

# Support for Change

## Approaches and models for the development of provision for children and young people's mental health 2008

### Chapter 8

#### Models and approaches for development: Children who are looked after and accommodated



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## 8. Models and Approaches for Development: Children who are Looked After and Accommodated

**Table 8.1 The Mental Health of Children and Young People: a Framework for Promotion, Prevention and Care: summary of core sections that relate to children who are LAAC**

Service elements	Selected examples of activities required	Relevant outcomes
Proactive multi-agency liaison to establish specific local policies and procedures to identify and support those in need of additional or specific emotional support in a range of contexts	Multi-agency local needs assessment Joint planning and commissioning Integrated assessment, care planning, service delivery and review	Mental health promotion is integral to policies, procedures and practice Clear pathways to NHS CAMH services Integrated delivery of support services
Provision of general training, consultation and support on the emotional and mental health needs in particular groups for: <ul style="list-style-type: none"> <li>Residential care workers</li> <li>Foster carers</li> <li>LAC Designated Teachers</li> <li>Adoptive parents</li> <li>Adoption Panel members</li> <li>Foster Panel members</li> </ul>	Partner agencies review and address training needs of those working with LAAC children Explicit arrangements in place in each NHS CAMH team to address LAAC mental health in all care settings / sectors Explicit arrangements in place to ensure support and supervision of staff working with children with additional support needs	Carers have a basic understanding of mental health and child development and how they can contribute  Carers know how to access specialist help and advice
Provision of training and consultation on specific mental health issues (e.g. aggressive behaviour, self-harm) for: <ul style="list-style-type: none"> <li>Residential care workers</li> <li>Foster carers</li> <li>LAC Designated Teachers</li> <li>Adoptive parents</li> <li>Adoption Panel members</li> <li>Foster Panel members</li> </ul>	NHS CAMH staff work with partners to ensure provision of topic specific training for staff	Carers able to understand child behaviour Carers are confident and supported in implementing approaches to address behavioural issues
Accessible and confidential support for looked after and accommodated children and young people, those adopted from care, and those who have been abused	Provision of one to one counselling support Development and implementation of anti-bullying policies	Children who are LAAC: <ul style="list-style-type: none"> <li>Have access to opportunities to talk in confidence</li> <li>Feel safer</li> </ul>

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

Interagency communication about assessment, action planning and reviews for children and young people with complex needs	Information sharing protocols in place Children have appropriate information about assessment, planning review and about sources of support	Child's needs understood by all involved Services received are experienced as holistic and seamless
CAMH liaison with services for looked after and accommodated children and young people	Planning and commissioning ensure CAMH services are accessible and acceptable for children who are LAAC	Mental health needs of children in local authority care are identified and addressed

### 8.1 Key themes affecting development and implementation

#### 8.1.1 Level and nature of mental health need among children who are LAAC

The latest available data indicate that at 31<sup>st</sup> March 2006, 12,966 children were looked after by local authorities, an increase of 5% on the figures for 2005.

The proportion of children in Scotland who are looked after and accommodated now stands at 1.16% of the child population, the highest since 1982. Children in kinship care account for 56% of the overall LAAC population. Thirteen per cent are in residential accommodation. In 2005 – 06, 2,800 young people were reported to be entitled to local authority aftercare support (although these data are not complete). Local authorities had lost contact with 15% of these young people (Scottish Executive, 2006).

Of the 7,460 children looked after away from home, 29% have had three or more placements during their current period of being looked after. Fifty-four per cent had been looked after for two years or more, 22% for 5 years or more.

Research illustrates the poor health, educational and social outcomes for many young people who have been looked after and accommodated (Kidner, 2005; Scott et al 2006).

There are higher levels of mental health problems among this group, compared to peers who are not LAAC (Meltzer et al, 2004). It is important to recognise that mental health problems are just as prevalent among those who are looked after and living at home with their families as among those who are in foster care or residential care. Reasons for poor mental health are likely to include: quality of and consistency of parenting, exposure to abuse, trauma, loss, bereavement and illness, environmental and material disadvantage, exclusion and poverty.

