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Mimi Tatlow-Golden

School of Psychology, University College Dublin, Ireland

mimi.tatlow-golden@open.ac.uk

Rosaleen McElvaney

School of Nursing and Human Sciences, Dublin City University, Dublin 1, Ireland

Abstract

Children and young people in the care system typically experience very high levels of mental health difficulties, yet their views of these difficulties and of mental health services have rarely been explored. For this qualitative study we spoke with eight young adults aged 18 to 27 years with experience of the care system in Ireland about mental health challenges, service experiences, and how they felt mental health services needed to improve. Themes from the interviews illuminated young adults' views of their emotional well-being while in care, and the double stigma of being in care and mental health difficulties. In terms of services, young adults wanted these to be flexible and sensitive to level of need; to offer choice and more congenial environments; to provide more creative routes to engaging young people; and to offer honest, reciprocal, caring communication – treating children in care as one would any child. Recommendations highlight three key needs: an ethic of care in services as well as an ethic of justice; mental health training for all professionals in contact with children in care; and the need to listen, hear and act on what children and young people say.

Keywords: children; young people; care; looked-after; mental health

1. Introduction

Young people in care belong to the most vulnerable populations in society (Tarren-Sweeney, 2008). Prevalence studies consistently report that about 70-80% of children and young people in care have behavioural difficulties, substance abuse and mental health challenges (Chitsabesan et al., 2006; Ford, Vostanis, Meltzer & Goodman, 2007; McNicholas et al., 2011), often with multiple co-morbidities (Tarren-Sweeney, 2008). These high rates may indeed be underestimates, as children in care often experience attachment- and trauma-related difficulties not identified by standard psychiatric diagnostic systems (DeJong, 2010; Tarren-Sweeney, 2008).

The challenge of adequately supporting traumatised young people is underlined by the fact that in Ireland between 2000 and 2010, the deaths occurred of 196 children and young people in care or known to child protection services. A review by the Independent Child Death Review Group (Shannon & Gibbons, 2012) concluded that mental health services failures had been partly responsible, and that inexperienced social workers were often working unsupported by mental health services for the most serious cases. Pressures on services are further exacerbated by reduced spending on public services in Ireland and by consistently rising numbers of children entering state care: Ireland's Health Service Executive reports that from 2006 to 2012 numbers rose 21%, from 5,247 to 6,332 (HSE, 2012).

Children's complex mental health difficulties are attributed to multiple factors, including pre-natal maternal substance use; early neglect and/or trauma resulting from parental mental illness, alcohol and drug use, and from disadvantaged and disorganised backgrounds including domestic violence and abuse; and trauma involving the primary caregiving relationship leading to disturbed attachments (DeJong, 2010; Golding, 2010; McAuley & Davis, 2009). Experiences in the care system, such as placement instability, exacerbate mental health challenges (Golding, 2010). Addressing the needs of these exceptionally vulnerable young people is particularly challenging. However the imperative to do so is expressed in Ireland's National Children's Strategy (NCS; Department of Health and Children 2000), one of whose goals states that children will receive quality supports and services, to promote all aspects of their development.

The two other goals of the NCS are that children's lives will be better understood and that they will have a voice in matters that affect them in accordance with their age and maturity. In line with such goals, a number of studies have explored views and experiences of young people in care. For example, McEvoy and Smith (2011) consulted with 211 children and young people with experience of the care and youth justice systems in Ireland. Participants spoke about their complex relationships with families of origin; difficulties caused by multiple placements; the need for foster carers to be assessed and trained; and the value of a single person who could support them through their time in care.

However, few studies have considered perspectives on mental health of young people with experience of care (see Holland 2009; Winter, 2010). Davies and Wright (2008), reviewing studies of children's views of mental health services, found that few encompassed the views of children in care; only two (total 20 children) met their criteria for inclusion in the review. These studies concluded that children in care were ambivalent about professional intervention and about talking, but that they valued other forms of communication such as drawing or play. In the UK, one study noted that young people generally had a poor understanding of mental health and they relied on drugs, alcohol, anger and talking to cope with problems (Mullan, McAlister, Rollock, & Fitzsimons, 2007). Another UK study explored mental health with young people in care, identifying key themes as mixed experiences in relationships with mothers and carers; stigma of the care system; having choice about receiving professional help; and involving care leavers in services (Stanley, 2007).

1.1 Aim

This study was conducted within a larger project that explored multiple stakeholder perspectives of policy and services for the mental health of children with experience of the care and youth justice systems in Ireland (McElvaney, Tatlow-Golden, Webb, Lawlor & Merriman, 2013). This portion of the study aimed to identify young adults' understanding of mental health; their views of their mental health; their experiences of mental health supports while in care; and their recommendations for improving services.

2. Method

2.1 Ethics

Ethical approval for the study was granted after full review by the University College Dublin Human Research Ethics Committee. Young adults' preferences and the voluntary nature of their participation were reviewed at several points through the study.

