurse: Play an important role bridging the gap between health and education, and have a safeguarding responsibility. They are alert to signs of neglect and abuse, and report any concerns they may have. They are accountable to the Nursing and Midwifery Council and their NHS Trust.

Voluntary and Community Sector

Community Workers: This is intended to refer to all those who are in a position to support a child or young person's mental health through voluntary activities such as clubs (sport, drama, music). These activities are in themselves supportive of mental health and emotional wellbeing; at the same time, community workers may be in a position to identify and respond to the individual needs of children and young people. People working in the voluntary sector are accountable to their organisations, which should provide guidance and training on safeguarding.

Voluntary and Community Health Professional: Some therapeutic services which are supporting children and young people, and caregiver's mental health and wellbeing are provided by voluntary and community sector. Health professionals employed in the voluntary and community sector are accountable to their organisations, and to their commissioning bodies.

Education

Teacher/Designated Teacher: All maintained schools and academies must have a designated teacher for looked after children. The designated teacher should have lead responsibility for helping school staff understand the barriers and trauma which might affect how children and young people learn and achieve. The designated teacher should have lead responsibility for helping school staff understand how being in care might affect how children and young people learn and achieve. The designated teacher should: promote a culture of high expectations and aspirations; be a source of advice for staff about differentiated teaching strategies appropriate for individual children; make sure looked after children are prioritised in one-to-one tuition arrangements; make sure that carers understand the importance of supporting learning at home, and a voice in setting learning targets; and have lead responsibility for the development and implementation of the child's personal education plan (PEP) within the school; and monitoring the child's progress to ensure the child/young person gets the support needed to achieve their full potential. They are accountable to the school's Head Teacher.

Head Teacher: As leader of the school, has greatest responsibility for educational provision and is responsible for ensuring appropriate safeguarding measures are in place in maintained schools and academies, and arrangements for liaising with other agencies where necessary.

Virtual School Head Teacher: The lead officer in the local authority responsible for discharging the local authority's duty to promote the educational achievement of its looked-after children, wherever they live or are educated. Virtual school heads are likely to work closely with local authorities' education services, schools and colleges to support the educational achievement of all their authority's looked after children as if they all attended a single school. Accountable to the Local Authority.

Youth Justice and Youth Support Services

Youth Justice Board: The Youth Justice Board seeks to prevent children and young people under 18 from offending or re-offending, and addresses the causes of children's offending behaviour. They ensure custody is safe and secure which adhere to applicable regulations, and oversee youth justice services.

Youth Support Services (YSS): These are locally dependent but many of the teams are based in local youth centres to offer accessible local responses and services, and provide Youth Information Advice and Counselling Services. Youth Support Services staff work with partners including health professionals, schools and colleges, the police and voluntary organisations so that support can be tailored to each individual.

Appendix 4: Case studies

Please note that these case studies are meant as illustrative examples and do not represent any person/s.

Case Study 1: Nathan coming into care

Prevention	
<p>Background: Nathan, aged 11, was placed in the care of the local authority because of ongoing sexual abuse from his father and uncle. He is currently in foster care. Nathan is close to his maternal grandmother and he has told his social worker on several occasions that he would like to live with her. Presently, the social worker is assessing the suitability of Nathan being placed with his grandmother on a Special Guardianship Order (SGO).</p>	
<p style="text-align: center;">Stage 1: Initial health assessment</p> <p>Nathan attends the initial health assessment for all children entering care of the local authority, conducted by a pediatrician or designated health professional. This includes a structured developmental and mental health assessment, with input from Nathan's school, social worker, Grandmother and foster carers.</p>	
<p style="text-align: center;">Stage 2: Identify current state of wellbeing and potential risks</p> <p>The initial health assessment identifies that Nathan has complex trauma and the recommendation is a referral to CAMHS for further assessment and support. Additionally, the assessment identifies the importance of Nathan's grandmother as part of his support network and recommends that Nathan and his grandmother are supported to continue contact.</p>	
<p style="text-align: center;">Stage 3: Risk factors and recommendations shared</p> <p>The assessment and risk factors are shared with professionals working with Nathan including social worker, foster carers and grandmother.</p>	
<p>Stage 4: (4a) Routine care and monitoring (4b) Access to specialist support</p> <p>Nathan's social worker is responsible for ensuring he has access to specialist support (4b)</p> <ul style="list-style-type: none">• Nathan has a CAMHS assessment and is offered weekly counselling with a psychologist• Nathan's foster carers are able to contact the CAMHS team for advice and support.• Nathan's social worker arranges for Nathan to visit his grandmother and informs the grandmother of developments in the assessment and decision-making process regarding the SGO. The grandmother is given information, advice and support to help understand the impact of Nathan's experiences.	<p style="text-align: center;">Stage 5: All those in eco-system monitor and respond to need. There will be a follow up assessment at year 1 (earlier if need changes)</p> <p>Nathan's social worker has case responsibility of recording his care plan, and ensuring information is shared appropriately with the foster carers, grandmother and CAMHS workers. The social worker organises the looked after children's review meetings which is chaired by the Independent Reviewing Officer (IRO) who ensures Nathan's voice is heard, and that the care plan is put into action. The Children's Services team manager has oversight of ensuring that Nathan's social worker is working effectively. Nathan's CAMHS Psychologist should share information appropriately about Nathan's progress.</p>

