

Mental health of looked after children

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Abstract Looked after children are disadvantaged with regard to their mental and physical health and education. Research is limited on this population, but dramatic findings prompted the Government to produce a number of guidance and policy documents over the past 5 years. This paper discusses the available research and highlights the problems that looked after children face. The new policy initiatives are listed, along with a number of obstacles to be overcome if the care of these young people is to be improved.

'Looked after' is the term introduced by the Department of Health (1989) to describe all children in public care, including those in foster or residential homes and those still with their own parents but subject to care orders.

It was estimated that there were 58 900 looked after children at 31 March 2001 in England. This represented 52 per 10 000 children under 18 years of age. Fifty-five per cent of these were boys and 43% were under 10 years of age (Department of Health, 2001a).

The number of looked after children has increased in recent years. The number under care orders has risen by a quarter since 1997, to an estimated 37 800 at 31 March 2001. Sixty-five per cent of these children are in foster placements. Over the same period, the number cared for in children's homes (including secure units) increased to 6400 and the number placed with parents to 6900. The number adopted during 2000–2001 rose to 3100. Between 31 March 2000 and 31 March 2001, the largest increase in looked after children was in the under-1-year-olds, up by 5.2% (Department of Health, 2001a).

Information about ethnicity was collected for the first time in 2000. The ethnic origin of children in public care at 31 March 2001 can be seen in Box 1.

In England, looked after children enter care at a variety of ages and remain in care for varying lengths of time. Nearly 40% return home after less than 8 weeks, more than half will have gone home within 6 months and 70% within 1 year (Department of Health, 2000). However, many children and young people stay longer. For example at 31 March 1999, 28 000 children had been in care for more than 2 years and nearly 12 000 had been in care for 5 years or more (Department of Health, 2000).

Box 1 Children in public care at 31 March 1999: breakdown by ethnic origin

White (82%)
Black or Black British (7%)
Mixed (6%)
Asian or Asian British (2%)
Other ethnic groups (3%)
(Department of Health, 2001a)

Outcomes for young people leaving care

Young people experience high levels of social disadvantage, ill health and risk-taking behaviours after leaving care. Fifty per cent will be unemployed on leaving care and 20% will experience some kind of homelessness within 2 years (Biehal *et al*, 1995; Broad, 1998). A Department of Health (1999) report stated that a further 25–30% of young women leaving care are teenage parents and 25% have some kind of disability. A small study ($n = 48$) of care leavers, who were mainly female, reported that eight had long-term mental illnesses or disorders including depression, eating disorders and phobias (Saunders & Broad, 1997). Seventeen (35%) had engaged in deliberate self-harm since the age of 15, 29 (60%) had thought about taking their own life and 4 out of 10 had actually tried. Sixteen (31%) had referred themselves for mental health problems, of whom 12 (77%) did not find the service useful.

The statistics for the educational outcomes for care leavers are equally alarming. One study, conducted about 10 years ago, found that about three-quarters

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of care leavers complete their schooling with no formal qualifications (Garrett, 1992). Although recent figures (Department of Health, 2001b) suggest that this has improved, with 37% gaining at least one GCSE or GNVQ, these young people's school performance still compares poorly with that of the general population, 94% of whom attain at least one GCSE or GNVQ. Between 12 and 19% of care leavers go on to further education, compared with 68% of the general population (Biehal *et al*, 1995).

The Social Exclusion Unit (1998) reports that 'the permanent exclusion rate among children in care is 10 times higher than the average and as many as 30% of children in care are out of mainstream education through exclusion or truancy'. Reasons for the high level of exclusion include: the absence of an adult consistently to advocate for them in contacts with education services; difficulties in concentrating at school because of problems at home; and possibly stigmatisation by pupils and teachers. Also, many young people experience large gaps in schooling while their placements are set up. It has been reported that two out of three children who move to a foster home change school and that 80% of looked after children whose placements break down change school again. These moves lead to problems in coping with curriculum changes owing to the number of different schools attended (Morgan, 1999).