2.2 Design, participants and method

As part of the design process, two young adults with former experiences of care were consulted on the interview questions and on practical matters such as meeting locations. To contact potential participants, professionals in two agencies supplying after-care supports, Empowering People In Care (EPIC) and Focus Ireland, who served on an advisory committee to the study, acted as gatekeepers, as researchers face considerable difficulties in accessing such populations. The gatekeepers directly approached young adults within their respective agencies, giving them written information about the study. They only approached individuals known to them, who they felt would cope with an interview on their mental health, and whose best interests would not be undermined by participation. Although introducing the potential for sampling bias, this was considered necessary due to the sensitive nature of the research topic and to minimise the chance of adverse consequences arising from participating in the study for this vulnerable population. To the best of our knowledge, all the young adults approached agreed to participate in the study.

Participation was voluntary, and potential participants were given least a week to consider taking part. The on-going nature of consent and right to withdraw at any time were emphasised. We offered participants the choice of focus groups or individual interviews. All chose interviews, and these were held on services' premises at times chosen by each participant. Care staff were on site to provide follow-up support if necessary. Interviews took approximately 70-90 minutes each. A €10 phone credit or store voucher was given to each participant after the interview, as a surprise token of appreciation for their contribution. Eight young adults (seven women and one man) participated in the study, seven aged 18 to 24 years and one aged 27 years.

Interviews were conducted by both authors, both of whom are qualitative researchers. The first author is a research psychologist specialising in working with vulnerable populations

such as children, young people, and people with mental health difficulties or disabilities. The second author is a clinical psychologist and psychotherapist with several years' experience working in the public health service in addition to experience of training social care workers in an academic setting. Semi-structured interviews used open-ended questions and probes to explore (i) difficulties participants experienced in care and how they coped; (ii) what supports were available, including mental health services, and what helped and what didn't; and (iv) what services need to do to help young people in care who are facing mental health challenges.

2.3 Analysis

The approach to data collection and analysis was informed by principles of Consensual Qualitative Research (CQR: Hill, Knox, Thompson, Williams and Hess, 2005). CQR employs "consensus among judges to construct findings and the use of words rather than numbers to reflect meaning in the data" (Hill et al, p. 197) and integrates a rigorous approach with features of exploratory, discovery-oriented qualitative methods, drawing primarily on phenomenology, grounded theory, and comprehensive process analysis. Essential components of CQR are using open-ended semi-structured questions in interviews, to collect consistent data across individuals yet detail the individual nature of experience; recognition of researchers' positions and potential for bias; having multiple judges for data analysis to foster multiple perspectives; and employing a consensus approach to judging the meaning of data.

The first author carried out initial thematic data analysis, establishing codes of meaning; combining these into themes; exploring recurring themes, commonalities and differences in the data set; and creating broader domains where themes were conceptually related (Braun & Clarke, 2006). During the analysis, the second author reviewed codes, themes, domains, and associated examples, and as part of the 'ongoing reflexive dialogue' recommended by Braun and Clarke (2006), differences were resolved by regular discussion (Hill et al., 2005), to arrive at consensual judgments about how themes and domains reflected the meaning of the data. Both researchers are psychologists, but our differing professional backgrounds brought varying perspectives to the interpretation of the data, and discussions formed part of a triangulation process to support the validity and credibility of the analysis (Hill et al., 2005; Yardley, 2006).

2.4 Experiences in care

To contextualise young adults' experiences and their views about mental health and services, we briefly summarise their backgrounds and mental health-related experiences here. In order to avoid identifying participants we have pooled the nature of their care and mental health experiences, and have assigned a number to each participant in the sections that follow.

The eight participants entered care aged between 1 and 15 years, having experienced some or all of the following: neglect; sexual abuse; parental mental illness; parental alcohol or drug problems. Some had family support workers in the home, or were in extended family care. Each experienced between 2 and 23 care settings (relative foster care, foster care, residential and secure units). All participants described traumatic experiences before entering care; several spoke of further traumatic experiences in care. Almost all had received mental health diagnoses, such as depression, bipolar disorder, schizophrenia, psychotic symptoms, deliberate self harm, suicidality and experienced other difficulties such as bedwetting, sexualised behaviours, drug use, anger and aggression. They had experience of various mental health services, including being seen by social workers, psychologists and psychiatrists in Child and Adolescent Mental Health Services (CAMHS); attending residential-based counselling; and being admitted to in-patient child and adult services. Some are currently attending adult mental health or Rape Crisis Centre services although others have disengaged from such supports.

3. Results

Twelve themes from young adults' interviews are described here, within three domains: (1) **Emotional well-being**; (2) **Views of mental health and mental health services**; and (3) **Young adults' advice: What mental health services need to do** to support children and young people in care. In presenting these themes, our goal has been to rely on the voices of the young adults who participated in this study as much as possible, drawing on their words to illustrate the various themes and demonstrate how these are well grounded in the data.

3.1. Emotional well-being

The themes in this section relate to descriptions that young adults gave of their experiences and how they felt about these experiences, in particular how these experiences impacted on

their emotional well-being: the lack of continuity in their lives; the ways they described coping with their feelings; and their sense that many staff lacked understanding.