However we need to understand better the nature of the mental health problems experienced by children and young people who are LAAC. From a public health perspective, the factors that lead to a child becoming LAAC combined with the experience of being LAAC have major implications for the current and future mental health and wellbeing of a child or young person. This reinforces the case for maintaining a focus on the whole LAAC population to encompass the promotion of mental health and wellbeing, the prevention of mental problems and the provision of treatment, care and support when required.

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

Where children require treatment and care, experience indicates that therapeutic work with LAAC population is not adequately delivered through 'standard' CAMH arrangements. This is in part a question of how services are organised and resources allocated, for example waiting times from referral to assessment and the fact that services may be provided in clinical settings that are perceived as stigmatising by children and young people (Health Scotland, 2006). However it also stems more fundamentally from the conceptual frameworks on which services are constructed (Scottish Development Centre for Mental Health, 2006).

The manifestations of poor mental health in children who are LAAC are complex and variable and do not constitute a readily definable set of symptoms. For this group of children, the appropriate starting point may not centre on establishing a diagnosis using categorical models of disorder but may emerge from concerns elicited by the child's behaviour. Experienced practitioners suggest that it is more useful with this population to work with concepts of change, trauma, resilience, loss and attachment and to take an ecological view of the presenting behaviour. These are significant considerations in relation to the types of service models and interventions that are likely to be useful in addressing LAAC mental health.

### **8.1.2 Drivers for development: key issues that service systems need to address**

#### National policy drivers

National policy provides a supportive framework and a set of levers that can support local development. Getting it right for Every Child establishes common parameters for multi-agency working, emphasising on corporate parenting responsibilities. GIRFEC also implies that partners articulate the rationale and values underpinning actions and interventions and this can be effective in fostering common understanding of purpose and roles.

Additional Support for Learning legislation affords opportunities for greater engagement by Education with the NHS and with Social Work to work together on achieving better outcomes for children who are LAAC.

The Extraordinary Lives review of care for children who are looked after and or / accommodated identified six key messages:

- Looked after children can overcome adversity in childhood and lead successful adult lives
- Too many adults have low expectations of what looked after children can achieve. Children and young people can do well when they are cared for
- Relationships with skilled adults can help looked after children and young people develop successfully
- Children and young people looked after away from home need stability and the chance to put down roots. Being moved frequently from one care setting to another is damaging and often restricts their access to education and health care

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

- Tackling the disadvantage and discrimination still experienced by many looked after children requires planning at every level in a local authority and between them and their partners in delivering children's services. Champions are needed to make sure that local authorities and their partners provide the best possible care
- Developing an understanding of what children and young people think about services intended to help them supports effective engagement and long-term service planning

The review states that looked after children and young people can have poorer health than their peers and therefore achieving and maintaining good health is a priority for them and their carers. To this end it is recommended that details about a child's health are fully recorded and the information passed quickly to new carers if a child moves placement. Care providers should recognise the increased risk of self-harming and know where to get help and be aware of the increased likelihood that some looked after children and young people may develop mental health problems, in which case medical help should be sought at an early stage.

The review highlights the importance of coordinating local services to help looked after children and young people get the best possible health care. Services have a responsibility to ensure that looked after children get the opportunity to take part in consultations about health delivery (SWIA, 2006).

Research carried out by the SNAP working group surveyed the experiences of a wide range of professionals working with children, young people and families and identified some key concerns among the residential care workforce.

These included the high perceived need for training on mental health, better access to advice and support to enable them to care appropriately for children and young people in distress and the need for specialist services to be more flexible to provide 'outreach' support to fit the context in which the child is being supported (Health Scotland, 2006).

The recent Ministerial Task Force on health inequalities makes a recommendation that all NHS Boards should assess the physical emotional and mental health needs of children who are looked after and act on that assessment with their local partners, to ensure that health services are more accessible to looked after children and to young people moving on from care to independence (Scottish Government, 2008).

### Achieving improved outcomes

Research to investigate features that contribute to good quality residential care has tended to come to the conclusion that it is simplistic to pinpoint specific aspects of a particular service in isolation from the wider care system, the complex social and familiar factors that shape the course of a child's life and wider cultural expectations and influences. What appears to be important is the recognition that 'everything counts': structures, relationships, the physical environment, interventions, access to specialist resources, access to family and community supports (Clough et al, 2006).

