RESEARCH ARTICLE

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A qualitative investigation into care-leavers' experiences of accessing mental health support

Alice R. Phillips[1] ![ORCID] | Rachel M. Hiller[2,3] | Sarah L. Halligan[1] |
Iris Lavi[1] | John A. A. Macleod[4,5] | David Wilkins[6]

[1]Department of Psychology, University of Bath, Bath, UK

[2]Division of Psychology & Language Sciences, University College London, London, UK

[3]Anna Freud Centre for Children and Families, London, UK

[4]The National Institute for Health Research Applied Research Collaboration West (NIHR ARC West) at University Hospitals Bristol and Weston NHS Foundation Trust, Bristol, UK

[5]Centre for Academic Primary Care, Bristol Medical School, The University of Bristol, Bristol, UK

[6]Children's Social Care Research and Development Centre, School of Social Sciences, Cardiff University, Cardiff, UK

Correspondence
Alice R. Phillips, Department of Psychology, University of Bath, Bath, UK.
Email: arp91@bath.ac.uk

Abstract

Introduction: People who grew up under the care of children's social services are a highly vulnerable group, with 50% of this population meeting the criteria for a mental health problem at any one time. Emerging evidence suggests that there is a disparity between the number of people who require support, and those that receive it, and that they face several barriers to accessing timely and effective mental health support. We have a limited understanding of how to support the mental health of this group as they 'age out' of children's social services, and the transition to independence, which occurs around the age of 18. We aimed to explore how care-leavers understand their experiences of help-seeking from formal mental health services.
Methods: We used qualitative interviews, and Interpretative Phenomenological Analysis with 9 care-experienced young people aged between 18 and 25 years old. This work was co-produced by a team of care-experienced adults, from the conception of the study to write-up.
Results: Qualitative analysis revealed several themes which centred around: (1) taking reluctant steps towards recovery, (2) challenges with being understood and the importance of gaining an understanding of yourself, (3) navigating trust and (4) the legacy of not having your mental health needs met.
Conclusions: We identified several important implications for health and social care practice, across primary and secondary health care settings. This work highlights ways to better support this highly vulnerable group in accessing evidence-based mental health support, and how to maintain engagement.

INTRODUCTION

Approximately 50% of children in care meet the criteria for a mental health disorder (Bronsard et al., 2016), and these mental health difficulties are more complex than found in the general population, with greater rates of comorbidity and suicidality (Engler et al., 2022; Murray et al., 2020). This trend continues into adulthood, with prevalence rates for mental health disorders between 30% and 53% of care-experienced adults (Murray et al., 2020; Seker et al., 2021). Such problems among care-experienced people may be a consequence of significant early adversity and trauma, including exposure to substance misuse, parental mental health difficulties, violence and maltreatment, as well as ongoing instability (and potential further trauma exposures) within the care system. There is also robust evidence of multiple disadvantages for care-experienced people, ranging from health, education, employment, as well as high rates of homelessness and criminal justice system contact (Gypen et al., 2017; Phillips, Halligan, Denne, et al., 2023; Phillips, Halligan, Lavi, et al., 2023) Emerging evidence suggests that care-experienced people face several barriers with accessing appropriate mental health support, yet this problem is underexplored (Fargas-Malet & McSherry, 2018; McGuire et al., 2022; Phillips, Halligan, Denne, et al., 2023; Phillips, Halligan, Lavi, et al., 2023).

In England, being 'in care' refers to young people under the age of 18 years, who usually live away from their family of origin (e.g. in foster care, residential care), and are cared for by the local authority (Children Act, 1989). For many, entering care represents a move towards physical security and safety, however, others experience ongoing disruption (e.g. placement instability, separation from siblings, victimisation and exploitation while in care; Department of Education, 2021; Euser et al., 2016; Katz et al., 2020). There is growing evidence within the UK and internationally, that ongoing disruption of this kind during childhood is associated with poor adult mental health outcomes (Hiller et al., 2022; Hiller & St. Clair, 2018; Rock et al., 2013). Care-leavers who experience instability in housing, employment and education during adolescence fare worse in terms of mental health outcomes in adulthood (Phillips, Halligan, Denne, et al., 2023; Phillips, Halligan, Lavi, et al., 2023). It is likely that this is a bi-directional relationship, and indicates that young people in care would benefit from support to achieve both stability and better mental health.

The transition out of care, often referred to as 'aging out', is often a time of great change for care-experienced people. This time is associated with a sudden increase in responsibilities (e.g. managing finances, household tasks), at a rate which is much faster and at a younger age than their non-care-experienced peers (Baker, 2017). Guidelines in England and Wales state that planning for the transition out of care, begins around the age of 16, and that social care professionals should consider emotional and behavioural development needs during this time, among other things (Childrens Act, 2000; Department for Education, 2010). There is limited evidence around how this is managed in practice, but a review of qualitative evidence indicates that care-experienced people feel that insufficient recognition and support exist for well-being and mental health (Atkinson & Hyde, 2019).