3.1.1 So many people in and out of your life

Lack of relational continuity and lack of consistency in how staff responded to young people was a central theme in young adults' stories. At home and in care, adults cycled in and out of their lives: social workers, care workers, staff in residential centres, foster families, counsellors, psychologists and others. *There's so many people in and out of your life, do you know what I mean, so many people* P8. One said continuity has worsened: *I had a steady social worker when I was younger … she was there when [mother] died… from then on there was a social worker every year or two. Give or take.* P5.

This constantly shifting landscape of relationships, where there was insufficient time for relationships to build up, was depicted as relentless by one young person: *I was just thrown to meet with people and to build a relationship with them … from one … to another relationship with someone and then another one, and just kept going on and on and on* P6. Young people had often viewed connecting with staff and building relationships as pointless: *because you'd be thinking at the back of your mind 'there's no point, I'll be gone in six months, and anyone that I speak to here, I'll never speak to again'* P4.

The shifting landscape of relationships was further exacerbated by a lack of consistency in staff behaviours, particularly with regard to discipline: *constantly doing the opposite of what another person was saying, there's no sort of stability that's what I found …. if you're in residential care and you're grounded, sure, one of them might say 'aw go on out there for half an hour and then come back' and then another one will tell you 'sure go you off for the day' or somebody else would be strict and go 'no go up to your bedroom'* P4. Several participants also wished staff would find a balance between boundaries and leniency: *if they were too strict on me I'd be kinda 'oh I'm not gonna bother with them', but then again like, they're too lenient, letting kids get away with murder… basically saying to them 'you can go out and do what you want, we'll still bring you home'* P1.

3.1.2 Ways of coping

The young adults described many ways of coping with emotions, including distraction, drug use, self harm, and turning to others for support. Several suppressed difficult thoughts and

feelings: *Not think about it, shove it away, yes. … It's the easiest way to do it* P5. During primary school, two had coped by doing housework; one had parents who were alcoholics, and she cooked, cleaned and looked after her young siblings: *I just found it really helpful because it was something to do* P7; *If I had nothing to do, I'd crack*. P6. Another participant tried different strategies, using drugs and cutting her arms to deal with pain and anger, though she didn't feel this had been constructive: *You try to go back to normal, but it doesn't work, cause you're looking at scars on your arms then. Y'know, your whole body ruined.* P1

Some noted relationships that were supportive; one described how her foster father would sit and listen and how she still kept in contact with staff at her former residential home: *I'd always ring them. … no matter what time it is … there'll be always someone on the other end of the phone* P2. Three further participants mentioned staff as *my coping mechanism really* P4.

Almost all had learned positive distraction: *Do whatever makes you happy, and your mood'll start increasing, and you'll start feeling a bit more happier in yourself* P1. Activities such as listening to music, DVDs, reading, singing, writing a diary, going on Facebook or Twitter, video gaming, going for a walk, or going outside to get some space were described as helpful distractions. One liked to *blare the music on the iPod* P1; another said *I just like to sing, it calms me... Or I read, or I write in my diary*. P7. However, one participant said *nothing* helps her cope with her mental health challenges, except for her psychiatric nurse, who she felt was sick of listening.

3.1.3 They don't see what's right in front of them

Young adults expressed the view that staff, foster parents and others lacked the necessary experience, insight, skills and training to be able to understand young people's emotional struggles. On discovering self-harm, *some staff would think that you were pretending* P1. One participant attended a school-based guidance counsellor, who she felt *was no more trained in counselling than any other teacher in that school* P5. One participant felt staff needed to go beyond listening, and hear what foster children said: *not many kids who're in foster care actually get listened to. Well, they do, but it goes in one ear and out the other* P2. One participant, who has now trained in social care, reflected that theory-focused staff cannot relate to young people: *like, 'this is resilience theory in its finest, right here' or, 'this is*

attachment theory, that's an ambivalent attachment there if I ever saw one' … *they don't have that kind of insight* P4.

These young adults felt they had not been heard or understood: *A few who I felt, yeah, listened to me [but] most of them … it just felt to me like they didn't* P3; they *don't see what's right in front of them* P8. One young adult described unmotivated staff who *don't really care, like, about the young people or anything, they just do their job …I just never thought they had the experience that I needed* P1.

3.2 Views of mental health and of mental health services

The young adults we spoke with reflected on the mental health services they had encountered while in care. The themes identified within this domain were: the meaning of the term mental health: *your health in your head*; the stigma experienced: *there are all the mad children*; the expectation that they should share their thoughts and feelings with professionals: *tell a complete stranger*; oppression experienced in interactions with services *they tried to force me*; and being let down by services, *being helped, and being let down*.

3.2.1 Your health in your head

We asked all participants what the term 'mental health' meant to them. They referred to thoughts, moods, daily living, and supports. For one, mental health encompassed: *your brain, and how you think, and how your mood is, and how it affects you throughout the day* P7; another summed it up as *Your health in your head* P1. One disliked the term 'mental health': *makes me think of my mother – schizophrenia, depression… suicide…* P5, and two had originally been frightened by the idea of engaging with 'mental health' services *"Oh my god. No way"* P7. In a context of widespread stigma, where people assume *you need to be in a mental hospital* P7; and *say "oh, like, you're mental"* P2, most participants explicitly distinguished their own understanding of mental health from society's attitudes: *Everybody thinks that you're schizo, you're mental. But really you're not* P6. Some were happy to use the term 'mental health', whereas others preferred *'my mood'* P2; *'depression'* P5; or normalising phrases … *'young people that have difficulties'* P6.

