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# Evaluation of a New Mental Health Service for Looked After Children

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## ABSTRACT

**A mental health team for looked after children, and the evaluation of its first phase are presented. The team combines primary mental health worker, psychology and psychiatry skills. It offers telephone and face-to-face consultation to local authority staff, assessment, treatment and training. Forty-five children and their carers, who consecutively attended the service, were independently assessed by a researcher at the time of referral and at five-month follow-up. Outcome measures included the Strengths and Difficulties Questionnaire (SDQ), the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and a service satisfaction questionnaire. At 5 months, children had significantly improved on a number of HoNOSCA scales, and on the emotional SDQ scales. Carers perceived the interventions as targeting different aspects of the child's functioning, but wished they were more involved in decision-making. Carers and children were generally positive about their clinical contact. The findings are discussed in the context of developing mental health services for vulnerable children and young people, and interagency partnership.**

## KEYWORDS

*care, children, looked after, mental health, service*

IT IS well established that children and young people looked after by local authorities have high rates of mental health problems and disorders (Brand & Brinich, 1999; Hukkanen, Sourander, Bergroth, & Piha, 1999; Richardson & Joughin, 2000; Roy, Rutter, & Pickles, 2000). For example, McCann, James, Wilson, and Dunn (1996) found

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that up to two-thirds of children looked after in a UK district, predominantly those in residential care, presented with mental health problems that justified a clinical assessment. Dimigen et al. (1999) found that half of their sample of 123 young people in foster and residential care had significant behavioural and emotional problems, often multiple difficulties or comorbidity. Older children were more likely to be affected, particularly those in residential care. Minnis and Devine (2001) found similarly high rates of 60% children in foster care within the clinical range of behavioural and emotional problems.

These high levels of mental health need among children looked after are related to their early adverse family experiences, as well as secondary effects of their experiences within the care system, particularly frequent moves and placement breakdowns (Minty, 1999; Quinton & Rutter, 1984). These are interrelated with social, educational and relationships difficulties. Vice versa, children with mental health problems are less likely to achieve placement stability, thus often entering a sequence that is difficult to break (Barber, Delfabbro, & Cooper, 2001). There are also continuities with mental health disorders after leaving the care system (Buchanan, 1999; Cheung & Buchanan, 1997).

Despite this evidence, the extensive mental health needs of looked after children remain largely unmet (Harman, Childs, Kelleher, & Kelly, 2000; Payne, 2000; Richardson & Joughin, 2000). There is substantial variation in the provision of Child and Adolescent Mental Health Services (CAMHS) for looked after children, the interventions offered and the disciplines or agencies involved (Minnis & Del Priore, 2001). Problems in accessing CAMHS include narrow referral criteria, non-detection of mental health problems, referrers' reluctance to pathologize children's behaviour, children's

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**FRANCIS PACE** completed his medical training in Malta, where he also participated in epidemiological WHO research. He continued his General Psychiatry training in Coventry, before joining the Leicestershire Specialist Registrar training scheme in Child and Adolescent Psychiatry and subsequently taking up a Consultant post.

**PANOS VOSTANIS** is Professor of Child and Adolescent Psychiatry at the University of Leicester and Consultant of the Young People's Team, which is described in this article. In addition to the evaluation of services for vulnerable children and young people, he is involved in the evaluation of interventions in primary care and for traumatized children in war zones.

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mobility and engagement (Hatfield, Harrington, & Mohamad, 1996; Minnis & Del Priore, 2001; Nicol et al., 2000). For example, Phillips (1997) found that many social workers may have recognized that a particular young person needed mental health intervention, but did not refer. This could be a result of placement instability, dissatisfaction with CAMHS, and lack of local authority resources. Looked after children have similar difficulties in accessing other health services (Bundle, 2001; Mather, Humphrey, & Robson, 1997; Polnay, Glaser, & Rao, 1996).

There are some existing publications which describe the work of generic CAMHS teams for residential units and foster carers, however, these teams have often developed from existing CAMHS staff, and thus cover only a proportion of the looked after population (Barrows, 1996; Butler & Vostanis, 1998). Such teams have been faced with overwhelming demand, and the complex social and educational needs of a client group which requires the co-ordination of different agencies (Arcelus, Bellerby, & Vostanis, 1999). Recent policy changes in the UK (Department of Health, 1998) have led to the provision of funding for dedicated mental health posts for looked after children. The aims of this study were to describe: (i) client and service characteristics of a new dedicated mental health service for looked after children and their carers, and (ii) short-term mental health outcome and client satisfaction.

## Methods

### Setting

The health district has a general population of 900,000, living in inner-city, semi-urban and rural areas, shared by three local authorities. One quarter of the population are aged under 18 years. The mental health team covers young people accommodated in 10 statutory residential units, 5 private children's homes, and approximately 700 foster or pre-adoption placements. The total population of young people in care in this district is generally around 800 (813 in July 2001).