There are several factors which make addressing the mental health needs of care-leavers challenging. Some of these concerns are common across adolescents and young adults in the general population. For example, a preference for informal sources of support (i.e. friends, teachers), and concerns around stigma and confidentiality prevent young people from reaching out altogether (Powell et al., 2021; Radez et al., 2020). Research has identified several practical and structural barriers which disproportionately impact children in care in the UK, such as transient living situations, or challenges with accessing evidence-based mental health support (McGuire et al., 2022; Phillips, Halligan, Denne, et al., 2023; Phillips, Halligan, Lavi, et al., 2023). There is increasing recognition that emerging adulthood (up to the age of 25) is a sensitive developmental period, especially in relation to mental health (Arnett, 2000;

Fusar-Poli, 2019; Kessler et al., 2007). Yet, current models utilised by youth support services in the United Kingdom usually treat young people up until the age of 18 years old. This means that during later adolescence, many young people may need to transition from children's mental health services to adult services, which is a point at which many young people fall through the 'treatment-gap' despite ongoing needs (Islam et al., 2016). Care-leavers may face additional challenges accessing care during this time, as they simultaneously transition out of care into independent living. There remains a major gap in our understanding of how care-leavers navigate mental health support and services in the immediate years after leaving care, and what could be done to improve this access.

Help-seeking is a complex and iterative process, involving multiple points of decision-making (Rickwood, 2020). Help-seeking behaviour can be influenced by social norms, attitudes towards therapy, practicalities and availability of support (Ajzen, 1991; Bonfield et al., 2010; Tomczyk et al., 2020). The present study aimed to explore this complexity, by investigating the lived experience of help-seeking for mental health support, among those who have recently transitioned out of social services.

MATERIALS AND METHODS

Design

We used qualitative interviews, and interpretative Phenomenological Analysis (IPA; Smith et al., 2009) to explore how care-leavers understand their experiences of help-seeking for mental health problems. IPA builds upon phenomenological and hermeneutic philosophical traditions and allows for a detailed enquiry into a person's lived experience. This meant we could explore the help-seeking journey beyond literal descriptions of events which occurred. We aimed to access physical, material, emotional and relational experiences, as well as cognitions and meaning-making aspects of these experiences. By utilising these methods, we allowed participants to reflect on the significance of events and understand how they make sense of it.

Ethical approval was obtained by the University of Bath Ethics Committee (REF: 21–087), with further permissions obtained from participating local authorities. All names were pseudonymised and participants provided informed consent to participate.

Recruitment

Nine care-leavers were recruited by self-selection opportunity sampling, most of which were recruited through advertisements circulated on social media ($n = 6$), as well as via a large urban children's social service ($n = 3$). Eligibility criteria were: (1) aged between 18 and 25; (2) having 'aged-out' out of children's social care (3) sufficient fluency in English and capacity to provide informed consent to take part in the research study (4) had experience of trying to access professional mental health support services since leaving care (e.g. NHS mental health services, private or third sector psychotherapy).

Due to the qualitative nature of this study, it was not appropriate to statistically calculate the sample size required for adequate power. Nevertheless, based on guidance for IPA we aimed to recruit between 6 and 15 participants (Smith & Nizza, 2022). The exact number of participants recruited was determined by the richness of the data provided by participants, which was monitored during data collection (Malterud et al., 2015; Smith & Nizza, 2022).

Data collection

This study took place during the COVID-19 pandemic. Due to social distancing restrictions in place, while we were collecting data (throughout 2021), all interviews were conducted by telephone or video

call. In terms of participant characteristics, we gathered basic demographic information (age, gender and ethnicity), descriptions of care experience (e.g. number of places lived, types of accommodation; age of entry and exit from care; accommodation upon exit from care), mental health history (whether they had ever been given a formal diagnosis) and mental health support history (access to formal mental health support before leaving care; access to formal mental health support after leaving care; type of support accessed; source of support).

Semi-structured interviews were recorded and then transcribed verbatim. The interview schedule was informed by using Rickwood (2020) model of help-seeking for young people, which meant we included questions on key stages of help-seeking, including: the development of symptoms, decision making around services, the prompt for help-seeking, engagement with services, and whether their needs had been met (see supporting information for interview schedule). We began interviews by asking participants to give a brief overview of all instances in which they sought professional mental health support since leaving care, to create a timeline of events. Once the timeline was agreed upon, we asked participants to orient themselves to each incident and gathered descriptions of events, with a focus on salient emotions, cognitions and reflections. The interview schedule set out questions and prompts as needed, but was organically adapted for each participant, to allow authentic personal accounts in a move away from researcher pre-conceptions.