3.2.2 There are all the mad children

Young people described the double stigma – of having mental health difficulties and of being in care, which caused shame, affected openness with people, and threatened relationships. *I*

was ashamed …there's such a stigma around it. Kids in care, you're not normal P5. One participant's boyfriend ended the relationship on hearing she had been in care. Coincidentally, she recently lived near a care home, where a neighbour said *"that's the care home, … all the mad children"* P4. Participants described hiding the fact that they were in care from school and peers, as even current friends would say: *'there must be something wrong with you, you were in care' and I'd rather just not have that negativity attached to me* P3. One pointed out the painful irony of this: she had experienced sexual abuse, parental addictions and neglect, yet *people think, "Residential care? Oh my god, what did you do?" … But it's not always you who has done something bad, you know what I mean?* P7.

3.2.3 Tell a complete stranger

Young people resented being expected to create emotional intimacy with someone who was paid to do so: *to tell a complete stranger, who in my eyes was only doing this for money, about my personal life* P3. Others saw professionals as well-meaning but ineffective: *"I just want to help this young person, and I just want to make their life so much better" … they're in it for the wrong reasons, and they don't fully understand* P3, although several noted that some transmitted genuine concern: *some of them now, aren't in it for the money, some of them are just, they genuinely love working with the kids and they love it* P1

3.2.4 They tried to force me

Mental health service settings generated atmospheres of scrutiny and constraint for several participants. One experienced CAMHS as: *sitting in a little room* where *someone's just trying to get everything out of you* P1. Almost all participants threaded terms of coercion through their descriptions of mental health services, such as child sexual abuse assessment and therapy services, residential care or CAMHS: *had to*; *they made me*; *make you talk about things; they tried to force me; being forced into it*. Many felt professionals wanted to set the agenda: *like, "we're going to talk about this today"* P7. They felt rushed and pressurised to open up *straight away* when they were *really not ready* P6. One felt that professionals in a sexual abuse unit had probed – *"how did that make you feel?"* without first establishing a personal connection – *before even, like, talking to ya … I didn't like it* P7.

In contrast, two participants singled out mental health professionals who offered choice, control, and time. One psychologist invited the young person to choose *the date, and where* for appointments *… it kind of made me feel like I was in some form of control*, and *if I didn't*

want to go that was no problem P3 – a stark contrast with life in residential care, he said. A social worker said*, "you can talk about anything … You can talk about shoes… anything you want"*, and did not dictate terms, or probe, but used creative activities to access and process emotions: *She would ask me to write it down or draw a picture of how I'm feeling, or how I think I feel. Or just write a word to describe my mood, and we'd just rip it up* P7.

These two young adults stressed that trust takes time: *Over a period I started to trust him and became more open and … things started to get better* P3; *For years I didn't talk about* [the sexual abuse], *and then eventually I did … In time like, you should just be able to open up* P7. This approach didn't always work, however; another saw a psychologist for four years, who *used to just come, sit down, and ask me how was me weekend*; This young person described feeling increasingly frustrated with this approach: *and then I ended up starting to cut my arms* P1.

3.2.5 Being helped, and being let down
Four participants described feeling let down by mental health services, when they had forced engagement, made things worse, or hadn't provided supports. One said: *Every single system I ever used let me down … I don't trust services* P8. This young person described a life goal: *to open my own service that centres around the emotions that young people feel going through the care system. None of that is dealt with. None of it is dealt with*. Another young person described how it made things worse: *I came out worse … I'd rather not have talked about any of [sexual abuse], or even opened my mouth about it* P6. A third found attending a psychologist pointless : *he wasn't coming into the core of anything anyway, so there was no point in me sitting there* P1. Another young person described being forced into therapy at their father's insistence. Two other participants felt mental health services had been supportive: *CAMHS was just the best, it helped me so much* P7 and a psychologist at a residential unit: *helped an abundant amount* P3.

Several young adults reflected that mental health professionals working with young people in care were at an inherent disadvantage, because: *they wouldn't really know what's going on in your head cause you find it so hard to open up*. Opening up was hard for them because of their earlier experiences: *many people in care find it hard to open up about their pasts … obviously their pasts aren't gonna be that nice* P1.

The transition to adult mental health services proved a salient experience for two participants. For one young person, who had had previous positive experiences in CAMHS as well as a difficult experience in a sexual abuse unit, the first adult mental health appointment was *the worst day of my life, and that is no word of a lie* P7. This young person was asked *"have you been sexually abused?"* and had to *talk about everything* over again, feeling cross-examined under repeated questioning by the psychiatrist: *I said "I had to look after my sisters", And he would be like "… and how old were you, how did people not know?"*. The process was described as re-traumatising: *And I was like, "I can't do this any more" … I couldn't talk I was crying so hard… I didn't go to my next appointment after that* P7. That experience of being pressured to disclose immediately to a new professional in adult services contrasted with another participant's experience in a Rape Crisis Centre. There, the therapist said they would have at least 20 sessions before they would address the experience of childhood sexual abuse.