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

### Service system issues

The material gathered in the course of the Support for Change project from local areas and reviewed in the literature indicates the following to be among the major issues that service systems need to address to ensure adequate responses to meet LAAC mental health needs:

- Awareness and understanding among decision makers and care providers of the importance of mental health and wellbeing, likely influences on the mental health of children who are LAAC and steps that can be taken to improve outcomes
- Capacity to support young people in their care settings by creating therapeutic, mental health promoting environments, in order to encourage permanence and maximise stability and continuity through crises
- Accessibility of mental health expertise when required, along with 'stickability' and continuity of services
- Co-ordination of roles and responsibilities – critical in view of the complexity of the issues young people face and the multiple sectors and agencies likely to be involved across the service system. This includes ensuring effective links with CAMH specialist services
- Involvement of young people and families

The views of young people who have been LAAC provide further useful pointers to guide service and practice development which have direct relevance for mental health work. Sources indicate that children and young people identify the following features of the care they received as critical in enabling them to achieve good outcomes:

- Having people who care about you
  - Experiencing stability
  - Being enabled to have high expectations
  - Receiving encouragement and support
  - Being able to participate and achieve
- (Happer et al, 2006)

Below we consider these issues in more depth to explore the implications for the development.

### **8.1.3 Strategic attention to LAAC mental health**

There are inherent tensions between the need to cope with and respond to the immediate mental health needs of the current LAAC population and the need to take a longer term strategic focus on achieving potentially more lasting solutions. The latter requires action to support families, facilitate early intervention, prevent family or placement breakdown, and enable children to receive care within an area, as far as possible. Taking steps actively to address mental health needs can make a significant contribution towards achieving the longer term health, social and economic outcomes desired for this group.

In developing local capacity to address the mental health needs of the LAAC population, it may be useful therefore to distinguish between:

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

- Short term goals: to bridge gaps between services, build confidence and capability in service systems to support the mental health needs of young people who are LAAC and enable existing care services to promote mental health and create therapeutic environments
- Long term goals: to bring about culture change in how we support children, young people and families, with greater prioritisation given to early intervention, participation, parenting support

### 8.1.4 Developing a dedicated resource for LAAC mental health

Whilst the long term vision may be to 'mainstream' mental health as a core part of the work of Residential Units (RUs), foster care services and CAMH services, for the foreseeable future the need remains for transitional investment in service models such as those developed in Lanarkshire, Edinburgh, Fife and Greater Glasgow.

These services share common goals to:

- raise awareness of the mental health needs of children who are LAAC
- build capacity within care settings to respond to needs and to engender a mental health promoting care environment
- provide a bridge between CAMH specialist services and foster care and residential care
- enable clear communication and information sharing among care providers
- inform planning and strategic development

#### ***Examples: factors that shaped the development of LAAC mental health services***

##### Funding

Availability of funding streams through development monies provided opportunity to develop resources to meet identified need among LAAC, where there had not been means to do so previously. In one NHS area the Changing Children Services Funds provided a lever to ensure that LAAC mental health featured higher on the local authorities' planning agenda through the main strategy group.

Tight resources meant case study examples had to make hard decisions about staging developments and selecting where to focus:

In one area the decision was made to focus on accommodated young people only in the hope that this work could be expanded over time. As the service demonstrated its worth and effectiveness, it is recognised that further resources need to be identified to cover children who are looked after, and those placed out of area F2.

In a second area, the service started with a limited focus on 2 RUs in each of the 2 Las and then broadened out to all RUs as service became established and developed its operational model. This service is now looking to expand to cover foster care as well as residential care (L1).

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

### Multi-agency working

In one area a multi-agency approach was taken from the outset, starting from local work to assess needs and working together on defining the model required. It had proved valuable to find ways to tap into local ideas, energy and partnership arrangements, using national policy such as the Framework, as a wider point of reference (F3).