Data analysis

We followed the IPA process outlined by Smith and Nizza (2022) which involved: close analytic reading, extensive familiarisation with the data and exploratory notetaking; formulating experiential statements; creating a table of personal experiential themes for each participant. Next, we identified divergent and convergent patterns across participants to build a table of group experiential themes. Please note that Smith and Nizza (2022) have offered a refined terminology for the analysis. We have followed this new terminology in this paper (i.e. referring to Group Experiential Themes, rather than Master Themes).

Care-experienced advisory team and methodological integrity

This project was supported by a team of care-experienced advisors, who were involved in the project at several stages, including: research design; development of the interview schedule and interpretations of findings (see Appendix S1 for more information). To ensure methodological integrity, the lead author kept reflective logs throughout the analysis process, to increase awareness of potential pre-conceptions that arose during the analysis. Interpretations of the data were discussed with research supervisors throughout the analysis. We also held a meeting with the advisory team, whereby participant quotes were presented alongside interpretations. This was performed as a sense check of interpretations, as well as an exercise to gain other potential insights into the data. Within this meeting, we also discussed the potential implications of research findings, in terms of clinical practice (across primary and secondary health), and social care practice. This ensured that the emerging themes were well grounded in the data and that important elements of the participants' experiences were adequately represented in the emerging analysis.

RESULTS

Participant demographics

Nine participants were interviewed, and interviews lasted between 20 and 120 min. Demographics and social care experiences are summarised in Table 1. Participants were aged between 19 and 25, were mostly women ($n=7$) and were from varied ethnic backgrounds (see Table 1). Based on participants'

TABLE 1 Summary of demographics and care-experience descriptives.

Basic demographic information	
Age	M = 22, SD = 2.6 (range 19–25)
Gender	7 women, 2 men
Ethnicity	4 White British 3 mixed ethnicity 1 Black British 1 Asian British
Care-experience descriptives	
Age of entry to care	M = 11, SD = 5 (range 0–16)
Age of exit from care	M = 18, SD = 0.3 (range 18–19)
Number of places lived	M = 4, SD = 2 (range 1–7)
Type of placement experienced (yes)	
Foster care	78% (n = 7)
Kinship care	22% (n = 2)
Residential children's home	33% (n = 3)
Other places (e.g. semi-independent accommodation)	78% (n = 7)
Type of placement upon exit	
Independent living (e.g. private renting)	67% (n = 6)
Semi-independent living	22% (n = 2)
Staying put arrangement[a]	11% (n = 1)

Note: All information is based on participant recollection.

[a]This is a scheme in England and Wales, whereby care-leavers can remain living with foster carers past the age of 18 (Children and Families Act, 2014).

recollection, the average age of entry to care was 11 years old and all participants exited care aged around 18–19 years old. Most participants spent time in foster care placements, though many had experienced other arrangements (e.g. residential care, kinship care; see Table 1). Table 2 presents participant-reported mental health diagnoses and histories of mental health support. Four main group experiential themes were identified, and across these themes 11 subthemes (see Table 3).

Theme 1: Taking reluctant steps towards recovery: Changes in willingness over time and facing fears

Willingness to engage with mental health support differed across participants, but also within participants over time. These changes were not linear, meaning that efforts to seek support could be quickly followed by periods of disengagement. Oftentimes participants related this to ways the system thwarted their efforts, and other times this related to personal fears or previous difficult experiences with discussing their mental health or trauma histories.

Avoiding and disengaging from professional mental health support

Nearly all of the participants described being avoidant of mental health support at some point in their help-seeking narratives. Avoiding mental health support was an active choice for some, as they felt therapeutic work would impact their ability to engage with education or work: 'and I was just like I cannot deal with this right now because I, I have to continue education or that's it, my life is done right?'

TABLE 2 Pseudonyms and mental health history of participants.