3.3 Young adults' advice: What mental health services need to do

Conversations with young adults were rich in suggestions for what services needed to do to support the psychological well-being of these vulnerable children and young people. The themes identified were: current inadequacy of services: *proper services*; less formal environments: *chilled out, relaxed, comfortable*; timing of service provision: *the right support at the right time*; and the need to be heard and to be told the truth: *listen, hear and care*.

3.3.1 Proper services

Overall, participants felt that mental health services were inadequate:

> Interviewer: *What do we need to do to help young people more?*
> P5: *Proper services* [laughs].

On a practical level, participants wanted services to communicate with one another: *have all the documents, I don't think I should've had to talk about everything again* P7. One person proposed dual diagnosis services, to avoid cross-city commutes between mental health and drug addiction services; another suggested a dedicated helpline for children in care: *something along the lines of Childline … if something went wrong there was somebody at the end of a phone* P5

3.3.2 Chilled out, relaxed, comfortable

It was suggested that mental health services should offer less formal supports, not using the term 'mental health' and stressing that young people had choice: *they should just say "… Do you want to talk to somebody? …" Not "Do you want to go to counselling? There's a mental health service"* P7; instead of 'mental health' centre, one suggested services should be called *"Chat If You Want"* P7. Several suggested that settings should be more inviting: *If you give somebody a cup of tea, they will talk to you about anything … Or beanbags just to chill and relax or do meditation… It'd be amazing* P7. Two participants wanted punch bags to relieve their frustration and anger: *if they brought some sort of dummy with them that you could just punch and pretend that it was [foster mother]* P2.

3.3.3 The right support at the right time

Young adults described a wide range of levels of need while in care. Some suggested regular occasional contact: *a social worker that calls you once a week… just a friendly phone call and to know that there is someone there* P4. Others referred to the need for intensive therapeutic support: *serious psychotherapy* P8. According to some, services should be matched to level of need: *When I needed it the most, they weren't there. When I didn't need it they were there throwing it at me* P6. Several young adults reflected the importance of stepping in early: *There's not enough intervention early enough … Why couldn't I have had … help … when it could have sank in and I could have believed it… If I had been helped with my self-esteem …* P8. However, several also reflected with hindsight that at that time, they were not ready to engage with psychological or other supports.

3.3.4 Listen, hear and care

All participants said children needed *someone to talk to* P3, *someone they can relate to… get along with* P1; adults should *try to find out what they're interested in … who they are* P3. The care system needs *more people who've lived in care* P4, because *you have to have had some level of hardship in your life to have that level of understanding. I don't think you can teach experience like that* P8; professionals need to be: *more savvy … clued in to life and reality* P8, not *just talking to you from a book* P4.

All participants wanted to be listened to. One wanted children in foster care to have people who would come *to talk to us… someone you could let all your frustrations out at … [who] would kinda have a rough idea of what would be going on in foster homes, and be able to sit*

down and listen to the child, just sit down and listen to what they have to say P2. Another said it was quite simple: *Just be there to listen … cause everything they say is important* P3.

In addition to the need to listen carefully, two participants stressed that what adults told children in care was important. Even if honesty causes pain, it is vital to avoid children developing false hopes or unfounded fears: *Even if it hurts the child, they need to know the truth … instead of them building their hopes up and up…* P3. One staff member told the truth about a participant's mother's failure to appear *"look, your mam isn't here today, cause she's more than likely having a drink somewhere"*, but even though this was difficult, the participant considered it preferable to imagining that she herself was at fault: *because she mustn't love me, I must have upset her, when realistically that's not the truth* P4.

An overarching need was to be understood. Young people noted that adults need to allow for the difficult circumstances that bring children and young people into care: *They have to give you like a bit more understanding, like. The kids are in care for a reason* P1. Another wanted to challenge trainees*, 'that little young fella that is hanging around the corner, that ye call the little scum bag, do you look at how he got to be that … like where he came from, what his story is?'* P8. Several felt that being understood was unrealistic: *someone I felt could understand me and who knew what I was going through… that's an impossible thing to ask for* P3*.

Participants wanted services, staff and professionals to listen, hear, and care. Ideally, they wished they could have: *That one person. That one person who knows you inside and out* P8. One concluded: *Yes they're living in care, and they've come from crap backgrounds, but that doesn't have to define them… treat them, like, the way you would treat your own child, [or] any other child* P4.