A mental health team was established to provide a service to overlapping groups of vulnerable children, i.e. looked after (described in this article), young offenders, refugee and homeless children and families. The team consists of two primary health workers (PMHWs) for looked after children, four PMHWs for the two youth offending teams, one community psychiatric nurse for refugee children, five family support workers for homeless children and their parents, two psychologists and one psychiatrist who work across the four client groups. In this article, reference to the team will be confined to the looked after children component. The team roles include assessment and treatment; consultation to foster carers, pre-adoption carers, residential staff, social workers, and foster carers' link workers; and ongoing training to the same agencies.

The team is structured according to the guidelines suggested by the Health Advisory Service (1995), using a tiered-model of service provision (Figure 1), with PMHWs (tier 2) covering the interface between primary care professionals (tier 1; in this case, local authority staff) and specialist (tier 3) CAMHS (psychologist and psychiatrist in this team). The posts are recurrent, and were funded by CAMHS Modernisation Monies and Local Authority Mental Health Grants. The local partnership between health and local authorities prioritized the needs of looked after children, whilst acknowledging the substantial resource issues in the rest of CAMHS. The service is monitored by a multi-agency steering group, thus retaining strong working relationships with both social services and the rest of CAMHS. The role of the steering group is to plan developments in a strategic way, respond to new policies, oversee operation service criteria, and facilitate multi-agency training. The team members are National Health Service (NHS)

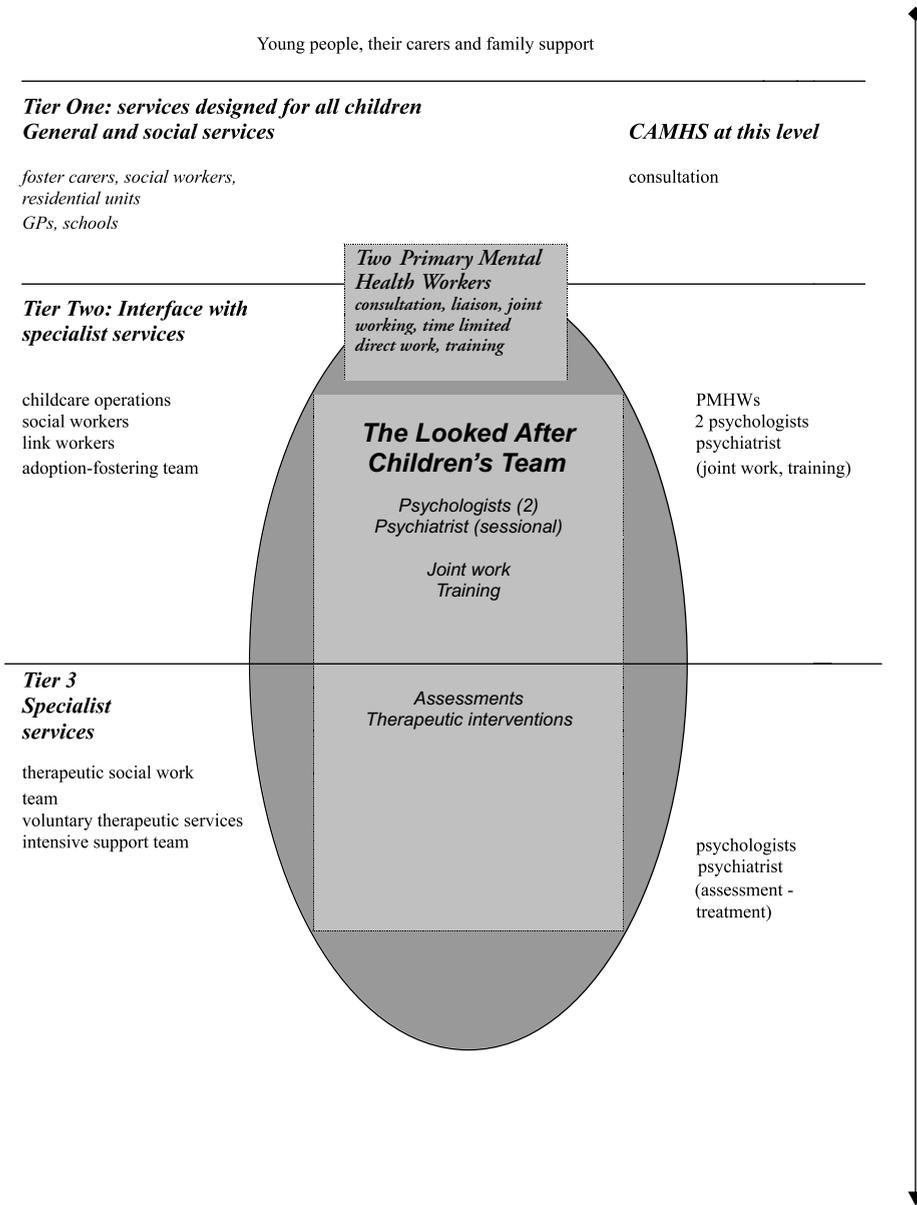


Figure 1. The role of the Looked After Children's team in the context of CAMHS and other services.

employees, and their accountability and management remain within CAMHS, as part of a mental health NHS Trust.