As regards crime, a Social Services Inspectorate's report (1997) found that 23% of adult prisoners and 38% of young prisoners had been in care. According to Hagell & Newburn (1994), the children identified in their study as 'persistent' offenders had higher rates of contact with social services and were more likely to have come to the attention of a social services department through supervision orders or to have been accommodated compulsorily.

Research limitations

There has been little research published about this group of vulnerable young people. A number of factors (summarised in Box 2) contribute to this.

Box 2 Summary of the limitations of research into looked after children

Many of the young people have had numerous placements
Health and social care professionals have used different terminology in the past
Systems of data collection have been poor
There are complex reasons why children enter the care system

Looked after children have always been a difficult group to study. Frequent changes of placement and changes in social worker, poor school attendance and mistrust of initiatives by the young people themselves present significant challenges to researchers. Research that addresses both health and social care is also hampered by the different use of language between these sectors. The social services' data collection systems have only recently been improved to include important data items such as ethnic group and reasons why a child is coming into the care system.

The problems experienced by looked after children may arise from a combination of interrelated causes. This makes the evaluation of outcomes of care, and relating this to their mental health, a complex process. It is very hard to disentangle the effects of family, social and environmental factors when trying to measure the impact of the care that these children and young people receive.

There is very little research relating to specific mental health problems in looked after children in the UK. However, studies in the USA have looked at the utilisation of mental health services by this population (Halfon *et al*, 1992). We will not discuss the US studies here, owing to the differences in treatment and service provisions between the USA and the UK.

The sample sizes of the research studies that have been conducted are relatively small. No longitudinal studies have examined the mental health issues of this population. A few, however, have studied the effect of adoption and fostering on the well-being of children and young people in the UK (Triseliotis, 1983; Minty, 1999). These outcomes do not specifically relate to mental health problems, although they do provide important information.

Very few studies conducted in the UK have looked specifically at the types and prevalence of mental health problems in looked after children and young people. Koprowska & Stein (2000) suggest the need for longitudinal studies to inform policy and practice. They highlight the fact that we currently do not know how many children in care are referred to child and adolescent mental health services, how many go on to enter the adult mental health services and how many suffer major mental disorders in later life.

Mental health research

'Looked after children especially those in residential care are identified as a group whose mental health needs are known to be greater than those of the general population of the same age' (Utting *et al*, 1997). This statement was made in response to a

study by McCann *et al* (1996) that systematically examined the psychiatric disorders of adolescents being looked after by local authorities in England. The study examined the prevalence and types of psychiatric disorder of all adolescents aged between 13 and 17 years in the care of the Oxfordshire local authority. The total weighted prevalence rate of psychiatric disorder for this group was 67%: 96% of adolescents in residential units and 57% in foster care had psychiatric disorders. The prevalence of psychiatric disorder in the comparison group was 15%. The most common diagnosis among adolescents in care was conduct disorder (28%), followed by overanxious disorder (26%). Twenty-three per cent suffered from major depressive disorder, compared with 4% of controls, and 8% were diagnosed as having unspecified functional psychosis. McCann *et al* (1996) noted that these adolescents showed high levels of comorbidity, reflecting the complexities of their difficulties, and also that a significant number were suffering from severe, potentially treatable disorders that had gone undetected. Kaprowska & Stein (2000) noted that McCann *et al* did not state whether any of the young people in their study were attending psychiatric or psychological services at that time.

McCann *et al* (1996) examined the prevalence of mental health disorders in adolescents who had been in care for 2.9 years on average. In contrast, Dimigen *et al* (1999) sought information about the mental health of children at the time they entered local authority care. During the study period, 89 children attended for health assessment within 6 weeks of admission into care. An accompanying carer completed a questionnaire for 70 of the children: 36 girls and 34 boys. Twenty-six of these children were in residential units and 44 were taken into foster care. Their mean age was 9.6 years. The most common disorders among this group were conduct disorder and depression. Thirteen boys and 12 girls showed severe conduct disorder. A higher proportion of the children in residential establishments had severe depression than was the case for children in foster care. Of the 70 children, 21 had severe attention difficulties and 18 had autistic-like detachment; 15 had very elevated levels (more than two standard deviations above the mean) of acute problems and 11 had anxiety disorders. Comorbidity was found in over a third of the children. Dimigen *et al* concluded that these results highlighted a serious problem of unmet need, because many of these children entering the care system with a serious psychiatric disorder had not been referred for psychological help.