In another area, earlier work on LAAC mental health needs assessment enabled partners to make use of development monies for a first stage initiative which entailed the appointment of a singleton worker. This experience demonstrated the limitations of a separate local authority service that lacked strong links with local CAMH services and illustrated the importance of appropriate support and monitoring and of being able to set clear boundaries. These lessons informed a successful subsequent bid developed by the CAMH specialist services and the Child Health Commissioner for funding from CCSF. ( L1).

### ***Examples: service rationale***

A common feature of various LAAC mental health services is the incorporation of several levels of provision within a tiered model that encompasses direct work with children and young people, training and consultation. The adoption of this approach has been driven by a number of factors:

Resource considerations, in order to make optimum use of specialist mental health expertise.

A recognition of the fact that front line care staff and foster carers need to be equipped to deal with crises and challenges in situ as they arise – which can be at 2 a.m. Therefore supporting care staff and building capability and confidence are critical.

To enable residential and foster carers to understand what may lie behind the presenting behavioural problems that can be difficult to manage. This might entail for example looking at the wider context, the child's history, early attachments, current relationships.

Experience that indicates that children and young people who are LAAC tend not to engage readily with conventional appointment systems as operated by many CAMH services and the consequent need to find other means of engaging effectively with those who require assessment and treatment.

There is, however, no blue print to determine the optimum configuration of a mental health LAAC resource or to determine the optimum scale or scope of such a resource. The primary aims of a service and the allocation of roles and responsibilities will vary from one local context to another depending on local service configuration and how skills and resources are deployed. It is important to note that the Framework talks of intelligent networks that operate organically not rigidly, and are shaped by a shared responsibility for LAAC mental health and an understanding of what constitutes a mental health problem that requires urgent attention.

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

### 8.1.5 Structures and relationships

The breadth and complexity of the service systems that have shared and specific responsibilities for children who are LAAC – health services (including primary care and CAMH services), health improvement, child and family social work services, education, youth justice, drug and alcohol services - requires clear delineation of roles in respect of mental health.

Operational management of the LAAC mental health services identified generally sits in the NHS, with the locus of interventions taking place in local authority settings and services. This creates complex relationships in terms of accountability and challenges in working with dual systems, but can ensure that the service has strong links into health and care. Joint services can face problems in getting access to both NHS and SW systems (databases) but experience demonstrates that these issues can be resolved (F1).

Practitioners observe a fundamental difference in culture between CAMH services and local authority services in relation to the pace of work and decision making criteria.

These differences may lead to outcomes which do not always reflect the best interests of the young person concerned. The impact on the young person's mental health and wellbeing of care planning and placement decisions, including after-care, arrangements is an area that warrants greater attention. (Wp2)

#### ***Examples: forging links***

##### Strategic links

In several areas, the Steering Group for the LAAC service includes senior representation from NHS, Social Work and Education and the voluntary sector. This has helped engender shared ownership not only of the service but of the mental health agenda as it relates to children who are LAAC.

The LAAC mental health service can provide a valuable mental health perspective on other areas of strategic development, such as LAAC health improvement, or reviews of care provision.

##### Operational links

###### *Social work services*

Established LAAC mental health services have found that social work membership of the team brings access to through and after care services as well as to adult social work.

Continuing efforts have been required to maintain the profile of the service and to keep attention focused on mental health within the care system. Service managers and unit managers are key allies in shaping the expectations of front line care staff and encouraging the uptake of training provision and consultation support.

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

Working across more than one local authority requires considerable adaptability and flexibility. One LAAC mental health service has developed distinctive ways of working with each of its local authorities to provide customised training and consultation, although joint operational discussions are held.

### *Residential care services*

Regular meetings with RU managers provide a means to identify and resolve issues.

Some LAAC mental health services have established formal mechanisms to engage with RUs e.g. scheduled consultation meetings, designated staff with a liaison role, written specification of mutual expectations and responsibilities.

### *CAMH specialist services*

Structural relationships between LAAC mental health services and CAMH specialist services are likely to be influenced by historical factors, service priorities, local service configuration and roles and responsibilities. Whatever the nature of local arrangements the key elements required are to ensure:

- Clear and agreed criteria and pathways for assessment, treatment and review where required, including for emergency and crisis situations
- Agreement on roles and responsibilities and accountability, including joint working on individual cases where indicated
- Opportunity for specialist CAMH services to feed into training of care staff where appropriate

In one area, the LAAC mental health services team is effectively a sub speciality of the CAMH team. This has proved useful in facilitating access to psychiatric assessment and enabling joint working on individual cases.