Primary mental health workers receive most of the referrals, provide telephone or face-to-face consultation to professionals and carers, or joint work with local authority professionals. Each residential unit has an allocated PMHW who regularly visits the home, providing consultation and training to staff teams. In fostering, PMHWs work with fostering link workers, social workers and adoption workers. The PMHW therefore

seeks to empower frontline staff and carers with basic mental health skills, in order to improve their identification of at risk young people, and to help them build their resilience. In addition to this consultative role, PMHWs provide time-limited direct interventions to young people whose difficulties do not meet the threshold necessary for referral to more specialized mental health professionals, and also provide direct support to their carers (foster carers or residential workers). The important and demanding role of PMHWs is fulfilled by experienced practitioners of either nursing or therapeutic social work background. The PMHWs receive additional training in a range of interventions, such as psychodynamic, behavioural and cognitive therapies for children with attachment difficulties and their carers.

At the second level, mental health assessment is provided by the psychologists and psychiatrist within the team, who also provide direct treatment, work jointly with the PMHWs, and contribute to consultation and training. If a child requires long-term psychotherapy, s/he is referred to a dedicated therapeutic social work team that covers the same local authorities. The team is located within CAMHS, and operates as an independent tier 2/3 service, alongside the sector specialist teams (i.e. those that cover geographical areas). The specialist staff (psychologists and psychiatrist) also work with the youth offending teams (YOT; Callaghan, Young, Pace, & Vostanis, 2003), refugee and homeless families (Vostanis, 2002), providing an integrated service for vulnerable young people in the area.

Therefore, children with forensic needs are managed within the team (unless requiring a secure placement). The same applies to those with severe mental illness, mainly psychosis, who may also be admitted to the local CAMHS inpatient unit (tier 4). Children with severe learning disability and autism may be co-worked with the outpatient child learning disability team (tier 3). The provision of residential therapeutic placements for adolescents with more extensive behavioural and emotional difficulties (aggressive behaviour and recurrent self-harm) remains problematic, and out-of-county units are sought, often with little success because of financial constraints.

The team provides ongoing training on mental health awareness, basic concepts of mental health problems, rationale for different interventions and staff roles. Team members run one- or two-day courses in pairs every 2 months, which are an integral component of the service. These not only have an educational objective, but predominantly aim at engaging other agencies and carers, and relating to them in a consistent way within a mental health capacity (i.e. distinguishing CAMHS roles from family support, case work or child protection). The courses are offered separately to local authority staff (residential social workers, foster carers' link workers or other social workers) and foster carers, because of their different levels of training needs.

The staff came into post over a six-month period. During the first 15 months, 277 cases were referred to the team, of which 195 (70%) were accepted. Of those, 123 were seen for direct assessment or treatment, and 72 were taken on for consultation or joint work.

### **Sample**

The first 50 consecutive referrals accepted for direct work by the Looked After Children's team were invited to participate in the study. Previous studies had included either children in foster care, or young people in residential care. As the objective of this service was to work across the looked after population, this was reflected by the research sample. Forty-five children and their carers agreed to participate, and five refused. There were 20 female (44.4%) and 25 male (55.6%) children, with a mean age of 11.7 years (range 4–17). Ten (22.2%) were accommodated in residential units, 33 (73.3%) with foster carers and two (4.5%) in pre-adoptive placements. Forty children (88.9%) were

of white British ethnic origin, four (8.9%) of dual heritage (African or Caribbean and white British ethnic origin) and one (2.2%) of dual heritage (Asian and white British ethnic origin). Of the 45 children, 39 (86.7%) were also available at five-month follow-up.

### Measures

The Health of the Nations Outcome Scales for Children and Adolescents (HoNOSCA; Gowers et al., 1999b) include 13 clinical/psychosocial scales (disruptive/aggressive behaviour, overactivity and attentional difficulty, non-accidental self-injury, alcohol or substance/solvent misuse, scholastic or language skills, physical illness/disability problems, hallucinations and delusions, non-organic somatic symptoms, emotional and related symptoms, peer relationships, self-care, family relationships and poor school attendance) and 2 items on carers' knowledge about the nature of the young person's difficulties, and of services available to them.

Each item is rated on a 5-point severity scale, 0 (*no problem*), 1 (*minor problem requiring no action*), 2 (*mild problem but definitely present*), 3 (*moderately severe problem*) and 4 (*severe to very severe problem*), with a detailed glossary for each point of the scale and item (Gowers et al., 1999a). Total scores were estimated for each item. All cases were rated independently by a researcher (JC), who had previously completed the video and manualized training for the HoNOSCA. Although there are no norms on the scales scores, a score of 2 or above on each scale (which represents a rating of at least 'mild' presentation) was considered of potential clinical significance.

The *Strengths and Difficulties Questionnaire* (SDQ; Goodman, 2001) is a measure of social, emotional and behavioural functioning. The 'parent' version was completed by an adult carer, and the self-report version, by children and young people aged 11–16 years. Each item of the SDQ has the response options, 0 (*not at all*), 1 (*a little, sometimes*) or 2 (*very much, all of the time*). Responses for each item are grouped into one of five subscales (prosocial, hyperactivity, emotional, conduct and peer problems), and a total difficulties score is also obtained. Norms have been established for likely clinical cases, i.e. those requiring further assessment and treatment (Goodman, Meltzer, & Bailey, 1998).