A study of social workers' views about the mental health needs of a sample of foster children appeared to confirm this (Phillips, 1997). Eighty per cent of

the children were considered by social workers to require treatment from a child mental health professional, but only 27% had received any input. The reasons given in the study for not referring for treatment were placement instability, inadequate child mental health resources and insufficient local authority funding.

A mental health service specifically for children in care was established in Birmingham in 1995. It aims to provide assessment and brief psychosocial interventions as well as diversion to longer-term services. It also provides support and advice for staff and families working with these youngsters (Arcelus *et al*, 1999). Thirty-two referrals, 18 boys and 14 girls, were received during the first 6 months of this direct-access of operation service opening (Butler & Vostanis, 1998). At this stage, young people were seen predominantly at the intake residential unit. The age of the young people referred ranged between 10 and 17 years and they were from a variety of ethnic groups. All but one of the girls and 10 of the 18 boys had disclosed or were known to have been suffering from abuse before entering care. When Butler & Vostanis looked at the mental health provision that had been made available to those who had disclosed abuse, only 10 of the adolescents had had any psychological input in the past. All but three of the adolescents had ICD-10 diagnoses, mostly mixed affective-conduct disorders. Sixteen of the group had features of depressive disorder and 27 had features of conduct/oppositional disorder. They concluded that the current system had failed to provide stability and nurturing for these very needy children and adolescents with emotional and behavioural disturbances.

The National Child and Adolescent Psychiatric In-Patient study (O'Herlihy *et al*, 2001) found that 12% of children and adolescents in tier 4 in-patient services in England and Wales were from the looked after population. This compares with 9% of young people presenting to child and adolescent mental health services (CAMHS) in general (Audit Commission, 1999) and 0.5% in the general population (Meltzer *et al*, 2000).

Why do looked after children have greater mental health problems?

Children in care are much more likely than other children to have experienced risk factors that predispose to the development of mental disorders. Indeed, these risk factors are often the reasons why they have entered the care system.

In 2001, the Department of Health started to record the principal need of the child that led to

Box 3 Factors resulting in intervention by social services

The experiences of young people taken into care during 2001 include:

- Abuse and neglect (62%)
- Family dysfunction (10%)
- Disability (4%)
- Parental illness or disability (6%)
- Family in acute stress (7%)
- Socially unacceptable behaviour (4%)
- Low income (1%)
- Absent parenting (6%)

social service intervention (see Box 3). As well as these factors, many of these children will also have experienced an early life environment (such as socio-economic disadvantage, poverty and homelessness) that predisposes them to mental health problems. For refugees and unaccompanied children, the experience of discrimination and disaster might compound the problem.

Protective factors

Children taken into care are greatly at risk of mental illness, but the picture is not completely bleak. Buchanan (1999) looked at life satisfaction for looked after children in adulthood. The study found that, although children who had been in care were significantly more at risk of psychological problems at age 16 and depression at 33, 75% did not have psychological problems at 16 and 80% were not depressed at 33. Therefore, not all young people in the care system develop mental health problems. This is something that needs to be researched further. Why is it that some young people who have experienced similar life experiences do not develop mental health problems? What are the protective factors?

The offer of acceptance and affection by their carers might eventually lead to improved self-esteem and security. Other basic requirements met by a placement in care include: living in good conditions, with adequate housing, food, clothing; and having needs for supervision and authoritative discipline met.