Background: Three months ago, Charlotte, aged 12, was initially removed from her family under Section 20 due to neglect. The local authority successfully applied for a care order but Charlotte is struggling to come to terms with her removal from her family. Her two siblings were also placed in care but she has not seen them since she was separated. Charlotte’s social worker referred her to CAMHS but Charlotte has not been seen yet. She has recently started a new school. At school, Charlotte is quiet and engaged in art classes. During one of the classes Charlotte rolls back her sleeve to avoid getting it dirty, and her friend James notices that she has self-harm marks on her arm. Charlotte quickly rolls back her sleeve when she sees James looking, but he is very concerned about his friend and speaks to the art teacher after class.

Stage 1 and 2: Who is involved and appropriate concern flagged

Professionals in the middle of the eco-map who are accountable – The art teacher reports what James has said to the Designated Teacher, and the advice is to have a conversation with Charlotte and talk to her about what will happen next. Her art teacher talks with Charlotte and explains that the information will be shared with her social worker, foster carers and Looked After Children Nurse. Concern flagged to gatekeeper, Charlotte’s Social Worker because Charlotte is under 18.

Stage 3: Initial information gathering/screening

Charlotte’s social worker conducts an assessment to identify Charlotte’s level of need. This includes inviting Charlotte and her foster carers to a meeting to discuss the options to address her mental health and wellbeing needs. Charlotte is encouraged to talk about the kind of support she would like. Her foster carers do not have any previous experience of self-harm and feel that they need to be supported in order to sustain the placement.

Stage 4: Referral and concern level

Charlotte’s social worker records a moderate level of concern (**4b**) and contacts CAMHS to make an appointment:

- Charlotte is able to access Tier 3 CAMHS. She meets with a CAMHS mental health worker and is offered counselling, which she refuses.
- CAMHS offers her a community run art based therapeutic intervention, which she agrees to attend if her aunt can take her to the first session.
- Foster carers are able to consult with the CAMHS team for ongoing support.
- Foster carers undertake training in mental health first aid course with their Fostering Agencies. The Agency also arranges the foster carers to join a peer support group.
- The teacher is able to work with the designated teacher to develop Charlotte’s Personal Education Plan to ensure that Charlotte has access to the right support.

Stage 5: All those in eco-system monitor and respond to need

Charlotte’s **social worker** has case responsibility of recording her care plan, and shares information appropriately. The **social worker** organises the Looked After Children review meetings. This is chaired by the **Independent Reviewing Officer (IRO)** who ensures Charlotte’s voice is heard. The Children’s Services **team manager** has oversight of ensuring that Charlotte’s social worker is working effectively. Charlotte’s **teacher and designated teacher** shares the Personal Education Plan in Looked After Children review meetings, and they are aware of the escalation process if Charlotte’s self-harm increases. The **teacher** updates everyone on the extra tuition sessions. Charlotte’s **community mental health worker** has agreed that she will keep in touch with social worker and foster carer to ensure that Charlotte keeps attending the art based intervention. It is understood that if the art therapy is not successful another alternative will need to be identified. **CAMHS mental health Worker** records and updates all on Charlotte’s progress.

Notes

¹ Hussey, J.M., Chang, J.J. and Kotch, J.B. (2006) 'Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences', *Pediatrics*, vol 118, no 3, pp 933–942.

² Fink, E., Patalay, P., Sharpe, H. et al. (2015) 'Mental health difficulties in early adolescence: a comparison of two cross-sectional studies in England from 2009 to 2014', *Journal of Adolescent Health*, vol 56, no 5, pp 502–507.