A *service satisfaction* questionnaire was devised by the researchers and was used at follow-up interviews. The items would apply to other CAMHS clients, but particular attention was paid to issues related to the attendance of looked after children and foster carers (Appendix). It was completed by the 39 adult carers who were available at follow-up, and 12 young people. Only 12 young people were available for interview at follow-up, either because they were pre-adolescent, they did not wish to be interviewed, or, in three cases, their social worker did not wish them to be interviewed. The service satisfaction questionnaire contained both closed- and open-ended questions, regarding their perceptions of accessibility of the clinician, the nature, appropriateness and effectiveness of the intervention offered, and the qualities of the clinician.

### Procedure

At the point of referral, an independent researcher (JC) visited each carer and young person, and asked them to complete a SDQ. A HoNOSCA was completed by the researcher by interviewing the case-holding clinician. This information was corroborated by reference to the case notes and the referral information for each young person. Five months later, each carer and young person was visited again, and asked to complete the SDQ, while the independent researcher (JC or FP) completed a short service satisfaction interview and the HoNOSCA. Within the resource constraints of the evaluation, a

*Table 1.* Main concerns cited as the reason for referral (*N* = 50)

<i>Main concern</i>	<i>N (%)</i>
Self-harm	9 (18)
Disruptive/oppositional behaviour	9 (18)
Depressed mood	6 (12)
Problems with anger management	4 (8)
Anxiety	4 (8)
Developmental delay/learning difficulty	4 (8)
Attention/concentration problems	3 (6)
Social difficulties/relationship problems	3 (6)
Other emotional problems	2 (4)
Enuresis/encopresis	2 (4)
Other	4 (8)

five-month follow-up period (short-term outcome) was considered adequate to provide an indication of young people's and carers' engagement and satisfaction with the service.

## Results

### ***Profile of the young people at the point of referral***

At the point of referral, young people had had between 1 and 7 placements (mean = 3.5) in the 12 preceding months, and 13 were described as being at risk of placement breakdown. Most referrals came from social services (*N* = 34, or 68%) with 5 (10%) from general practitioners, 4 (8%) from accident and emergency departments or the psychiatric on-call service, one from a health visitor and one from a consultant child psychiatrist. The mean number of weeks from referral to allocation to a clinician was 1.6 (range 1–6 weeks), and the time lapse from referral to the first appointment was on average 3.2 weeks (range 2–9 weeks). In the majority of cases (24) the case-holding clinician was a psychologist, with PMHWs holding 11 cases, and a child psychiatrist holding 10 cases. A psychologist was involved in 31 of the cases, a child psychiatrist in 22 cases, and a PMHW in 21 cases.

### ***Reason for referral***

Referrers were asked for the main concern that had triggered the referral (some gave more than one reason). These reflected a broad range of concerns, with the most common being self-harm, behaviour problems, mood and other emotional difficulties (Table 1).

***Health of the Nation Outcome Scales for Children and Adolescents*** Clinicians assessed young people referred to the Looked After Children's team as having a broad range of difficulties. Of 45 HoNOSCAs, the most common scales with a score of at least mild severity (score 2), were: emotional and related symptoms (*N* = 40, 88.9%), peer relationships problems (*N* = 38, 84.4%), problems with family life and relationships (these were defined as 'any current contact with biological family and relationships with foster carers or residential staff': *N* = 36, 80%), and aggressive, antisocial and disruptive behaviour (*N* = 32, 71.1%). However, there were also a large number of other clinically significant difficulties, suggesting that the young people referred to the team might have multiple and complex problems.

**Strengths and Difficulties Questionnaire ratings** At the point of referral, each young person aged 11–16 years and their carer were asked to complete an SDQ. Their scores demonstrate that most of the young people (33, or 77.78%) referred to the service and accepted for direct work had scores within the clinical range on the carer- and self-rated SDQ version. SDQ subscales scores indicate that many of the young people presenting to the Looked After Children's team have significant difficulties with emotional (60%), conduct (68.9%) and peer relationships problems (71.1%).

**Proposed intervention** Twenty-four of the young people referred were seen for direct work (typically cognitive-behavioural or brief psychodynamic therapy), six received some kind of direct work together with foster carers/residential workers, two were jointly worked by a team member and a member of the residential staff team, four were seen for assessment only, and nine for prolonged consultation (more than three sessions) with the foster carer. It was beyond the remit of the study to look at specific interventions.

### **Five-month (short-term) outcome**

At the point of follow-up, 27 cases were still open to the team. Of the 18 who had been closed, 10 had completed the intervention, 3 had been referred to another agency, 2 had been closed because the young person had moved out of the residential setting, and 3 were closed because the young person had been non-compliant with treatment. Carers who were interviewed reported that 13 of the young people had received a formal psychological or psychiatric assessment, 29 had had some kind of therapeutic intervention, 36 of the carers had received some sort of consultative work, and 5 had been offered referral to another agency.

An audit of case notes for the 39 young people revealed that, in total, 264 appointments had been offered and kept by the young people in the sample. In addition to these, clinicians had completed 86 consultations with an involved social worker, 198 consultations with their foster carers or key workers, and 23 consultations with other relevant professionals. As the sample size was small and the outcome period relatively short, it was not possible to consider placement stability as an outcome variable.