It seems that stability and continuity of care is also an important factor: Dumaret *et al* (1997) interviewed adults who had been raised in stable foster homes and had received specialist support from a dedicated fostering agency. They found that half of their respondents were 'well integrated socially' and 68% were 'well integrated' or 'average'. By contrast, placements that are not stable result in discontinuity in the child's care, education and

treatment for health problems. It is therefore important to provide appropriate training and support for foster carers, to prevent placements from breaking down. If, for whatever reason, a placement does break down, there is an even greater need to keep some consistency in the young person's life by, for example, keeping him or her at the same school and in contact with the same social worker.

Sometimes, though, the level of disturbance displayed by a child might make it almost impossible for the process of recovery to begin. The experience of early sexual abuse and violence predisposes some victims to become abusers themselves or to fear that they will do so. Very often, the despair about their lives or the need to draw attention to their dire predicaments leads to suicidal attempts and self-harming behaviour. Children might put themselves at further risk by running away, using drugs and alcohol, by promiscuity, prostitution and criminal acts. The problems rarely come singly. They are complex, often severe and of long duration.

Current support

Research by Ward (1995) found that parents in the community were more effective in accessing resources on their child's behalf than were local authorities on behalf of children in their care. Polnay & Ward (2000) write that:

'despite the Children Act 1989 requiring local authorities to monitor children's developmental progress and to ensure that each looked after child has an annual medical report, expectations remain low and [that] there is substantial evidence that common physical and mental health problems often fail to be identified or adequately managed'.

They give several reasons for this. There is no specification for the content of medical reports, which are often of poor quality and carried out by doctors who do not have access to the medical or family history. Very few young people view their annual assessment in a positive light and many refuse to attend: indeed the uptake of health assessments is as low as 25% in some local authorities (Butler & Payne, 1997). As already mentioned, looked after children are often excluded from school and are therefore denied help that school health services may have to offer, including health promotion classes. Many placements are not stable, and result in a discontinuity of treatment and knowledge; during the first 3 months of a child's placement, he or she would be registered at the local general practice as a temporary resident. Movement within the care system is a major factor preventing children and young people from gaining access

Table 1 Government programmes and documents launched in the past 4 years that have had an impact on the mental health and well-being of looked after children (Mental Health Foundation, 2002)

Programme/document	Launched	Government department
Sure Start	1997	Department of Health
Health improvement programmes	1997	Department of Health
Healthy Schools Programme	1997	Department of Education and Employment
Health Action Zones	1998	Department of Health
Education Action Zones	1998	Department of Education and Employment
Quality Protects	1998	Department of Health
National Priorities Guidance	1998	Department of Health
CAMHS Innovation Mental Health Grant	1998	Department of Health
Teenage Pregnancies	1999	Social Exclusion Unit
Drug Misuse Special Allocation Fund	1999	Department of Health
Crime Reduction Strategy	1999	Home Office
Youth Justice Reform Programme	1999	Home Office
Promoting Health for Looked After Children (consultation document)	1999	Department of Health
Guidance on the Education of Children and Young People in Public Care	2000	Department of Education and Employment & Department of Health
Children's Fund	2000	Department of Education and Employment
White Paper: <i>Adoption: A New Approach</i>	2000	Department of Health
Connexions service	2001	Department of Education and Employment
White Paper: <i>Valuing People: A New Strategy for Learning Disability for the 21st Century</i>	2001	Department of Health
National Service Framework for Children	Announced 2001	Department of Health
Children (Leaving Care) Bill	2001	Department of Health

appropriate primary and specialist health services. This is despite the statement by the Department for Education and Employment and the Department of Health (2000) that, in assessing a placement's suitability, consideration must be given as to whether it can meet the child's identified health needs as well as particular educational needs.

The Children's Safeguards Review highlighted deficiencies in the child care system in general and in child and adolescent mental health services in particular (Utting *et al.*, 1997). One of the findings from *Children in Mind* (Audit Commission, 1999) was that links with other providers of services for children are often weak, and children's access to services can be highly variable. Anecdotal evidence from that report suggested that social workers are concerned that children and young people have to wait a long time for appointments and that they are seen in a health service clinic, rather than in a setting they are used to. The report recommended that both health authorities and trusts should establish more consistent provision of specialist CAMHS and should link their activities with those of other agencies.