Pseudonym	Age	Mental health history and support received	
Katy	20	Diagnosis	Formal diagnosis of an eating disorder, anxiety & depression
		Support while in care	CBT with CAMHS; play therapy with 3rd sector organisation
		Support since leaving care	Trauma-focussed therapy with private therapist; Psychotropic medication
Mia	24	Diagnosis	No formal diagnoses, but reported anxiety, depression and OCD
		Support while in care	Play therapy with CAMHS
		Support since leaving care	General talking therapy through 3rd sector organisation
Amir	23	Diagnosis	Formal diagnosis of a personality disorder
		Support while in care	Play therapy with CAMHS; Therapy within Children's mental health hospital; Psychotropic medication
		Support since leaving care	CBT with AMHS; Psychotropic medication
Amy	24	Diagnosis	Formal diagnosis of PTSD
		Support while in care	Psychotropic medication; trauma-focussed therapy with 3rd sector organisation
		Support since leaving care	Talking therapy with 3rd sector organisation; group therapy for trauma-focussed support
Joe	25	Diagnosis	No formal diagnoses, but reported anxiety
		Support while in care	Talking therapy with 3rd sector organisation
		Support since leaving care	General Psychotherapy with private psychotherapist
Brooke	19	Diagnosis	Formal diagnosis of an attachment disorder, an eating disorder, anxiety & depression
		Support while in care	CBT and Coping Skills with CAMHS
		Support since leaving care	AMHS crisis support
Becca	19	Diagnosis	Formal diagnoses of Depression, PTSD, anxiety, attachment disorder and OCD
		Support while in care	CBT and general psychotherapy with CAMHS; Psychotropic medication
		Support since leaving care	CBT and general psychotherapy with CAMHS; Psychotropic medication
Skar	19	Diagnosis	Formal diagnosis of a Personality Disorder and Attention Deficit and Hyperactivity Disorder
		Support while in care	Psychotropic medication
		Support since leaving care	Private family therapy
Danielle	24	Diagnosis	No formal diagnosis, but reported PTSD
		Support while in care	General psychotherapy with CAMHS
		Support since leaving care	No support

Note: All information is based on participants' recollection. 3rd sector organisation = charities or children's social services.
Abbreviations: AMHS, Adult Mental Health Services (NHS); CAMHS, Child and Adolescent Mental Health Services; CBT, Cognitive Behavioural Therapy; OCD, Obsessive Compulsive Disorder; PTSD, Post-traumatic Stress Disorder.

(Danielle). For others, avoidance was more passive whereby they let their mental health difficulties 'go over my head' or did not 'pay attention to it' (Mia). Sometimes avoidance involved dropping out or skipping psychotherapy sessions, and in all instances this was described within the context of psychological barriers (as opposed to practical): 'basically some days I can get up and be in a mood and not want to

TABLE 3 Group experiential themes and subthemes.

Group experiential theme	Subordinate themes
Taking reluctant steps towards recovery: changes in willingness over time and facing fears	Avoiding and disengaging from professional mental health support
	Being forced to engage with professional mental health support
	Struggles retelling difficult stories
	Needing to talk about difficult experiences in order to move on
Challenges with being understood and the importance of gaining an understanding of yourself	Lacking the language to describe mental health needs
	Wanting expertise and answers from professionals
	Experiences of not being understood by professionals
Navigating trust: the power of consistency and relatability	Consistency and persistence
	Importance of the relatable-ness of professionals
The legacy of not having mental health needs met	A lack of hope for effective support in the future
	Deciding to cope without psychological support

speak to nobody' (Becca). Long waitlists could also exacerbate avoidance as participants experienced fluctuations in their willingness to engage.

> Joe: 'the waiting list is just… ya know you think that by the time you get to' end of the waiting list ya might have decided that 'nah I don't wanna do it'

As above, avoidance was sometimes related to previous instances of help-seeking which hadn't gone well. For example, participants explained that prior unsuccessful efforts to access support had a big impact on future help-seeking behaviour. For Mia, avoiding mental health support was a protective strategy, as she had been 'rejected' from mental health support a number of times: 'it probably stresses me more umm having that sort of rejection'.

It was common to discuss the key role of adults (e.g. social workers, teachers, personal advisors) in prompting their help-seeking behaviour, especially young people who described avoiding professional mental health support. This further highlights their reluctance to reach out for support independently.

> Becca: I am like, I will do it tomorrow, and tomorrow comes oh I will do it the next day, and it never happens. So having my social worker helps sometimes because he will make the call to [the service] and [the service] will make the call to me

Being forced to engage with professional mental health support

Many young people described times where their personal choice to avoid professional mental health support was challenged. It should be noted that for some, external help to access support was welcomed (e.g. Becca above), but at other times these help-seeking prompts felt heavy-handed. Some expressed fears about having their autonomy taken away by mental health teams and related this directly to experiences within social care.