**HoNOSCA ratings** The total HoNOSCA score of the 13 clinical items reflects a child's psychosocial functioning in a number of areas. Total scores were found to decrease significantly (Wilcoxon matched pairs test,  $z = -3.73$ ,  $p < .001$ ) between the first assessment ( $M = 17.7$ ,  $SD = 5.0$ , minimum 7 – maximum 26) and the follow-up ( $M = 13.1$ ,  $SD = 5.9$ , minimum 2 – maximum 26). Ratings on all specific items were also compared using the same statistical test, several of which were found to improve significantly (Table 2): disruptive, antisocial or aggressive behaviour ( $z = -3.82$ ,  $p < .001$ ), non-accidental self-injury ( $z = 3.34$ ,  $p = .001$ ), emotional and related symptoms ( $z = -3.29$ ,  $p = .001$ ), and family life and relationships subscales (defined in relation to contact with natural family, as well as relationships with foster carers and residential care staff:  $z = -2.89$ ,  $p = .004$ ). The two scales reflecting carer's knowledge of the young person's difficulties and of the services available to help them with those difficulties, also reflected a positive change ( $z = -2.82$ ,  $p = .005$ ; and  $z = -2.71$ ,  $p = .007$ , respectively).

**Strengths and Difficulties Questionnaires** The total difficulties score on the SDQ is a reflection of the broad range of clinical problems and their severity, while the subscales measure specific types of clinical problems. At five-month follow-up, the adult-rated SDQs showed significant improvement in emotional problems (Wilcoxon test:  $z = 2.06$ ,  $p = .039$ ), and total SDQ scores ( $z = 1.80$ ,  $p = .07$ ), although the latter did not reach

**Table 2.** Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) scores at first assessment and five-month follow-up ( $N = 37$ )

<i>HoNOSCA subscale</i>	<i>Mean score (SD) at first assessment</i>	<i>Mean score (SD) at follow-up</i>	<i>Difference (z) (Wilcoxon test) and p-value</i>
Scale 1: Aggressive, antisocial and disruptive behaviour	2.3 (1.2)	1.2 (0.9)	3.8 <.001
Scale 2: Overactivity and attention deficit	1.5 (1.0)	1.0 (1.0)	1.43 .15
Scale 3: Non-accidental self-injury	1.1 (1.3)	0.3 (0.6)	3.3 .001
Scale 4: Alcohol, solvent and substance misuse	0.4 (0.6)	0.3 (0.4)	1.1 .28
Scale 5: Scholastic or language skills problems	1.7 (1.2)	1.1 (1.0)	0.13 .89
Scale 6: Physical illness or disability	0.2 (0.5)	0.1 (0.5)	2.36 .018
Scale 7: Hallucinations, delusions and abnormal perceptions	0.5 (0.9)	0.4 (0.8)	1.09 .27
Scale 8: Non-organic somatic symptoms	1.1 (1.1)	0.4 (0.8)	1.66 .097
Scale 9: Emotional and related symptoms	2.3 (1.0)	1.6 (0.9)	3.3 .001
Scale 10: Peer relationships	2.5 (1.1)	1.7 (1.0)	1.26 .21
Scale 11: Self-care and independence	1.1 (0.9)	0.7 (0.8)	2.03 .043
Scale 12: Family life and relationships	2.5 (1.2)	1.8 (1.1)	2.9 .004
Scale 13: Poor school attendance	1.2 (1.5)	0.9 (1.4)	0.16 .87
Scale 14: Carer's lack of understanding of difficulties	1.6 (1.6)	0.9 (1.3)	2.8 .005
Scale 15: Carer's lack of information about services and management	1.3 (1.5)	0.6 (0.9)	2.7 .007

statistically significant difference (first assessment: total SDQ  $M = 19.8$ ,  $SD = 5.5$ , range 9–33; follow-up total SDQ  $M = 18.4$ ,  $SD = 4.6$ , range 5–28). There was no significant change in conduct ( $z = 0.25$ ,  $p = .81$ ), hyperactivity ( $z = 1.28$ ,  $p = .19$ ) or peer relationships problems ( $z = 0.49$ ,  $p = .62$ ). Self-rated SDQs showed significant improvement in peer relationships problems ( $z = 1.97$ ,  $p = .049$ ), while the other scales remained unchanged. The total self-rated SDQ scores were: first assessment  $M = 19.5$ ,  $SD = 5.4$ , range 6–27; follow-up  $M = 19.3$ ,  $SD = 6.1$ , range 8–30.