Policy

A number of recent government initiatives and reports have potential to improve the mental health of looked after children. It is possible that the sheer

amount of new guidance is a problem in itself. Workers and services can be overwhelmed by its volume and attempts to introduce new practices in a relatively short time. A number of these new initiatives and guidance require services to record new information, and many new targets have been set for the different agencies to meet. There has been little evidence of 'joined-up government' and often targets set for one specific agency do not apply to another. This can result in clashes of priorities between professional groups. Many front-line workers are not aware of the targets that their trust or local authority is attempting to meet and therefore can be resistant to changing their practice.

It is hoped that the National Service Framework for Children will bring much needed cohesion so that all professional groups working in this area will be working towards the same objectives.

Barriers preventing improvements in care (Box 4)

The use of language and terminology

These are important issues for young people and social services staff. Labelling a person with a 'mental health' problem is often seen as stigmatising in our society. However, the recognition of a mental health problem may also bring a sense of relief for the children concerned, as it may provide an

explanation for some of their difficulties and enable them to seek help, thus reducing disturbing behaviours, improving their relationships and increasing their self-esteem.

Funding

This remains an important issue. Although more money than ever is being invested in services for looked after children, this starts from a very low base and even more is likely to be required to bring about the major national changes that are needed for these young people.

Inter-agency collaboration

The Health Act 1999 opened the way for more flexibility in funding arrangements between health and local authorities. These new partnership arrangements, with pooled budgets and integrated provision, allow authorities to bring resources together or to delegate functions across authorities. In a few areas, 'complex care' panels have been established, whereby health, education and social service agencies individually refer and fund children and young people with complex problems rather than relying on a single agency to deal with them. However, although joint working and pooled budgets are being encouraged, there are still significant barriers to this level of inter-agency collaboration. This is not helped by the policy framework within which each agency is subject to separate national guidance and separate targets. Although the proposed Children's Service Framework will apply to all agencies, and enable them to work towards common targets, it has been suggested that legislation might be needed to implement joint working nationally.

Recruiting, training and retaining social services staff and foster carers

This continues to be a problem. For many foster carers, the children they look after exhibit extremely

challenging behaviour owing to the experiences that they have had before entering care. This often leads to conflict between the child and the foster carer, which can threaten the foster carers' marriage and even result in a child making a false accusation of abuse. There is a real need for foster carers to have training in understanding the mental health problems that may arise for these children and young people. The National Standards for Foster Care (National Foster Care Association, 1999) outline the training and support foster carers should be receiving in the UK.

Turnover of residential and field social workers

A social worker is one of the potential constants in the life of a child who has had multiple placements. A rapid turnover of social workers is therefore highly detrimental for looked after children. It also creates problems for foster carers, making it more difficult for them to provide consistent care and support to the child. And it can result in the carers being more experienced than the workers they have allocated to them.

The referral process to CAMHS

It is important for staff in social services and education to be able to call upon specialist CAMHS when necessary. The Audit Commission (1999) found that, in practice, NHS clinicians provide the main referral route to specialist CAMHS. More than half (52%) of the CAMHS referrals came from general practitioners and 15% from paediatricians. Only 14% came directly from social services and education combined, although there was significant variation between areas of the country. Anecdotal evidence from the Audit Commission's report suggests that the reasons why social workers make few referrals include their concern that the child would have to wait a long time for an appointment, and also that the child would be seen in a health service clinic, rather than in a familiar setting. This points to a need for better communication between the various sectors.

Usually, CAMHS include looked after children in their generic case-load with the same or similar referral procedures, i.e. referrals from general practitioners and social workers. However, these young people are disadvantaged when they are added to a waiting list because of the high number of placement moves that many of them experience. This makes them less likely to gain access to such services. Also, because they may have a number of different carers in short succession and a lack of advocacy, medical problems may be missed resulting

Box 4 Barriers to improved mental health care for looked after children

Language and terminology
Funding
Lack of inter-agency collaboration
Recruitment and retention of social workers and foster carers
Process of referral to Child and Adolescent Mental Health Services

in non-referral. Services therefore need to adapt to prevent this vulnerable group from missing out on receiving medical help.