In another area, the LAAC mental health service has sessional input from a psychiatrist from the CAMH service.

In a third area the LAAC mental health has a close working relationship with the CAMH service. The two services share the same premises and some staff straddle both CAMH team and LAAC team.

In several areas the CAMH service provides input to the LAAC training programmes for care staff.

### *Other service provision*

There are certain elements of the care system which LAAC mental health services are less able to reach, with consequences for equity of provision. Services are not currently able to work readily with out of area placement providers which include specialist care providers and residential schools.

One LAAC mental health service is actively looking to extend the services it offers to local private sector care providers.

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

### 8.1.6 Pathways

#### Access and referral to mental health expertise

Some LAAC mental health projects have focused specifically on providing direct support to children and young people, for example the LEAP service in Ayrshire that offered counselling support (Milligan, 2004). However, most combine direct work with training and consultation functions, in differing proportions.

Experience indicates that the preferred approach is to operate on the principle of universality rather than selectivity i.e. not to screen for 'mental disorders', in view of the high level of mental health problems likely to be present among this group of children. This has proved effective where the LAAC mental health service can both act as a resource to support the wider care system, including front line care staff and foster carers, in working with the child and can also undertake direct work with a smaller number of young people.

#### ***Examples: access routes to mental health expertise***

One area expanded the referral pathways to the LAAC mental health service to accept referrals from link workers and residential unit managers, as well as from child and family social workers.

A number of services took the decision to extend the age range to cover all children and young people who are LAAC and not to cut off at 16 years.

A variety of arrangements have been developed to assure access to CAMH specialist services as outlined above.

#### Through and after care

Commonly, services are not geared to sustain attention on the mental health needs of young people as they move on from care. Indeed it was noted that much of the focus of care planning tends to be on practical requirements needed to support independent living with less attention to emotional and psychosocial needs.

Many care leavers would not be eligible for a mental health service when they reach adulthood, but for those who require further support, the service transitions can present barriers. LAAC mental health services tend to work holistically. Adult services tend to be locality based and specialised in function, posing challenges for those with complex support needs.

### 8.1.7 Building capacity and capability to address mental health needs in care settings

Establishing a common conceptual framework to understand the mental health issues of the LAAC population has proved to be an important foundation for local development. The training programmes and case consultation offered by the LAAC mental health services have helped shape this shared understanding and have reinforced its operationalisation in practice across the care system.

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

This approach has enabled LAAC mental health services to build confidence and competence in addressing needs within care settings from a perspective that recognises the importance of promotion and prevention and does not only respond to presenting problems and crises that arise. In addition this has provided a means for care staff to gain a deeper understanding of the factors that contribute to a child's behaviour and of the impact of the care environment in promoting mental health and wellbeing.

### ***Examples: building capacity and capability within the care system***

#### Example 1

In one area the service offered is as follows:

- Direct therapeutic work with children and young people constitutes about 50% of the workload. Around 40% of the direct work involves longer term case work of at least six months duration
- Training for RU staff, tailored to needs. This includes specialist training on dealing with extreme behaviour
- Training for foster carers to enable foster carers to support individual children. This includes training for new foster carers
- Expertise is brought into the training programmes as required from CAMH specialist team progs
- Consultation work provides carers with a chance to talk about an issue or an individual child and to consider what support the carer / the child needs

Managers in this service stress the importance of robust governance arrangements. Here, an early decision was taken to separate service management and clinical leadership responsibilities and this is perceived to have been critical in enabling the service to function efficiently and effectively.

#### Example 2

In this service:

- The bulk of the work is consultation with residential care units
- Direct work accounts for the second main element
- Training is offered as part of the core training programme for residential staff. This comprises a nine week programme of three-hour sessions, which is run once a year
- When resources are available the service would like to develop a second level of training to cover issues in more depth or in more specialised topics

The LAAC mental health team takes part in care planning and review meetings and in educational support planning. The team meets twice a year with RU service managers and social work managers to identify and address emerging issues.

