Improving the mental and emotional well-being of looked after children: connecting research, policy and practice

Christine Cocker and Sara Scott

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Authors

***Christine Cocker**, Principal Lecturer Social Work, Middlesex University, School of Health and Social Sciences, Enfield Campus, Queensway, Enfield EN3 4SA, England*
Email: c.cocker@mdx.ac.uk

***Sara Scott**, Principal Research Officer, Policy and Research Unit, Barnados, Tanners Lane, Barkingside, Ilford IG6 1QG, England*
Email: sara.scott@barnados.org.uk

Corresponding author:
Christine Cocker, as above

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Abstract

The relationships between research, policy and practice in improving the mental and emotional well-being of looked after children are complex. There is a growing body of research that demonstrates that children in state care (or 'looked after children') are particularly vulnerable in terms of poor health and mental health outcomes. The current health and social care policy context is in the midst of tremendous change. Within this 'modernisation agenda' the mental health of looked after children has received welcome attention, and this in turn has stimulated a major expansion in specialist mental health services for looked after children across the UK. However, despite what we know about some of the problems looked after children face, we know very little about what is effective. Although the available evidence from research now gives a stronger indication about prevalence and identifiable risk factors for morbidity (or co-morbidity), it does little to assist in identifying what interventions are effective in improving mental health with this client group. Efforts now need to be made by practitioners, policy-makers and researchers to collectively concentrate on filling some of the gaps in our knowledge. This includes making better use of the evaluations of current services to inform the development of these services.

INTRODUCTION

Children in state care (or 'looked after children') are consistently identified by government and policy-makers as 'socially excluded' – the Government has defined social exclusion as: "a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, unfair discrimination, poor housing, high crime, bad health and family breakdown."[1] It is clear from a variety of sources that looked after children under-achieve within education[2, 3] and are also particularly vulnerable in terms of poor health outcomes.[4–6] Looked after children and young people are also over-represented within various excluded groups[7, 8] and this pattern continues into adulthood.[9] Looked after children are four times more likely to be unemployed and 60 times more likely to be sent to prison.[10] Between 30% and 40% of women in UK prisons have spent some part of their childhood in care.[11]

There is a great deal of need within this group of children. Scott[12] comments that policy and practice in relation to looked after children has become increasingly multi-professional and inter-agency: "There continues to be a lack of cross-over between traditional and 'medical model' research . . . with educational and social research into the care context, the development of resilience or academic achievement."

This paper begins the process of inter-connecting these seemingly disparate parts.

CURRENT PRACTICE CONTEXT

There are currently around 60,000 children in the looked after system in England.[13] There are consistently more boys looked after than there are girls (55% compared with 51% of boys within the general population) and the largest proportion of children in care are those aged 10–15 years. The majority (65%) of looked after children are placed in foster care.

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The Department of Health estimates that in 2003 local authorities had continually looked after 44,100 children for one year or more.[13] Over the last five years this number has increased annually. The largest sub-group of looked after children are those who remain in the looked after system for between one and two years. The majority of children are placed in care as a result of abuse or neglect, with the next largest group entering the care system due to family dysfunction (see Figure 1).

Although studies show links between a looked after child's experience of abuse and neglect and higher incidences of mental disorders,[4, 14, 15] it would appear that the public care experience may also play a significant part. Chambers[7] comments that: "The physical and mental health problems of children in care and leaving care may be deeply rooted in their pre-care experiences and circumstances, the very factors which led to their coming into care, but the worrying issue for care providers is the evidence that the period 'in care' can actually exacerbate rather than reduce existing problems and can even create new dangers.

"Far from remedying existing deficiencies . . . periods in public care have further impaired the life chances of some children and young people because of poor educational achievement, uncorrected health problems and maladjustment."[7]

The life-chances of looked after children compare poorly with the general population. This can be seen most readily in relation to educational attainment. Of the 44,100 looked after children who had been in care continuously for 12 months at September 2003,[13] 35,000 were of school age. Of these, over 1% were permanently excluded and over 12% had missed at least 25 days of schooling. The relationship between behavioural problems and poor educational experiences and outcomes is strong. However, schools are generally the least well integrated in partnership working for looked after children.

As shown in Table 1, the average national performance of looked after children in 2003 in attaining the target level in Maths and English Key Stage 2 is under half that of all children. This is well below the Social Exclusion Unit Public Service Agreement target of achieving 75% of their peers' outcomes.