**Service satisfaction** Thirty-nine carers (either foster carers or key workers) completed service satisfaction questionnaires. Most carers (36) felt that the service they had been offered was appropriate to the needs of the young person in their care. However, their sense of how effective the service was varied (Figure 2). In total, 51.3% of carers felt that the intervention offered by the Looked After Children's team had been effective for the

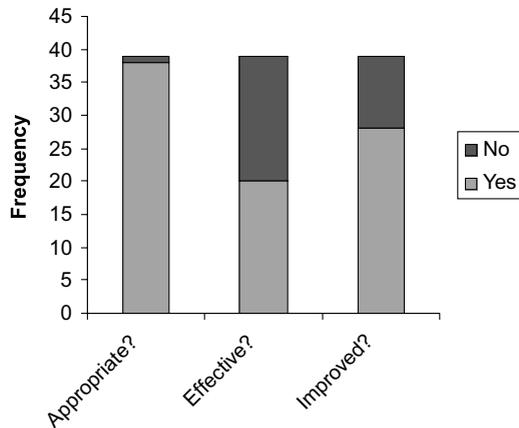


Figure 2. Did carers feel that the intervention offered was appropriate and effective, and had the young person improved?

young person in their care, and 71.8% felt that the young person had shown some improvement during treatment.

Carers reported that the interventions offered were quite wide-ranging, and most reported that they targeted more than one area, i.e. disruptive behaviours (28), emotions (23), social skills (20), communication (13), family relationships (13), social support (12), and cognitions (8). Most carers felt that the interventions suggested were practical (80%), and 60% said that they had tried to implement the clinicians' suggestions. Sixty-five per cent felt that they had learned new mental health skills in their interaction with the clinician, and 50% said that they would be able to apply those skills with other young people (Figure 3).

All carers stated that the clinician involved with their case was accessible for consultation in the first instance (66.7% strongly agreed with this statement, and 33.3% agreed), and most felt that they were available for follow-up consultations to discuss further concerns (25.6% strongly agreed, and 46.2% agreed with this statement). All carers felt that the clinician they worked with listened carefully to their concerns, and most (70%) felt that the clinician expressed themselves clearly and was easy to understand. Carers did not feel as involved as they would have wished in a partnership with the mental health team, as 50% felt that they were not included in decision making about the case, and only 60% felt that a range of intervention options was discussed with them (Figure 4).

The generally positive perceptions of the clinician were echoed by the young people themselves (Figure 5). All the young people interviewed ( $N = 12$ ) felt that the clinician was available to them, and most felt that the clinician listened to them and expressed themselves clearly. Although most felt that they had been helped by the clinician, several felt that they had not been helped.

## Discussion

In recent years, Child and Adolescent Mental Health Services in the UK have grown and developed models of direct provision in primary care settings, as well as vulnerable client groups such as looked after children and young offenders. National policies and

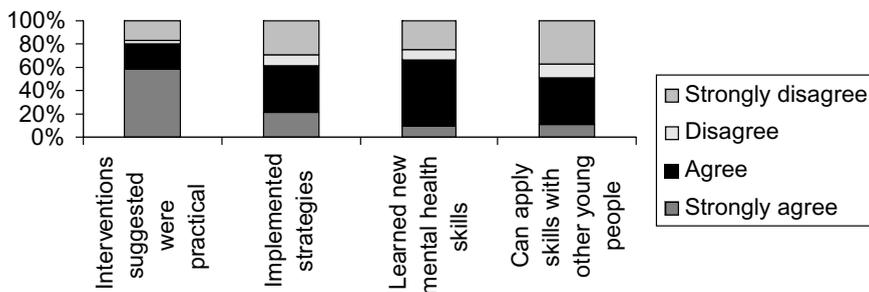


Figure 3. Carers' perceptions of the interventions suggested, and skills acquired. This chart summarizes adult carers' responses (expressed as a Likert scale) to statements about the interventions proposed by the clinician during consultation with them, and their perception of new skills they might have acquired. The number of responses to each Likert scale category are shown as a percentage of the total responses.

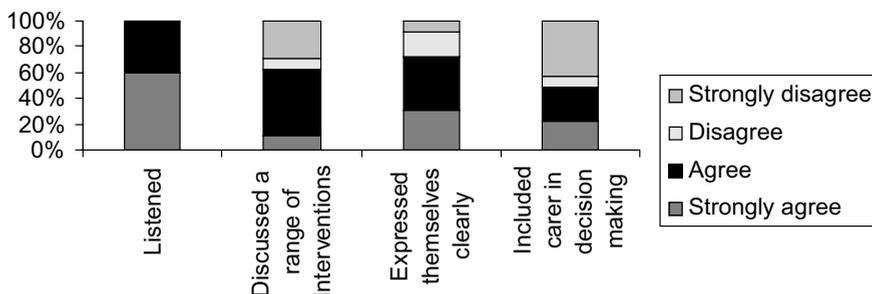
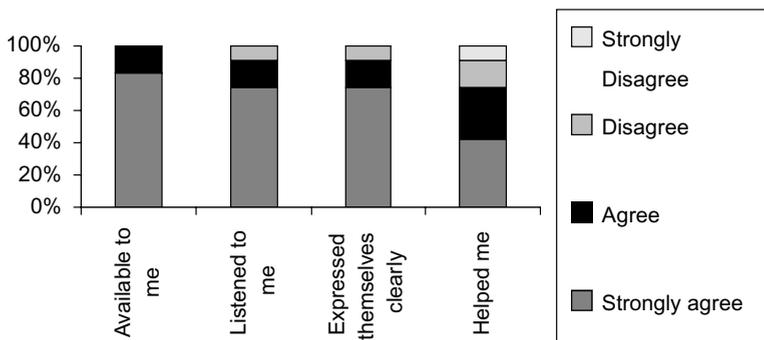


Figure 4. Carers' perceptions of the qualities of the clinician in consultation.



research findings on the needs of looked after children have set the framework for direct

Figure 5. Young people's perceptions of clinician.

input from CAMHS or the emergence of dedicated posts. However, as the range of CAMHS priorities remains diverse, it is often difficult to secure recurrent resources to provide dedicated services for looked after children, young offenders and homeless families. Services for the vulnerable groups continue to be provided under short-term

funding initiatives, which are, of course, far from ideal in retaining staff and adopting a strategic approach to a new service.