4. Discussion

In this study our goal was to explore the mental health difficulties of children and young people in care from the perspectives of young adults with experience of the system, to identify how services could better help children and young people with mental health difficulties. The young adults with whom we spoke reflected insightfully on their earlier experiences in the care system, including the mental health challenges they or their close family members faced. The conversations were rich in reflections on mental health itself, the

services they encountered in care, and suggestions for what was needed to support the psychological well-being of vulnerable children and young people. Overall, participants said that while in care, they had wanted to feel heard, to be told the truth, and to feel cared for. They were clear about the meaning of mental health, but described its socially stigmatised nature. To this was added the considerable stigma of being in care. In several ways, the young adults described a sense of being coerced by services in relation to their mental health – feeling forced to interact with services or to open up to people they didn't know well. The overall picture was of feeling helped at times but being frequently let down. Services, they felt, were too formal, often badly-timed, and inadequate.

It should be borne in mind that participants, who were all linked in with after-care services, had been selected by gatekeepers for invitation to participate on the basis that they could cope with a depth interview about their experiences and mental health challenges. Ethically, this represents a strength of the study. However, it is likely that the sample therefore does not reflect experiences of individuals who are struggling more in their day-to-day lives; indeed, several participants mentioned young people they knew from care who are currently experiencing greater difficulties, such as drug use and homelessness. In discussing the findings, we draw across themes to highlight what young adults said was needed for children in care, and consider how these findings are reflected in other research in Ireland and internationally.

4.1 What young adults say is needed

The key issues highlighted by participants were a need for stability and reduced stigma; further training for staff and professionals; improved services, offering choice, control and understanding; and listening to children, hearing them, and telling the truth.

4.1.1 Stability and reducing stigma

Young adults described a lack of stability with a relentlessly shifting landscape of relationships with social workers, with foster parents, and in residential care. This reflects current experience across the care system in Ireland and internationally. Foster and residential care inspections by the Health Inspection Quality Agency (HIQA) across Ireland in 2012-3 consistently cite high social worker turnover, as well as a lack of suitable foster carers and consequent unstable placements (for a summary, see McElvaney et al., 2013). As an example, the 2013 foster care inspection report for county Louth notes: "The impact on

some children… was placement breakdown and in some cases, multiple short-term placements over a short period of time" (HIQA, 2013, p.21). There is also agreement internationally that the widespread instability in care systems further traumatises children and young people (Golding, 2010; Stanley, 2007; Tarren-Sweeney, 2010; Winter, 2010).

Young adults also reflected on the painful experience of the double stigma of being in care and accessing mental health services. Negative attitudes are widespread, even among professionals. Professionals working with children in care in Ireland have noted stigma towards mental health and towards children in care in the attitudes and behaviours of colleagues in their own and allied professions (McElvaney et al., 2013). The stigma surrounding being in care and mental health are also cited regularly in the international literature (Blower et al., 2004; Plaistow et al., 2013) as requiring urgent, on-going attention.

4.1.2 Further training

Young adults described coping by pushing thoughts away, not talking about difficulties, self-harming, and using drugs, but felt adults around them did not understand these strategies. They felt that many staff lacked skills, experience and awareness; were excessively theory-focused; and didn't see what was in front of them. Participants wanted more understanding and someone to relate to. They felt this might be impossible, but wanted better training for staff, foster parents, mental health professionals and others who work with children in care.

Participants' views accord with repeated recommendations to reconfigure social workers' training to include specialist skills for working more closely with children in care and listening to them (Holland, Renold, Ross, & Hillman, 2008; Holland, 2010; Winter, 2010). Participants' perception of staff as theory- rather than person-focused is reflected in a recent UK critique of fostering practice (Goodyer, 2011), which argues that an excessive focus on theories such as attachment means that services fail to take account of young people's direct wishes and views, (e.g., if they say they do not get on with their carers). Many authors also recommend training for foster parents, including Morgan and Baron (2011) who explored parenting strain (stress, anxiety and depression) and placement breakdown, and found that foster parenting self-efficacy (having relevant skills and feeling a sense of mastery in the role) mediated parenting stress. Morgan and Baron suggest that to develop parenting efficacy, foster parents need training, in responding constructively to children's challenging behaviour and in recognising progress implicit in even small changes.

4.1.3 Better mental health services

Young adults wanted multiple changes to mental health services for children in care. They emphasised the need for flexible services that could be sensitive to the extent and timing of children's needs, ranging from depth psychotherapy to occasional check-ins from a social worker and a helpline for children in care. These views also accord with research indicating that resilience-associated factors in adolescents with complex needs who use multiple services are strongly, positively associated with experiencing respect from service providers and having the right to help choose services (Ungar, Liebenberg, Dudding, Armstrong & van de Vijver, 2013).

Participants' descriptions of supressing difficult thoughts and feelings in earlier years may indicate a need for earlier supports. Indeed, professionals in Ireland have suggested that supports are particularly likely to be absent where children in care may be internalising rather than externalising their difficulties (McElvaney et al., 2013). Furthermore, participants highlighted the need for agencies and services to communicate with one another. This includes the transition to adult services, which should be handled with greater care and as a single pathway (Plaistow et al., 2013). Multiple assessments, with requirements to describe traumatic experiences repeatedly, are likely to be re-traumatising.