³ Fryers, T. and Brugha, T. (2013) 'Childhood determinants of adult psychiatric disorder', *Clinical Practice & Epidemiology in Mental Health*, vol 9, pp 1–50.

⁴ Metropolitan Police (2017) Figures released ahead of National Child Sexual Exploitation Awareness Day. Available at <http://news.met.police.uk/news/figures-released-ahead-of-national-child-sexual-exploitation-awareness-day-227196>

⁵ Hussey, J.M., Chang, J.J. and Kotch, J.B. (2006) 'Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences', *Pediatrics*, vol 118, no 3, pp 933–942.

⁶ Department for Education (2017) Children looked after in England including adoption: 2015 to 2016, London: DfE.

⁷ Throughout the report we refer to CAMHS as this was the term most commonly used by frontline staff and members of the EWG. However, we recognise that during the consultation for Future in Mind, the decision was made based on evidence from children and young people to replace the term with Children and Young People's Mental Health Service (CYPMHS). This term is intended to be more inclusive of the full spectrum of mental health services for children and young people.

8 Frith, E. (2017) Access and waiting times in children and young people's mental health services, London: Education Policy Institute. Average maximum waiting times to assessment decreased from 508 days (2012-2013) to 266 days (2016-2017); average maximum waiting times to treatment decreased from 761 days (2012-2013) to 490 days (2016-2017).

9 Care Quality Commission (2017) Review of children and young people's mental health services, Newcastle-upon-Tyne: CQC

10 Green J, Leadbitter K, Kay C, Sharma K. (2016) Autism Spectrum Disorder in Children Adopted After Early Care Breakdown. *Journal of Autism and Developmental Disorders*, vol 46, no 4, pp 1392 – 1402

11 Kay C, Green J. (2013) Reactive attachment disorder following early maltreatment: Systematic evidence beyond the institution. *Journal of Abnormal Child Psychology*, vol 41, no 4, pp 571-581.

12 Woolgar, M. and Baldock, E. (2015), Attachment disorders versus more common problems in looked after and adopted children: comparing community and expert assessments, *Child and Adolescent Mental Health*, vol 20, no 1, pp 34–40.

13 Both at our stakeholder event and foster carer event, main caregivers highlighted not knowing what services were available and/or not being able to access support from those services.

14 We welcome the current consultation on DfE guidance on increased responsibility for mental health and wellbeing for the virtual school head and designated teacher. This is a direct outcome of Children and Social Work Act legislation.

15 This is in line with current person-centred policy initiatives, for example the Integrated Personal Commissioning programme, which includes children and young

people with complex needs in its cohorts. <https://www.england.nhs.uk/ipc/what-is-integrated-personal-commissioning-ipc/>

16 The scope of the EWG covers children and young people with a range of legal statuses. The above example is used to illustrate how the pathway could work for a child in care, however we have produced a range of eco pathways and a decision tree to suit the wide cohort of children and young people the project was asked to consider.

17 Department for Education and Department of Health (2015) Promoting the health and Wellbeing of looked after children, London: DfE/DH.

18 Department of Health, NHS England (2015) 'Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing', London: DH, NHSE.

19 House of Commons Education Committee (2016) **Mental health and well-being of looked after children, HC 481**, Paragraph 11, London: HCEC.

20 Fifteen-year-old girl in foster care, SCIE Children and Young People's group February 2017.

21 An individual consultation was held for unaccompanied asylum-seeking children.

22 Young Person's Stakeholder event, 11 April 2017. All media created by young people is available at <https://www.scie.org.uk/children/care/mental-health/young-peoples-views/young-peoples-artwork>

23 All information from consultations is available at <https://www.scie.org.uk/children/care/mental-health/findings>

24 'Expert by experience' written testimony to SCIE, 28 July 2017.

25 Department of Education, (2017) Children looked after in England, year ending 31 March, London: DfE Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/647852/SFR50_2017-Children_looked_after_in_England.pdf

26 Channa, K. (2017) A healthy state of mind, London: LOCALIS. Forty-two per cent of 5–10-year-olds compared to 7.7 per cent of that age group overall, and 49 per cent of 11–16-year-olds compared to 11.5 per cent of the comparable overall population.

27 Children’s Commissioner (2016) Lightning review: access to child and mental health services, London: Children’s Commissioner for England

28 National Audit Office (2015) Care leavers’ transition to adulthood Available at <https://www.nao.org.uk/wp-content/uploads/2015/07/Care-leavers-transition-to-adulthood.pdf>.