The mental health service described in this article is underpinned by a philosophy of partnership with the local authorities in strategy and implementation; a tiered response to needs, ranging from consultation to specialist assessment and treatment; direct access to children, carers and professionals; and training and support to professionals working with children and young people. The team combines primary mental health worker and specialist posts, each one bringing their own skills and role. The primary mental health workers apply the same principles of generic CAMHS (Gale & Vostanis, 2003), but adapted for tier 1/2 staff such as residential social workers, foster carers and link workers (Figure 1). Services to young offenders and homeless children have been evaluated through a combination of quantitative and qualitative methods (Callaghan et al., 2003; Tischler, Vostanis, Bellerby, & Cumella, 2002). This article described the evaluation of the first phase of the mental health service for looked after children, and provides data on the short-term outcome of children and young people who received assessment and intervention, albeit not on cases managed through consultation to referrers.

The large number of referrals, in the first year of the operation of the team, which comprised almost one third of the total local looked after population of the health district (most of whom were considered appropriate for some level of input), indicates that an appropriately resourced service can address the needs of a highly vulnerable client population. This helped to prevent delays in implementing children's care plans, reducing the need for (often unnecessary) mental health assessments; social workers were freed to concentrate on their role, such as assessment of parenting capacity and placement; and the other tier-3 outpatient (sector) CAMHS teams who previously saw looked after children as part of their generic case load, were freed from some complex and time-consuming cases.

The high level of need has been well documented by previous epidemiological research (Dimigen et al., 1999; McCann et al., 1996). The ratio of cases being managed through consultation or direct treatment is likely to have been reversed since the early phase of the service evaluated by this study. Consistent contact with, and ongoing training for, carers and local authority professionals should result in a larger proportion of behavioural and relationships difficulties being dealt at tier 1 level (Gordon, 1999; Minnis, Pelosi, Knapp, & Dunn, 2001).

The direct referral of most cases by social services staff and the response time of the mental health service provide evidence that the service is accessible and responsive. Also, the range of referrals accepted for clinical work (Table 1) suggests that the service is reaching young people across the spectrum of mental health difficulties. One criticism that has been levelled at CAMHS by social services has been that it tends to refuse referrals for young people with conduct related difficulties, despite the possibility that they may have other difficulties too. In this sample, both measures (HoNOSCA and SDQ) suggest a number of concurrent (or comorbid) difficulties. Overall, it would not be cost-effective or realistic for CAMHS to undertake routine mental health assessment of looked after children, but should rather target children with more severe problems or disorders, who would benefit from specialist intervention. CAMHS professionals should preferably provide a range of interventions, depending on the nature and presentation of the disorder, rather than a generic approach.

The literature has suggested that one of the main reasons for the poor access that young people in care have to CAMHS is related to issues around placement stability (Valios, 2002). Social services staff may complain that CAMHS will not accept young people until their placement is stable, and that this creates a vicious cycle, as placements

cannot stabilize while there are unresolved mental health issues (Barber et al., 2001). For this reason, the Looked After Children's team did not define placement stability as a prerequisite of referral. A fairly high proportion (28.9%) were regarded as at risk of placement breakdown at the point of referral, and the average number of placements in the year preceding referral was 3.5, indicating that many of the young people had not achieved placement stability, and would have had difficulty accessing service under routine CAMHS referral criteria.

These data suggest that there was an even distribution of cases among the members of the team, and the adopted approaches to treatment, although both questions were beyond the remit of the study and are constrained by the small sample size. A common debate concerns the criteria for psychotherapy (e.g. whether this should be offered by specialist CAMHS if there is a need for post-abuse therapy but no current mental health disorder; or whether less engaged young people can benefit), its model and duration (Barrows, 1996). This should be defined by the needs of the child within the overall management plan, rather than being perceived as a panacea for placement issues or being withheld because of the lack of stability.

Improvement between time 1 and time 2 on the HoNOSCA and some scales of the SDQ was positive, considering the children's complex difficulties. However, these findings should be interpreted with caution, because a large number of factors could have contributed to this improvement, and it is methodologically very difficult to isolate the impact of intervention in the absence of a control group. In other words, the detected improvement may have been at least partly due to non-mental health interventions. Placement stability and the presence of secure and consistent adult care are important factors in improving young people's overall psychosocial well-being, and could be a significant influence on the improvement noted on these scales. It should also be borne in mind, however, that the stabilization of the placements might be linked to the supportive involvement of the Looked After Children's team (Minnis & Del Priore, 2001).