Resource constraints mean that foster care is not covered by the service.

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

### Example 3

In this service:

- The main building block of this service is consultation work with RUs. Structures have been established to embed this as part of the routine practice of RUs
- Designated members of the LAAC mental health team are assigned to work with each RU. Each unit also appoints a member of its care staff to act as a mental health link worker
- Consultation meetings are regularly scheduled with each unit, every four weeks. Two levels of consultation are offered allowing for more in-depth, follow-on consultations with key workers where required. The service is also available to RU staff outwith consultation meetings, to offer telephone advice
- Foster carers are offered a consultation service

Training is offered on a flexible basis as requested. The service has also developed a resource bank of tools and materials that can be accessed by care staff.

The service works individually with young people in the residential units. This remains a relatively small element of the team's work.

### **8.1.8 Sustainability and impact**

As stated above the combination of functions enables the LAAC mental health services to develop capacity within local service systems in order to enhance longer term sustainability.

Services have purposively planned their interventions with this in mind:

- Training has been designed to maximise reach by building this into core training
- Formal link roles have been designated to enhance liaison between RUs and the mental health service
- One area implemented a cascade model of training that enables first wave of participating RUs to deliver training and support to peers in other units
- Services have worked closely with RU service managers and social worker managers to maintain effective working relationships and address emerging issues

Notwithstanding the difficulties attendant on the measurement of impact of interventions that seek to achieve change within a complex service system, several independent evaluations by SIRCC, SDC and others show promising results. Findings suggest that these types of dedicated LAAC mental health services can achieve gains in addressing problems inherent in the service system. There is evidence that:

## SUPPORT FOR CHANGE

Approaches and models for the development of provision for children and young people's mental health

- Levels of awareness, understanding and confidence in RC staff can be improved and that foster carers find the support valuable
- More attention is being given to the mental health needs of this population
- More children who are LAAC gain access to assessment and support for mental health needs

In addition these services show signs of making a significant contribution to changing cultures in residential care by promoting positive practice in addressing young people's presenting and more long standing problems.

## 8.2 Key learning points for development and implementation

### 8.2.1 Vision and leadership

Strong leadership across agencies is essential to achieve the long term shifts required to achieve stability and continuity of care settings for children who become LAAC.

### 8.2.2 Creating care environments that address children's mental health needs

To ensure systems of care are able to respond to the nature and the scale of mental health needs among the LAAC population requires the facility to undertake a mix of direct and indirect work. This helps build capacity and reinforces the primary role of care givers in promoting the mental health of the child; and ensures maximal coverage.

Practitioners and managers find it valuable to have a multi-agency forum / mechanism to share information and experience on service models and practice, although this opportunity is generally lacking at present.

#### Consultation

The provision of consultation support to care givers in residential and foster care is a valued resource. Experience suggests that this requires a great deal of ground work and relationship building to operate effectively but with perseverance it can enrich individual care and the care environment and can contribute to care planning and review.