Future directions

Services are beginning to change to meet the needs of these looked after children and young people. A number of models are emerging. These include the use of: designated mental health workers (e.g. psychologists, psychiatric nurses, primary mental health workers); existing CAMHS staff with protected designated time; and teams for high-risk groups among children and adolescents in care. However, such unevaluated and fragmented service developments do not enable policy-makers, commissioners and practitioners to draw generalisable conclusions on evidence-based interventions and effective use of resources. There is a need to map services emerging following recent Government policies.

Hopefully, improved communication between the professional groups will result in a better understanding and recognition of mental health problems by foster carers and social workers and will bring about changes in referrals to CAMHS, thus improving the support and care of looked after children. These young people should not be disadvantaged in either their health care or their education as a result of entering the care system and should receive the same life chances as their peers.

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Multiple choice questions

- 1 In 2001, the Department of Health began to collect the following data on looked after children:**
- age at which they enter the care system
 - length of stay in the care system
 - reasons for entering the care system
 - number of educational qualifications achieved at GCSE
 - ethnic status.

2 Research evidence suggests that:

- a 10% of young people who have been in care go on to become young prisoners
- b looked after children are 10 times more likely to be excluded from school than their peers
- c of young women leaving care, 25–30% are parents
- d young people leaving care have a 1 in 10 chance of become homeless
- e recent government figures show an improvement in the educational attainment of looked after children.

3 From the research:

- a in one local authority, 67% of looked after children had a psychiatric disorder, compared with 15% of the comparison population
- b many children in care show high levels of comorbidity
- c the most common disorders exhibited by looked after children are conduct disorders and depression
- d young people in foster care experience greater mental health problems than those in residential care
- e 8% of looked after children in one local authority had a diagnosis of unspecified functional psychosis.

4 Which of the following are true?

- a the main reason children and young people enter the care system is family dysfunction
- b many of the problems experienced by looked after children are severe, complex and of long duration
- c we have information on how many looked after children use adult mental health services in later life
- d we need national data on the type and prevalence of mental health problems in looked after children
- e placement stability is a key factor in protecting against mental health problems.

5 With regard to policy:

- a a number of policy documents published in the past few years are concerned with improving life chances for looked after children
- b problems with recruiting and retaining foster carers and social workers is preventing improvements from taking place for looked after children
- c complex care panels have been set up nationally to encourage all agencies to work collaboratively
- d child and adolescent mental health services usually include looked after children in their generic case-load
- e emerging models that child and adolescent mental health services are adopting for looked after children must be evaluated.

MCQ answers

1	2	3	4	5
a F	a F	a T	a F	a T
b F	b T	b T	b T	b T
c T	c T	c T	c F	c F
d F	d F	d F	d T	d T
e T	e T	e T	e T	e T

INVITED COMMENTARY ON Mental health of looked after children

Richardson & Lelliott (2003, this issue) highlight the multiple and complex mental health, social and educational needs of looked after children and young people. A number of recent policies in the UK have defined this vulnerable client group as a priority for commissioners and practitioners, and have called for greater inter-agency partnerships to meet their needs. Descriptive and longitudinal research has established the characteristics of looked after children, their social and mental health outcomes and their poor access to services. The latter is related to children's frequently changing placements, disengagement and lack of advocacy, as well as to the fragmented and uncoordinated involvement of agencies. The remit of mental health

service input is often not clearly defined and it inevitably overlaps with placement and social issues. In an extension of the UK national mental health survey, Meltzer *et al* (2000) are currently investigating the nature and prevalence of psychiatric disorders among children in foster and residential care. But how can we best meet their needs, and what should be the focus of future service development and research?

Looked after children should receive prompt and continuing treatment within comprehensive child and adolescent mental health services (CAMHS). However, this may not be universally possible until CAMHS are adequately resourced to respond to primary care referrals (i.e. from general practitioners,