> Joe: you're not in control… pre 18 you're not in control of your life are ya? Got people making decisions on your behalf and obviously you, you know subconsciously that any wrong comment will do, they record everything

In this way, some participants were careful about what they shared with health professionals for fear of their autonomy being taken away, and this led to feelings of isolation:

> Becca: [mental health professionals] are supposed to be there to help you to talk to you and stuff, but then you still feel isolated because you cant talk about everything properly because you are scared of what to tell them as well

Similarly, some young people had concerns about what they would be asked to talk about in mental health assessments and therapeutic settings. Participants had personal limits around what they were willing to discuss (e.g. pre-care experiences), and where these limits were perceived as not being respected (e.g. through repeated questioning), participants shut down engagement. For example, Becca felt apprehensive about therapy following a mental health assessment which felt too intrusive:

> Becca: To be honest I was thinking I hope they don't call me. I was like, 'oh I know how they are going to be now cause that is how they were at the assessment', I was like 'oh I am dreading it to be honest'

Mia dropped out of counselling after a couple of sessions because 'they aim you know to like to bring out all the stuff (…) my trauma kind of thing'. In this way, it was important that mental health professionals were aware of the need to build trust and understand the young person's personal limits and not push these too soon.

The problem with having to retell difficult stories to multiple people and services

Speaking to the complexity of the mental health services they were navigating, and the many professionals coming into their lives, many participants told us that it was difficult to repeatedly describe their mental health problems and pre-care experiences to health care professionals during their help-seeking journey. For example, some participants first spoke with General Practitioners, then had mental health assessments with mental health services, before seeing a mental health therapist. Others had engaged with several different support services over time, which meant that they had to 're-spill' several times (Katy). Amy reflected that repeatedly talking about the past was something that social services and mental health professionals had in common.

> Amy: when you first go into care that's just expected, you tell your story over and over again as I said like when I first went into care it was a ton of police interviews so by the time they got the you know [mental health] professionals when I was 19 it, it was just like this happened to me so long ago now why am I still talking about it kind of thing

While some participants described how repeatedly describing difficult experiences (with social care teams, the criminal justice system and health care professionals) now meant that they can now talk about their trauma 'factually' (Amy), for others this was still a challenging experience. Some described how they 're-lived' the past when they discussed it in mental health assessments or felt as if they were having to 'bare all' (Brooke). Mia spoke about the potential benefits of comprehensive record-keeping within their health care files (e.g. around care-experienced status) to improve communication between services. For Katy and Becca, working with health professionals who already knew about their past was positive, as it meant that they did not have to repeat the past again.

> Katy: [GP] is very, she's good because she like remembers as well, like … I dunno she's not the kind of- I don't have to go in every time I see her- I mean obviously I do see her like every week or every other week or whatever, but like she does remember bits that I tell her

Wanting to talk about difficult experiences in order to move on

Just under half of the participants explicitly sought mental health support in order to give themselves time and space to talk about trauma experiences, highlighting that many care-leavers feel conflicted about accessing mental health support. Several participants looked for psychotherapists and mental health support groups designed for people who had experienced trauma. Talking about the past appeared to be a challenging, but unmet need: 'I never really got the chance to fully like express how I was feeling, or even express my emotions really' (Danielle). When we asked why Joe sought trauma-related support specifically, they spoke of it being necessary in order to move on from the past: 'Well just like it's either, do you wanna live, live in shadows forever, or get cracking, let's move on?'

Key to engagement was feeling like the professional was equipped to discuss trauma experiences. For example, Amy accessed group therapy, but did not talk in the group until she felt 'these people are, you know, probably trained and might know how to do this'. Amy also spoke in positive terms about a career mentor who '*didn't flinch*' when she 'told him everything about my childhood', indicating that normalising trauma experiences is important. When professionals did not respond sensitively to discussions around trauma, participants were less likely to open up in the future. For example, after a negative experience with a therapist, Danielle described feeling 'ashamed' and like she will be unable to 'fully express herself' in future therapy sessions.

Theme 2: Challenges with being understood and the importance of gaining an understanding of yourself

Nearly all participants described times where they did not feel understood by mental health professionals. Some felt that this was their fault for not expressing themselves accurately, others described periods of frustration where they did not feel understood, and others focussed upon their desire to 'get answers' in the future.

Lacking the language to describe mental health needs

Several participants seemed to lack the language needed to describe their mental health problems. When asked to do so within the interview, Katy repeated 'I don't know, I don't know how to put it'; Mia felt she couldn't communicate the severity of her mental health problems: 'whenever I talk to a person and um articulate myself to them, I sound completely fine'; Joe spoke of 'underlying stuff that's always been there'; Brooke conceptualised their mental health as '*chaotic*', 'out of control' and without clear 'triggers' and Danielle lacked the language to describe her experiences with dissociation: 'I just call it like um depression like um numbness'.

Some participants reflected on challenges they experienced with communicating their problems to mental health professionals. For example, Mia asked her personal advisor to attend her GP appointment to 'sort of like [explain] the main umm things with what I needed support on'.