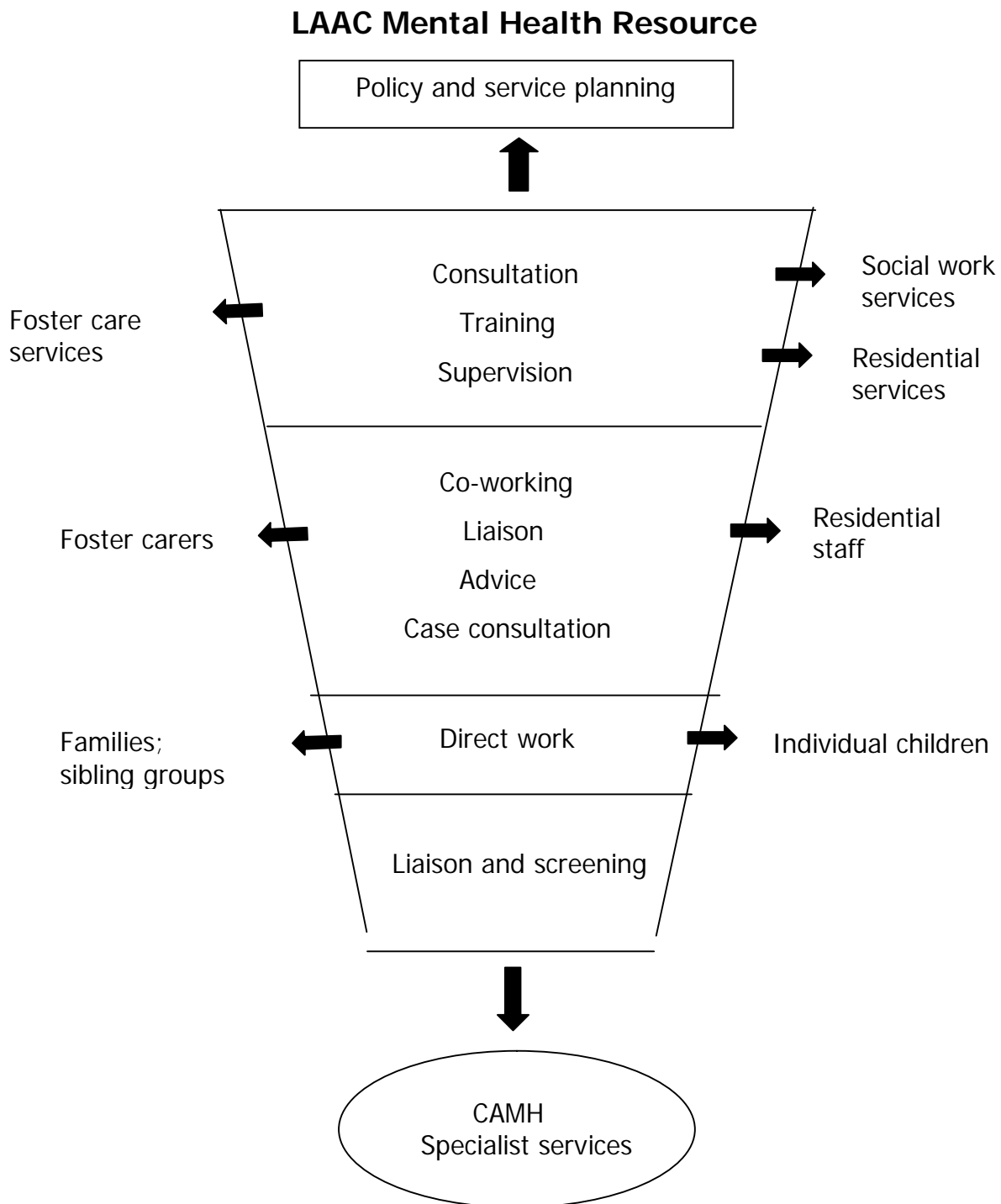
#### Access to mental health assessment and treatment

In relation to direct work with children who are LAAC, there is a need to consider how mental health services can become more accessible and acceptable. This may need resource-intensive interventions to support young people to use services, possibly learning from some of the approaches developed by youth justice.

In relation to specific mental health interventions, further research and development is required to build on what looks to be promising e.g. multi-systemic therapies. There is also a need to gain a better shared understand of what should constitute priority for more intensive interventions, e.g. where a foster care placement is at risk of breakdown.

Figure 8.1 shows a model of how a dedicated resource of mental health expertise can serve a range of functions in supporting the service system to achieve better outcomes. Table 8.2 provides a representation of levels and intensity of intervention and the roles of services in delivery of care, support and treatment.

**Figure 8.1: Model of Mental Health Resource for Children and Young People who are Looked After and Accommodated**



### **8.2.3 Planning and development**

#### Groundwork

The importance has been demonstrated in the case studies examined of investing time and effort in raising awareness of mental health needs and in developing agreement on approaches, structures and relationships.

This development work needs to understand and work with the differences in service cultures. Residential services may be reluctant to engage with an external service seen as 'expert' although there is an established tradition in residential care of using consultation. A shared focus on the child's wellbeing can help establish common ground. The LAAC mental health service can then be viewed as a resource for care providers seeking to address mental health issues.