29 David Graham, national director of the Care leavers Association.

30 Age-based Transitions out of CCG-commissioned CYPMHS has been included as one of 13 mandatory national indications in the Commissioning for Quality and Innovation (CQUIN) payments framework in 2017-19. This sets out a framework for joint-agency transition planning with young people at its heart, to enable better transition experiences for young people. It will apply to all transitions out of CCG-commissioned CYPMH services, whether to adult mental health services, to other relevant CCG-commissioned local services (such as a service for young people with a learning disability), or discharge. A national data collection is taking place in 2018/19 to review the scheme.

31 The full findings of our Call for Evidence can be found at: <http://www.scie.org.uk/children/care/mental-health/findings/call-evidence-findings>.

32 All minutes of the EWG can be found at:

<http://www.scie.org.uk/children/care/mental-health/about-the-project/expert-working-group>.

33 For the purpose of the report, caregiver refers to those directly caring for the child or young person. This includes foster carers, kinship carers, special guardianship orders, adopted parents and residential key workers.

34 All Party Parliamentary Group for Children (2017) No good options: report of the inquiry into children's social care in England, London: National Children's Bureau

35 Munby, J. (2017) In the matter of X (A Child) (no.3) EWHC 2036 (Fam)

<https://www.judiciary.gov.uk/wp-content/uploads/2017/08/x-a-child-no-3-2017-ewhc-2036-fam-20170803.pdf>

36 NHS England is part way through a programme to improve access to mental health services for children and young people. This includes the opening 150-180 new in-patient beds, rebalancing bed distribution across the country, and improving crisis and community care. NHS England has committed to eliminating inappropriate admissions for children and young people by 2020/21. The programme is explained by a short animation available at **<https://www.england.nhs.uk/mental-health/cyp/children-and-adolescent-mental-health-service-inpatient-services/>**

37 Ofsted (2016) 'Annual social care report', Manchester: Ofsted

38 Children and Social Work Act 2017

http://www.legislation.gov.uk/ukpga/2017/16/pdfs/ukpga_20170016_en.pdf

39 Children's Commissioner (2017) 'A rapid review of sources of evidence on the views, experiences and perceptions of children in care and care leavers', London: Children's Commissioner for England

40 For further information, see Call for Evidence, p 18

41 For further information, see Call for Evidence, p. 35

42 Tarren-Sweeney, M. (2007) 'The Assessment Checklist for Children – ACC: a behavioural rating scale for children in foster, kinship and residential care', *Child and Youth Services Review*, vol 29, no 5, pp 672–691.

43 Bazalgette, L., Rahilly, T. and Trevelyan, G. (2015) 'Achieving emotional wellbeing for looked after children: a whole system approach', London: NSPCC

44 McCrory, E.J., Gerin, M.I. and Viding, E. (2017) 'Annual research review: childhood maltreatment, latent vulnerability and the shift to preventative psychiatry – the contribution of functional brain imaging', *Journal of Child Psychology and Psychiatry*, vol 58, no 4, pp 338-357

45 Children and Young People's Event, 11 April 2017.

46 Collishaw, S. (2015) 'Annual research review: secular trends in child and adolescent mental health', *Journal of Child Psychology & Psychiatry*, vol 56, no 3, pp 370–393.

47 The project acknowledges that the legal status and contact allowed with birth families can vary significantly from child to child. Our evidence was primarily focused on main care-givers including residential staff in children's homes, however we recognise that there are birth families that can and should contribute to the process, where legally appropriate.

48 Both at our stakeholder event and foster carer event, main caregivers highlighted not knowing what services were available and/or not being able to access support from those services.

49 We welcome the current consultation on DfE guidance on increased responsibility for mental health and wellbeing for the virtual school head and designated teacher. This is a direct outcome of Children and Social Work Act legislation.

50 Both at our stakeholder event and foster carer event, main care-givers highlighted not knowing what services were available and/or not being able to access support from those services.

51 Member of EWG, written submission to SCIE July 2017

52 The scope of the EWG covers children and young people with a range of legal statuses. The above example is used to illustrate how the pathway could work for a child in care, however we have produced a range of eco pathways and a decision tree to suit the wide cohort of children and young people the project was asked to consider.

53 The membership of the EWG can be found here:

<http://www.scie.org.uk/children/care/mental-health/expert-group/>.

54 Steve Miley, director of children's services, EWG member.

55 'Expert by experience' written Testimony to SCIE, 28 July 2017.

56 Office for National Statistics (2016) 'Why are more young people living with their parents?' **<https://visual.ons.gov.uk/living-with-parents/>**

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