Their mental health needs being underestimated by professionals

Narratives often centred around times where their needs were underestimated. For example, after a mental health assessment, Katy felt that the summary letter did not adequately reflect what she had said in the assessment:

Katy: when I got the, like piece of paper after, that they send you out, it's a summary of whatever, it's all like… yeah she's fine like she was well presented and she looked like she'd had a shower, in the last week like that kinda thing and it's like, just cause I do the odd face mask and wash my hair, does, does not mean I'm not struggling kind of thing

For others, being misunderstood was considered evident because they weren't offered any mental health support, despite obvious needs.

Mia: okay well you've lost your [birth parent], this is like you know, you're, you know a care leaver, this is the support that we give around sort of grief, there was none of that

Others felt they were misunderstood because they were offered mental health support which was too generic or was not 'serious' enough: *telling somebody with that… with the history of mental health that I had to do yoga, was… is, is a bit condescending* (Katy). Others noted occasions where they had been given advice which was too challenging or impossible for them. For example, Brooke was advised to 'have a hot bath', but this was not possible as 'I can't stop running and walking and you want me to sit in a bath'. Across participants, it was evident that when therapists did not adapt therapeutic exercises to suit their needs, this could result in disengagement.

Wanting expertise from professionals around their mental health problems

For several participants, the central motivation for seeking support was to understand what their mental health problem was, though the extent to which participants were focussed upon diagnostic labels differed. For example, Danielle frequently discussed wanting 'tests' to be run to find out what they 'might have'. For Becca, receiving a 'correct' diagnosis was key to receiving effective mental health support:

Becca: I feel like I have another diagnosis there and it needs to be sorted out, because if they do then they can put me on the right medication to make me better, otherwise I am just going to take like this all the time

In some ways, the unique position of a mental health professional as an expert could also become a source of hopelessness for the young people when their expectations around getting answers were not fulfilled. This was a source of frustration for Brooke, who had engaged with several mental health professionals:

Great, so you're a mental health professional but you don't know what to do, great, and, and neither does your manager, (laugh) it's, really useful.

(Brooke)

Several participants felt frustrated or judged when health professionals asked about their support preferences. This may be because these questions inadvertently placed onus on them to know how to get better, which caused offence as participants felt they did not fully understand what their mental health problem was in the first place: 'it's like well no you're a doctor, you know? I'm not a doctor, you should be telling me' (Joe).

Theme 3: Navigating trust: The power of consistency and relatability

Within help-seeking journeys, all participants had experiences of trusting professional relationships and cases where trust was absent or was broken. There were certain qualities of professionals which could facilitate or break trust: persistence and relatable-ness.

Consistency and persistence

Several participants spoke of the importance of consistency and persistence when it came to mental health professionals. Katy had a good relationship with her GP, whom she met with regularly to review her mental health support needs. Key to building trust was the length of their relationship:

> Katy: (initially) it didn't feel very different. I wasn't her biggest fan… erm… like originally…erm, she was just a doctor and she just rang me… erm, it took, it took almost three months of seeing her before I was like yeah you're alright

Similarly, Brooke had an ongoing relationship with an organisation which delivered therapy. As she had 'known them for ages' and so 'felt like I could trust them more, I was able to be very open with how I was feeling'.

Conversely, Skar had an experience whereby a mental health professional whom she trusted left suddenly. She said: 'so it's like after that, I don't really trust anyone, I don't really speak to anyone, it's just me, myself and my [relative]'. She also drew direct connections between transient mental health professionals, and transient social workers, and said that as a result of this experience she doesn't 'really try and make a relationship with (mental health professionals) 'cause if they're gonna leave in like three weeks there's no point'.

Relatable-ness of mental health professionals

Several participants felt that their willingness to open up to or accept support from health professionals was connected to how relatable the therapist was to them. For example, when talking about a GP, Joe described them as being 'worlds apart from ya' and this limited how 'approachable' they felt to him. When talking about a therapist whom she trusted, Skar listed several matching physical characteristics (e.g. ethnicity and age) before saying: 'she understood me, I could tell her everything that was my business'. Conversely, Becca felt professionals couldn't understand her because they 'had their life easy' whereas 'we've got nothing, we have to go live with strangers'. When discussing his psychotherapist, Joe felt that they were 'just normal', that they 'addressed [me] normally. They speak normally they speak to ya so… that works' (Joe), indicating the importance of language.

Theme 4: The legacy of not having your mental health needs met

All participants spoke about how their past experiences of accessing mental health support impacted their future help-seeking intentions and hopes, and coping mechanisms.

A lack of hope for effective support in the future

While some participants had hope around receiving effective mental health support in the future, for others this hope was entirely lacking. For example, when reflecting on help-seeking journey, Katy described herself as '*naïve*' for thinking that mental health support would be available. Skar, on the contrary, felt that despite her best efforts to access support, the 'system' was 'absolutely useless', and concluded that she was 'on my own'.