#### Funding

Funding for LAAC mental health initiatives has often been insecure, despite the volume of need, evidence of unmet need and the inequalities experienced by this population. The practice of funding LAAC mental health developments from CCSF sources that have subsequently been mainstreamed into SW budgets has left uncertainty in some areas about the role and contribution of the NHS.

#### Structural issues

Different responsibilities of NHS and LA vis a vis local populations affect provision for children who are LAAC: the NHS has responsibilities for all those resident in its area; a local authority has responsibilities to all those children whose placements the authority funds.

Responsibilities for children placed out of area need to be reviewed to ensure equity in terms of access to support with mental health issues, in particular for those in placements in residential schools or secure provision. This may be an area where national guidance would be useful.

#### Participation and involvement of young people

Although there has been considerable investment in enabling young people involved with a care system to have a stronger voice, levels of involvement in specific mental health initiatives for those who are LAAC remain relatively low and require development. Recent evaluations provide one, albeit limited, opportunity for views of young people to be expressed. Some LAAC mental health services have also involved young people in designing information about the services offered

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Approaches and models for the development of provision for children and young people's mental health

**Table 8.3: LAAC mental health**

Level of service	Activity / intervention	Delivered by
<p><b>Universal services (Tier 0-1)</b></p>	<p>Mental health promotion in care, education and health care settings</p> <p>Information, support, training and awareness raising for:</p> <ul style="list-style-type: none"> <li>• care staff and foster carers</li> <li>• service managers and planners</li> </ul> <p>Input to service planning and development</p>	<p>Care staff and foster carers, education staff</p> <p>Mental health promotion services LAAC mental health service</p>
<p><b>Additional support (Tier2)</b></p>	<p>Short term interventions and support for children, young people and carers</p> <p>Training in specific mental health issues for front-line staff</p> <p>Consultation and liaison with education, CAMH services, drug and alcohol services etc</p> <p>Co-working</p> <p>Input to care planning and review</p> <p>Assessment and referral</p>	<p>Care staff</p> <p>LAAC mental health services</p>
<p><b>Intensive support (Tier 3- 4)</b></p>	<p>Therapeutic interventions to address</p>	<p>LAAC mental health services CAMH services</p>

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Approaches and models for the development of provision for children and young people's mental health

### Case study profile: LAAC

#### Area A

##### Origins

Established in 2006

##### Staffing

- Project co-ordinator (Senior Social Worker)
- Project secretary (50% WTE)
- Sessional clinical input:
  - Lead clinician: child and adolescent psychotherapist (0.4 WTE)
  - Clinical child and adolescent psychologist (0.4 WTE sessions per week)
  - Senior OT input (qualified play therapist) (0.2 WTE)
  - Art therapist (0.5 WTE)
  - Child psychology student

##### Interventions

Direct work with children accounts for 50% of workload. Team has capability to offer range of therapeutic interventions.

Training offered to foster carers and residential care staff. Services liaises with family placement service to ensure training is tailored.

In first 12 months of operation the service provided:

- training to around 53% of RU care staff and to 46% of foster carers. All unit managers have been trained
- support (both direct and indirect) to 20% of accommodated children in RUs in the area
- support to 27% of LA foster carers

Developments desired / planned

Mental health screening for all LAAC children young people: tools currently in development

Extension of training to private sector care providers

#### Area B

##### Origins

Established in 2005. Grew out of an initiative that created a singleton mental health post based in local authority to work with children who were LAAC. Developed with renewed funding opportunities into a multi disciplinary team that is a sub speciality of the CAMH service.

Funding : originally through CCSF. More recently one of the two LAs has agreed to mainstream funding.

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Approaches and models for the development of provision for children and young people's mental health

### Staffing

- Clinical team manager
- Counselling psychologist (WTE)
- Clinical psychologist (50% WTE)
- Mental health clinician (WTE)

### Interventions

Provides a service to all 15 RUs in two local authorities

- Direct clinical work
- Consultation with RU staff
- Annually run training programme for RU staff

### Developments desired / planned

Extend coverage to foster care

Extend training programme

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Approaches and models for the development of provision for children and young people's mental health

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