Carers described a number of targeted difficulties, including relationships, emotions, cognitions and communication, rather than the more obvious behavioural problems. However, it needs to be highlighted that these perceptions may not be shared by carers being supported through consultation rather than direct contact. This important component of CAMHS requires extensive evaluation. The preliminary data on young people's views also need to be explored further on the kinds of help they wish, or find appropriate and effective (Heptinstall, Bhopal, & Brannen, 2001; Stanley, 2002).

There are a number of discrepancies or inconsistencies between informants in the reported outcomes, which merit consideration. For example, clinicians reported more positive outcomes than either the carers or the children; most carers found the service appropriate but just under half found it ineffective; although generally positive about the clinicians, carers reported that they were not sufficiently involved in decision making; and young people's reports in relation to perceived helpfulness were mixed. In addition to potential measurement issues, such as the frequent lack of agreement between informants in child mental health research, and the tools used as outcome measures (the HoNOSCA was predominantly designed as a clinical outcome measure, whilst the SDQ as a screening tool), the definition and perception of outcome is a key factor in working with looked after children. Clinicians are more likely to have reported 'narrow' symptomatic changes, whilst foster carers, young people are more likely to have included satisfaction or frustration related to the foster or school placement, or the overall care plan. This requires more detailed exploration in future research, for example, through qualitative interviews. It also indicates that the role and objectives of CAMHS involvement need to be defined and communicated clearly from the outset.

This study has a number of limitations. The relatively small sample meant that it was not possible to examine the effectiveness of specific interventions such as cognitive-behavioural brief psychodynamic therapy. Future trials of service effectiveness should include a comparison group from routine or alternative services. The clinical outcomes of this study should be broadened to include multi-agency outcome variables such as stability and quality of the placement, educational attainment, quality of relationships and rates of offending behaviours, which will reflect the child's care plan. Other questions that were not addressed were: the relative impact of other important factors, medium or long-term outcomes; costing of service input; in-depth perceptions of children, young people, their carers and other professionals involved; and evaluation of the other service components, i.e. consultation and training. These issues will need to be the focus of future research, as similar service models for looked after children evolve.

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**Appendix**

**Service Satisfaction Questionnaire: Young person's version**

What were the things that worried you or made you unhappy, that you hoped that X (psychologist / psychiatrist / PMHW) would be able to help you with?

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What did you and X do together to help you with the things that worried you?

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Did you feel this helped you?

Yes / No

Why do you feel this?

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Have things got better?

Yes / No

Why do you think things have / haven't got better?

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Could you tell me whether you agree with these statements about the things X and you did together? (be prepared to explain this, and to repeat instructions for each statement):

I knew that X was available if I wanted to talk to them.

SA    A    D    SD    Unsure

X listened carefully to me.

SA    A    D    SD    Unsure

X made different suggestions about things I could do that might help.

SA    A    D    SD    Unsure

X expressed him/herself clearly, and I understood the things they said to me.

SA    A        D        SD        Unsure

X included me in making decisions about what s/he would do.

SA    A        D        SD        Unsure

The suggestions X made were practical.

SA    A        D        SD        Unsure

I tried to do the things that X suggested.

SA    A        D        SD        Unsure

X was available if I needed to talk to them again later.

SA    A        D        SD        Unsure

The things that X and I talked about looked at my:

Feelings	
Behaviour	
Friendships	
Support from other people	
Family relationships	
Talking to other people	
The way I think about things	
Other	

Do you have any suggestions that might help the team develop a better service for young people in care?

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**Service Satisfaction Questionnaire: Adult version**

Could you tell me about the concerns you had that led to (young person's name) being referred to see (psychologist / psychiatrist's name)?

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What kind of service were you and (young person's name) offered?

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Did you feel this service was appropriate to your and (young person's name)'s needs?

Yes / No

Why do you feel this?

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Did you feel that the service that you were offered was effective in dealing with the young person's needs?

Yes / No

Why do you feel this?

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Have things improved since the service became involved?

Yes / No

Why do you think this is the case?

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Please indicate whether you agree with the following statements:

X (the psychologist / psychiatrist / PMHW) was accessible for consultation? (clarify the concept of accessibility if needed).

SA    A    D    SD    Unsure

X listened carefully to my concerns.

SA    A    D    SD    Unsure

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X discussed a range of interventions with me, making different suggestions about things we could do to help.

SA    A    D    SD    Unsure

X expressed themselves clearly.

SA    A    D    SD    Unsure

X included me in making decisions about (the young person).

SA    A    D    SD    Unsure

The interventions X suggested were practical.

SA    A    D    SD    Unsure

I implemented the suggestions that X made.

SA    A    D    SD    Unsure

I learned new mental health skills.

SA    A    D    SD    Unsure

I feel I could apply those new skills with other young people.

SA    A    D    SD    Unsure

X was available for follow-up discussions.

SA    A    D    SD    Unsure

The interventions that X suggested targeted (tick as many as apply):

Emotions	
Behaviour	
Social Skills	
Social Support	
Family relationships	
Communication	
Cognitions	
Other	

Do you have any suggestions that might help the team develop a better service for young people in care?

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