For Brooke, this appeared to be related to the fact that she had 'tried absolutely every strategy under the planet'. This meant she had lost hope around whether there was a treatment which could help her feel better. As a consequence of this lack of hope, some participants felt that they had 'given up' on receiving external support, and would only do so in the future if they were in 'crisis':

I think I'd need to be in quite a, you know, crisis sort of point to access support again. Umm because I've been told there's nothing they can do. So why would, do you know what I mean, why would I then go back to… that all over again

(Brooke)

Deciding to cope without psychological support

As a consequence of not having their mental health needs met by professionals, some participants used other methods to cope with their mental health needs. Mia and Amir's main concern was that their mental health was impacting their ability to remain employed. For Mia, her focus was 'more about' getting practical support (e.g. with employment), such as a letter which will allow her 'time out' when she is struggling. For Amir, a combination of physical activity and medication was supporting him to feel better: 'So I do a lot of physical activity, so I've joined a ermm this fitness programme which I keep busy for urm… 3 4days in a week […] with the the erm combination of medication I just feel better'. Amir also felt fatigued with talking therapy: 'do ya know I've talked and talked, I've, I've been on CBT but there hasn't been any improvement'. For this reason, his support preferences were focussed on practical help as opposed to psychological, in order to improve daily functioning (e.g. paying bills, cooking and washing clothes).

Reflections from advisory team: Implications for practice

This work was supported by a team of care-experienced research advisors. Following analysis, we held an online workshop with members of the advisory team, whereby we presented findings and discussed potential implications for social care and health care practice. Several suggestions were made and are summarised in table three. In short, they felt that care-experienced people and social care professionals would benefit from psychoeducation or training around the benefits of psychological support (i.e. how to address avoidant coping). Social care and mental health professionals needed a better understanding of how to manage care-leavers' apprehensions by engaging with support. Fast-track access to therapeutic support (or financial support to access private therapy) was seen as key to improving engagement, as was the capacity to re-engage easily and flexibly with support after non-attendance.

DISCUSSION

In this study, help-seeking narratives centred around four central themes: avoidance and fears around addressing mental health and trauma; challenges with being understood; navigating trust and the consequences of not having needs met. Speaking to the complexity and diversity of help-seeking experiences for care-experienced young people, we also identified 11 subordinate themes.

Several young people wanted to talk about their past trauma, and indeed felt it was necessary to help them 'move on'. However, all participants described being reluctant to address their mental health problems or past trauma at some point, and consequently, their motivation to get support was fragile. This finding resonates with other qualitative research, which has found that people who have experienced trauma can be avoidant of mental health support for a number of years (Stige et al., 2013). Our focus on the help-seeking journey meant that we were able to uncover that help-seeking is not linear, and motivation to access support fluctuates over time within individuals. It should also be noted that there were several system-related factors which thwarted efforts and exacerbated avoidance towards accessing support, for example, long wait lists, being rejected from services and being misunderstood.

Several extant psychological models centre avoidance as a maladaptive coping mechanism, which exacerbates mental health problems and trauma-related distress (e.g. Compas et al., 2017; Ehlers &

Clark, 2000). In this way, reducing avoidance remains an important goal for professionals who care for traumatised youth and adults. Trusted adults had in encouraging them to access support, meaning that it is important for health care professionals across the entire help-seeking journey (e.g. primary health care, secondary health care) to understand any apprehensions care-leavers have around accessing support, and adjust their approach to meet the needs of the individual. It may be useful to provide psychoeducation to care-leavers, in particular around the value of addressing trauma-related experiences, encourage engagement with mental health services.

Some young people had difficulties articulating their mental health needs to health professionals or felt their mental health needs were misunderstood. Limited resources within both primary and secondary health services are likely to make it more difficult for practitioners to gain a thorough understanding of care-leavers' mental health needs (e.g. limited time for mental health assessments, unavailability of face-to-face appointments), especially given that the mental health needs of care-experienced people are often complex (Engler et al., 2022; Seker et al., 2021).

It may be that there is a disconnect between how care-experienced people and health professionals conceptualise or discuss mental health (Harper & Vakili, 2021). For example, despite the diversity of mental health problems experienced in this sample, trauma was brought up in all of the interviews, indicating the central importance of these experiences for mental health and well-being for this group. There is very little research which has investigated how health professionals conceptualise trauma, or factor this into treatment decision making, especially in the care-experienced population. However, a review by Read et al. (2018) indicates that histories of maltreatment or abuse are not consistently identified by mental health professionals in the general population. Looking forward, it is important we develop a shared language and understanding of mental health and well-being between care-experienced people, researchers and health care professionals (Devaney et al., 2023). It is also important to examine the acceptability of existing psychotherapies for care-leavers, integrating views from care-experienced young people, with mental health and social care professionals.