Sixty-eight per cent of young people in the general population enter further education[9] while estimates for looked after children vary between 19% and 31%.[9, 16]

However, there are some small signs of improvement in recent years. Between 2000 and 2003 the percentage of care leavers with at least one GCSE pass increased from 31% to 53%.[9] Within the general population, 95% of children achieve this standard. The numbers of looked after children passing their GCSEs with five or more at grade A-C was 6% in 1998 and 9% in 2003. (Fifteen per cent of councils had at least 15% of their looked after children achieving five or more grade A-C GCSE passes.) Within the general population, 53% of children pass their GCSEs with five or more at grade A–C.[13]

THE SCALE OF THE PROBLEM: THE MENTAL AND EMOTIONAL WELL-BEING OF LOOKED AFTER CHILDREN

The classification of 'mental disorders' has become increasingly sophisticated. The original Diagnostic and Statistical Manual of Mental Disorders (DSM) published in 1952 listed 60 types and subtypes of mental disorder, while DSM-IV, the current edition, contains well over 200.[17] Difficulties experienced by children and young people represent one of the areas of classificatory expansion that has both reflected and inspired research interest in the field.

In England research undertaken by Meltzer and colleagues for the Office for National Statistics allows us to compare the mental health – as represented by identifiable 'disorders' – of children looked after by the state and children in the overall population.

In Meltzer *et al.*'s 'The Mental Health of Children and Adolescents in Great Britain',[18] information was collected on an assessment of 10,000 children, and the results found that:

- Among 5–10-year-olds, 10% of boys and 6% of girls had an identifiable disorder.
- Among 11–15-year-olds, 13% of boys and 10% of girls had an identifiable disorder.

Figure 1

Categories of neglect

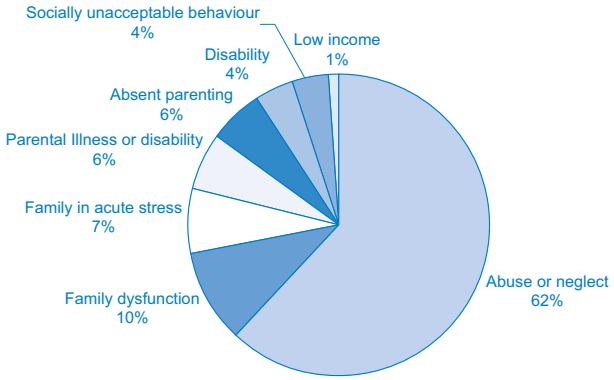

Table 1

Key Stage 2 performances

	All children	All looked after children
Percentage of 11-year-olds attaining target in Maths Key Stage 2	73%	35%
Percentage of 11-year-olds attaining target in English Key Stage 2	75%	37%

Source: Department for Education and Skills[13]

- Conduct disorder accounted for half of all cases. Boys were twice as likely as girls to be identified as having a conduct or hyperkinetic disorder.

In Meltzer *et al.*'s 'The Mental Health of Young People Looked After by Local Authorities in England',[4] information was collected on 1,039 children, and the results found that:

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

Research such as this exposes the fact that one in ten of all children display behaviours of the same magnitude as those currently being accepted and treated by Child and Adolescent Mental Health Services (CAMHS). This rises to almost half of all looked after children. It can therefore be read as identifying a large constituency of children in need of mental health services. The answer to this need is sometimes conceived in terms of more child psychiatrists, psychologists, in-patient beds and primary mental health care workers. However, in relation to the mental health needs of children in state care, such provision, even if it were forthcoming, is unlikely to provide a complete solution. The reasons for this lie in the origins and causes of most emotional and behavioural difficulties in looked after children, as well as issues of the appropriateness and accessibility of traditional mental health services.

The work of Meltzer *et al.*[4] is particularly helpful because it includes information about looked after young people's physical health, use of services, placement type, educational achievement, social networks and lifestyle issues alongside the prevalence of mental disorders. Two-thirds of all looked after children were reported to have at least one physical complaint, the most common being eyesight, speech and language problems, co-ordination difficulties and asthma. Forty-four per cent of those identified as having a mental disorder were in touch with child mental health services.

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

WHAT DO WE KNOW ABOUT HOW TO IMPROVE THE SITUATION?

A number of key themes consistently appear in the literature. These include the importance of: a) knowing what interventions work for which children;[19, 20] b) understanding the effects of institutional care on looked after children;[7] c) understanding the specific needs of looked after children;[21] d) multi-agency working and supporting the professional network via consultation; and e) consulting with children and young people about their wishes and feelings.[8, 12, 22, 23]

Understanding that emotional and behavioural difficulties in childhood are not necessarily predictive of mental health problems in adulthood is also important. Although such problems are associated with a range of psychosocial outcomes including poorer educational attainment, higher unemployment, relationship difficulties, early parenthood and involvement in crime, it is probably most helpful to think not so much in terms of direct cause and effect relationships but what Rutter calls 'indirect chain mechanisms'.[24] We can think of these as potential pathways along which personal failure and social exclusion are likely to be cumulative.