Young adults wished for service settings to be more relaxed and informal, a consistent finding in the literature for mental health services in general (Plaistow et al., 2013). Some community services in Ireland have built on these principles, such as the youth mental health service Headstrong, or Pieta House, a suicide crisis intervention service, but we are not aware of anything similar available to children and young people in care.

Brierley (2012) suggested that for children in residential care in Ireland, the challenge for mental health services was less about service availability than about young people's engagement. Participants in this study indicated several possible reasons for lack of engagement. One is mental health stigma, a powerful factor that also affects engagement by young people in the general population (Plaistow et al., 2013). In the present study, young adults' descriptions of their early responses to attending mental health services reflects this negative interpretation; one can conjecture that this may be particularly challenging for children and young people who are already stigmatised for being in care.

To promote engagement, the young adults in this study argued for choice and control in how they engage with services. This is particularly important to young people in care, given their histories and care experiences of having little control over their lives, a finding supported by Stanley (2007). People who have experienced trauma may find safety in avoiding trust, and may therefore reject a therapist for much longer than others, as noted by the UK-based children's mental health charity Young Minds (Young Minds, 2012). One participant found creative methods helpful, concurring with Davies and Wright's (2008) finding that non-verbal methods of engagement may be more effective with young people than talking about difficulties and Young Minds' (2012) finding that creative routes to establishing trust and relationships may be required for the therapeutic process to begin. Participants movingly described the challenge of opening up repeatedly to strangers, and the sense of coercion generated by the atmosphere and mode of mental health service delivery. Nevertheless, they wanted adults around them to offer services early, and to persist until they were ready. Piggott, Williams, McLeod & Barton (2004) also found that young people who self-harmed said staff should persist even when their overtures were rejected. These findings suggest that services need to find ways to offer flexibility in giving children choices in settings, timing of appointments and to devise accessible services.

Young adults stressed the need for honest reciprocal communication, where children are not only listened to, but also feel heard, and by someone who is not seeking to categorise them, stigmatise them or theorise their experience, but is interested in who they are. They also wanted honest information about their family situations, reflecting findings of Mullan et al. (2007), who noted the importance of sharing information with young people. Participants wanted to feel more understood and suggested that more people with experience of the care system need to be working in it; this is also a consistent theme in the literature (Stanley, 2007).

Finally, the young adults in this study wished for a form of care that might be summarised as parent-like, wanting one person who knew them "inside and out" and suggesting that adults should treat children in care as they would treat their own child. This perspective is echoed in other Irish and international findings from children in care and clinicians who work with them. In McEvoy and Smith's larger-scale consultation (2011), children and young people requested that a single person accompany them on their care journey, and one of the

foremost clinicians in the field has summarised the view he believes services should take: "At a most human level [clinicians] need also to ask the question, What would I want for this child, if he or she was *my* child or grandchild?" (Tarren-Sweeney, 2013, p.217).

4.2 Study limitations and strengths

As with all qualitative research, the features of the sample and the backgrounds of the researchers mean that certain perspectives may have been privileged in our findings. Both researchers have professional backgrounds in psychology. We do not represent the disciplines most involved with children in care, social work and social care and are likely to have particular perspectives on mental health, although we both also have considerable experience working with interdisciplinary teams. We both have considerable experience of interviewing young people about sensitive topics and believe that the richness of the data gathered is a testimony to the young adults' openness and willingness to share their experiences.

In terms of participants, these were limited in certain ways. They were accessed through support services, and approached by professionals known to them; all those approached agreed to participate. Therefore, experiences of young adults no longer connected with services are not reflected – neither those who are doing well without ongoing supports, nor those whose aftercare trajectories are substantially less positive. In addition, seven of the eight participants were female, which does not reflect the gender representation of children in care, and may reflect women's greater tendency to access services.

In terms of ethnicity, it should be noted that all the young adults participating in this study were White Irish. This likely reflects the ethnicity of the care population in Ireland when these participants were children. Ireland has a history of being highly monocultural: in the 2002 Census, the largest minority recorded was 6% Irish Travellers (CSO, 2003). As the proportion of White Irish in Ireland had fallen by 2011 (84% of those aged 19 or under: Tusla, 2014), the sample may reflect the current care population somewhat less, although overall data on the ethnicity of children in care are not given in the latest available report on services (Tusla, 2014). It has recently been estimated that up to 25% of children entering the care system through the courts in Ireland have at least one parent of non-White Irish ethnicity (Coulter, 2014). However, as 62% children currently in care in Ireland entered

through voluntary agreement rather than court proceedings, this may not indicate the degree to which the current care population is non-White Irish.

Finally, it should be borne in mind that the sample for this qualitative study was not selected with the intent of being demographically representative of young people in the care system but rather with the goal of accessing a wide range of care experiences to meaningfully illuminate issues relating to the mental health of this vulnerable population. The purpose of the study was to build on a sparse literature base, to enhance understanding and inform policy development in this field.