Several young people spoke of the extent to which they felt they could build trust with health professionals. Individuals who experience childhood adversity oftentimes show disruptions in their trust in others and the world (Campbell et al., 2021; Eldridge et al., 2020). We have shown here that this has knock-on effects for health care-related decisions. Transient relationships were a key driver for disruptions in trust, including within interactions with health care professionals (Hyde et al., 2017). Increasing continuity of care is a well-established target within children's social care, and this should be extended to supporting the health care of care-experienced people into adulthood (MacAlister, 2022).

There are some similarities between the themes we identified in this project, and the broader literature on why young people do (or do not) approach mental health services for support. For example, we identified that like young people in the general population, care-experienced people can develop a preference for self-management or independent coping and that some struggle to articulate their needs (Radez et al., 2020). At the same time, some themes were more central to narratives, such as the importance of building trust and trauma avoidance. Regardless, the implications and recommendations of this study could be applied more broadly to our approach to caring for young people in the general population.

Our care-experienced advisory team identified several implications of this research for policy and practice (Table 4). Though we have identified several psychological barriers with accessing mental health support, many of these recommendations focus on the broader system around care-experienced people. For example, one key recommendation is that social care teams should be up-skilled in relation to mental health so that they can better facilitate, and advocate for the support needs of care-experienced people. Looking forward, it is important that solutions do not just focus on individuals and are implemented across the entire system which care-leavers exist within (e.g. social care practice, primary and secondary health care services).

TABLE 4 Reflections from the care-experienced advisory team: Implications for social care and health care practice.

- Raise awareness within social care teams around the concerns care-experienced people may have with accessing mental health support (e.g. avoidance, difficulties building trusting relationships and preference for independent coping).
- Up-skill social care teams so that they can better facilitate, and advocate for the support needs of care-experienced people (e.g. attending mental health assessments)
- Psychoeducation mental health, and better signposting for care-experienced people towards evidence-based mental health support
- Given limited National Health Services resources, children's social care teams could provide bursaries to care-experienced people so that they can access private mental health support quickly. Alternatively, consider priority access to mental health support for care-experienced people with National Health Service
- Up-skill mental health professionals in relation to mental health problems frequently experienced by care-experienced people, as well as consistent implementation of evidence-based treatment

Strengths, limitations and future directions of research

There are many strengths of this research study. We investigated a highly vulnerable group of young people, using qualitative methodology which allowed us to build a rich picture of help-seeking experiences. The involvement of a care-experienced advisory team allowed us to check the resonance of interpretations, contributing to the credibility of findings (Kelly et al., 2018). Despite interviews taking place remotely, we found that participants were forthcoming and open with their experiences. In line with other qualitative studies which investigate sensitive topics, we found that phone and video conferencing interviews created a relaxed and informal atmosphere, which facilitated the disclosure of material which might have otherwise been withheld in a more formal setting (Heath et al., 2018).

However, there are also several limitations. Help-seeking experiences are not homogenous, and we used self-selection sampling, meaning that it is unlikely that we have fully captured the variety of individual experiences with our limited sample. For example, it is unlikely that those who do not want to talk about their help-seeking experiences or mental health would take part in the study. Furthermore, given the provision of mental health support differs across the UK, findings may reflect current practice in those areas as opposed to broader experiences of help-seeking.

Future research should focus on other groups of care-experienced young people, who may face additional structural and psychological barriers to accessing mental health support. For example, unaccompanied asylum seekers and neurodivergent young people. We focussed on care-leavers' experiences specifically, but future research should consider the wider systems they exist within. For example, the role of social care professionals, or experiences of treating care-experienced people across primary and secondary health care systems.

CONCLUSIONS

The uptake of mental health support for care-experienced people is disproportionate to the level of need (Hansen et al., 2021). There are several clinically relevant implications which can be drawn from this research across both primary and secondary health care settings, which may address the need-provision gap. Care-leavers may benefit from psychoeducation around the benefits of mental health support (i.e. addressing avoidance). They would also benefit from fast-track access to therapeutic support (MacAlister, 2022), and the capacity to re-engage after a disengagement or non-attendance easily and flexibly. Greater awareness of the apprehensions care-experienced feel towards support, may help health care and social care professionals engage in conversations around support more sensitively.

AUTHOR CONTRIBUTIONS
Alice R. Phillips: Conceptualization; investigation; writing – original draft; methodology; formal analysis; project administration; data curation. **Rachel M. Hiller:** Conceptualization; funding acquisition;

CONFLICT OF INTEREST STATEMENT
The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT
Research data are not shared.

ORCID
Alice R. Phillips https://orcid.org/0000-0003-0387-6131

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Appendix S1

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