This metaphor of 'pathways' reminds us that interventions for multiple disadvantaged young people, who are likely to be exposed to continuing and potentially cumulative risks, may need to take a long-term approach. Evidence-based interventions for behavioural problems tend to be short-term cognitive behaviour therapy and have rarely been evaluated specifically in relation to looked after children.[25] It can be argued that for looked after children generally, good mental health care should be more analogous to dental care such that regular check-ups, repair-work and daily care need to be built into service provision. This is one conclusion from the research which has, as yet relatively unexplored, implications for policy and practice.

Research into children's resilience makes it clear that key resilience promoting factors are likely to be weakened for looked after children, notably capacity to exert agency, parental support and positive educational experiences.[9, 26–29] However, it also suggests that well designed, accurately targeted and efficiently delivered education, leisure and social care services may make a real difference to children who have experienced adversity. The messages drawn from research in relation to the resilience facilitated by strong social networks and education are particularly pertinent to looked after children, but have not yet been integrated into policy or practice development.[30]

One of the most important factors in enabling children to remain engaged with education (itself protective and predictive of mental health) is placement stability. Evidence is accumulating to show the effectiveness of appropriate training, involvement and support of foster carers in improving placement stability and also reducing emotional and behavioural difficulties in the children.

"The only interventions with demonstrated effectiveness in reducing the emotional and behavioural problems of looked after children are those delivered either in close liaison with foster carers, or directly through foster carers."[31]

In addition, securing and reinforcing a relationship with a main carer represents current best wisdom in relation to attachment problems, and placement stability and permanence are important proxy indicators.[32] However, a major difficulty is that, despite the recognition of the importance of attachment, we lack an evidence base supporting interventions in relation to older children with attachment

difficulties. And there is as yet no research that effectively unpacks the different elements – in interventions based on enhancing training and support to carers – which make a difference to stability of placement and improved outcomes.[33]

Despite the need for more research, there is adequate evidence to suggest that policy and practice aimed at improving the mental health of looked after children should have facilitating placement stability and engagement with education high on the agenda.

THE POLICY FRAMEWORK

The policy arena for children's social care, education and health services is in the midst of immense change, due in part to the current Government's agenda of modernising public sector services, but also because of the Laming Inquiry Report[34] published following the death of Victoria Climbié. Although Victoria was never herself in care, many of the developments which have followed the publication of this report will primarily affect looked after children. These developments include the publication of the green paper 'Every Child Matters'[35] and The Children Act 2004;[36] the Common Assessment Framework (CAF); the National Service Framework (NSF) for Children;[37] the shift of children's social care services from the Department of Health to the Department for Education and Skills and the creation of Children's Trusts. Recent Department of Health initiatives have placed a requirement on local authorities to set up specialist services for looked after children who have mental health difficulties.*

The green paper 'Every Child Matters'[35] proposed the introduction of a national CAF, which is now in the process of implementation. This arose from concerns that the existing arrangements for identifying and responding to the needs of children who are not achieving the five outcomes identified in the green paper do not work as effectively as they might.[38] The five priority outcomes identified in the green paper are:

- Being healthy: enjoying good physical and mental health and living a healthy lifestyle;
- Staying safe: being protected from harm and neglect;
- Enjoying and achieving: getting the most out of life and developing the skills for adulthood;
- Making a positive contribution: being involved with the community and society and not engaging in anti-social or offending behaviour; and
- Economic well-being: not being prevented by economic disadvantage from achieving their full potential in life.

Through the CAF, the intention is to implement a common approach to needs-assessment that can be used by the whole children's workforce, both universal and specialist services, for any child in need of support:

"Its aim will be to provide a mechanism whereby any practitioner working with a child or young person can conduct a good quality, but relatively non-specialised, assessment of unmet needs and, where appropriate, share it with other agencies. It aims to provide a non-bureaucratic 'whole child' assessment, drawing on good practice, enabling the practitioner to make a decision about how far they themselves can meet the needs and who else needs to be involved. Where a referral to a more specialised practitioner is required, use of the CAF should help ensure that the referral is really necessary, that it is to the right service and that it is supported by accurate, up-to-date information."[38]

The NSF for Children[37] identifies looked after children's special needs, and emphasises the particular importance of multi-agency and partnership working for them. In developing the NSF, the Department of Health established an external working group whose remit was to define standards to support the delivery of services that will improve the mental health and well-being of children and adolescents. The Outcomes Subgroup of the Child and Adolescent Mental Health External Working Group issued a report examining possible standards for inclusion in the Children's NSF.[39] This contains useful information on outcome indicators.