4.3 Three key areas to address

Drawing across these themes from young adults' views of mental health and services, we make three overarching recommendations for care services in general. These should be considered in the context of a bio-psycho-social view of psychological well-being: that it is situated not only within an individual, but flows from their relationships with others and from the settings in which they live, learn and play – which are themselves affected by social, political, economic and cultural factors (Barry, 2008; WHO, 2005). Therefore, the task of promoting mental health needs to be undertaken in all these settings, not just in mental health services. Furthermore, regulations and standards addressing mental health needs are required, but should go beyond the issue of services for those with diagnosed difficulties, to include building protective factors for children's mental health within placements. Standards should also refer to the need for foster parents and care staff to receive training and support to assist them in the psychological well-being of children in their care (McElvaney et al., 2013).

4.3.1 Training in mental health

Young adults in this study referred to insensitive approaches made by professionals, poor timing of interventions offered, and dissatisfaction with professionals' expertise. Care and frontline staff such as social workers often lack mental health training, particularly in identifying mental health issues (Ross, Hooper, Stenhouse, & Sheaff, 2009) and in handling challenges such as self-injury (Williams & Gilligan, 2011). The Independent Child Death Review Group Report (ICDRG, Shannon & Gibbons, 2012) explored circumstances leading to the deaths of children in care or known to child protection. It concluded that professionals had not recognised or addressed emerging mental health issues or warning signs, and

recommended training for all working in child welfare and protection. Case workers should be able to identify emotional or behavioural problems, and should know about evidence-based interventions, their availability and how to access them (Dorsey, Kerns, Trupin, Conover, and Berliner, 2012).

In Ireland, of a sample of 92 social workers, half (49%) reported no prior mental health training (McNicholas & Bandyopadhyay, 2013) and 98% said they would like further training; mental health disorders, abuse and neglect were considered the most important topics. In a study of Irish residential social care workers' views of young people's self-harm, few had received specific training and all called for staff working with children in care to receive this (Williams & Gilligan, 2011). A lack of training means that currently, staff may interpret challenging behaviours such as self-harm as risky (Stanley, 2007) or attention-seeking (Piggott et al., 2004) rather than as a response to psychological pain.

4.3.2 An ethic of care in services

The young adults interviewed for this study highlighted the importance of relationships for their psychological wellbeing. In policies and practice for children in care, an ethic of justice predominates. This entails a focus on rights, fairness, and autonomy, and on measurable performance indicators and standardised assessments and reviews (Holland, 2010). Although this is of great value in countering poor care and abuse, the danger arises that principles of care receive less attention, or are even forgotten. An ethic of care needs to be incorporated into the care system, developing attentiveness, responsiveness to need, responsibility, integrity and caring relations (Holland, 2010; Tronto, 1994). Despite the dominant individualistic focus of rights-based approaches to ethics, the reality remains that all persons in society are interdependent and both receive and give care in shifting patterns throughout their lives (Barnes, 2007; Holland, 2010). Therefore, care relationships permeate society and should not be devalued. This will entail a 'cultural shift' in services, moving from tight controls and regulations to more supportive relationships, so a more 'normal' experience of growing up can be created for children in care (Mullan et al., 2007).

4.3.3 Listen, hear and act on what children and young people have to say

Young adults interviewed referred to the need for a 'listen, hear and care' approach to care provision, and to the need to be understood. In mental health services, a clinical perspective predominates and young people's views are rarely solicited (Stanley, 2007), although Day (2008) notes that this is changing to a certain extent for children in the general population.

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Roberts (2008) draws a distinction between listening to children, and hearing them. When listening to children and young people in care, do adults hear what they are saying? The reflections from participants in this study suggest this is often not the case.

The provisions of the United Nations Convention for the Rights of the Child (United Nations, 1990), and of Ireland's National Children's Strategy (Department of Health and Children, 2000), entail considering children's views, but doing so according to age and maturity, provisions that may frequently be interpreted from an adult-centric perspective. In the mental health field, adults may doubt children's ability to report accurately on their emotional experience and to devise treatment goals (Day, 2008), with the result that in particular younger children are often excluded from consultation (Winter, 2010). In fact, research has demonstrated that, when methods are developmentally appropriate, even young children can reflect on their experiences and contribute meaningfully to decision-making (Day, 2008).

Finally, listening to children and hearing what they say are worth little if adults do not act on this knowledge. Notably, Worrall-Davies and Marino-Francis (2008) found that no study exploring young people's views of mental health reported on whether a change of practice was achieved as a result of hearing children's and young people's views. Currently in Ireland, service reconfiguration is taking place; at the time of writing this is on-going, and it remains to be seen whether any effective changes will result.

5. Conclusions

Young people in the care system are usually traumatised and are almost invariably psychologically vulnerable. Their complex needs are regularly noted in the international literature, as is the fact that they are frequently re-traumatised while in care through multiple placements, poor service availability, and poor inter-agency communication among other concerns. These concerns were raised again by participants in this study, who also noted that society needs to reduce the stigma of being in care and of mental health difficulties; indications are that this even extends to professionals working in the care system and allied professions. In addition, young adults with experience of care wanted services to be more flexible and sensitive to level of need; to offer choice and more congenial environments; to find more creative routes to engagement; and to offer honest,

reciprocal, caring communication, based on the principle of treating children in care as they would treat any child or indeed their own child.

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