These policy developments have been influenced by research identifying the scale of the problem, and the importance of joined-up working in identifying and meeting holistically the needs of looked after children. However, their focus is on the systems and structures through which 'help' is administered, rather than the content and priorities of that help. Lessons from research concerning 'what' as well as 'how' must therefore influence services by other routes.

"The general welcome for the NSF from all services is qualified by the usual concerns about money (no funds are announced) and local discretion in the absence of any details about implementation . . . the mere creation of structures – too often seen as a cure-all – will not of itself change professional cultures, working methods and practice."[40]

WHAT DOES THIS MEAN FOR SERVICE DEVELOPMENT?

In the last five years there has been a massive expansion in specialist mental health services for looked after children. In 2003 the current authors conducted an investigation of 'promising practice' amongst the rapidly increasing number of specialist services with a specific remit for improving the mental health/emotional well-being of looked after children.[12, 22] We approached all 150 local authorities in England, and received a response from 25%.

A number of projects included in the study described practice that met the 'promising practice' criteria that the researchers had identified. The main elements of these criteria are: a) Does the service/initiative respond to identified local needs? b) Is the service/initiative based on the best available evidence of effectiveness? c) Are its objectives clear? d) Do these include the specification of intended outcomes for looked after children? e) Are targets set in relation to outcomes? f) Is data collected against targets? g) Is there evidence available of outcomes being achieved? h) Are there mechanisms for the meaningful participation of children and young people in service review/development (where appropriate)? and i) Is there evidence of good communication between agencies to the benefit of looked after children?

Projects identified include two that work solely with foster carers,[41, 42] one that works with hard-to-reach young people,[21, 43] and one of the 24 CAMHS innovation projects.[23]

One of the key issues emerging from this study was individual services' limited reference to the evidence base for their work. Very few projects were able to be specific about the type of interventions

they offered to children and young people with mental health problems. Very few specified clear, measurable outcomes for the children and young people with whom they worked, or were able to provide evidence in relation to outcomes. Where outcome-focused evaluations had been undertaken, there was no consistency of methodology, making comparisons across services difficult. These findings were consistent with those of an earlier study commissioned by the Department of Health evaluating the 24 CAMHS innovation projects they funded.[23]

It was not possible for us to confidently assess how far services were focusing on 'doing what works' as identified in the research literature. Many were clearly aiming to work in partnership with foster carers and residential staff, a far smaller number had increasing placement stability as an identified outcome. Neither the promotion of resilience or working to a 'dental care' model of service provision were much in evidence. Descriptions of specific 'interventions', treatment models or principles of care were scarce in the literature supplied by services or in their survey responses. A more in-depth study would be required to explore the utilisation of research evidence in such services.

It is clear that there is still considerably more to be done to ensure that the views and wishes of children and young people are heard and shared with service providers as well as policy-makers. We found that some services made no attempt to engage with the views of children and young people either in the development or ongoing evaluation of their service.

CONCLUSION

There is clear evidence to show that looked after children have much higher rates of mental disorder than do those who are not in care. Although such problems may exist because of children's experiences prior to entering care, there is emerging evidence that the care system also creates ongoing disadvantage to children in a variety of areas, including educational under-achievement.

Research and evaluation are crucial in determining 'what works' in improving the mental health of looked after children, and identifying whether what is being provided is making a positive contribution towards improving their lives. Although research has told us a great deal about prevalence and identifiable risk factors for morbidity (or co-morbidity) amongst looked after children and young people, it has made a far less substantial contribution to identifying what specific interventions are effective in improving mental health for this group. Practitioners, policy-makers and researchers in the field need to work together to address the following questions:

- What are the messages from research concerning what most helps or harms the mental health of looked after children?
- How can we best promote systems and interventions that maximise what we already know is helpful?
- Can we develop a core evidence-based mental health agenda for all services in contact with looked after children?
- How should the outcomes of policy and of interventions (including multi-faceted interventions) for looked after children be evaluated?
- How can we ensure the knowledge generated from evaluation influences future policy and practice?

Note

* Government announcements and initiatives regarding specialist CAMHS services are:

- On 17th January 2003, the Department of Health issued a local authority circular outlining the CAMHS grant guidance for 2003/04. This announced a substantial increase in funding to local councils in England, with the total CAMHS grant in 2003/04 set at £51 million. £44.1 million is allocated directly to councils, and is an increase of £28 million on the grant available during 2002/03. The remaining money is to be used for funding specific projects for looked after children.
- This links with a vision for CAMHS improvements set out in 'Improvement, Expansion and Reform – The Next Three Years: Priorities and Planning Framework 2003–2006' published by the Department of Health in October 2002.[44]
- During the last five years there were a number of reports published that highlighted the need for service review in this area.[8, 45, 46]
- The National Service Framework for Children[37] makes reference to CAMHS services for looked after children.

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