Developing new mental health services for looked after children: A focus group study

Looked after children have extensive mental health needs that are not often met by current mental health service provision. Jane Callaghan, Bridget Young, Maxine Richards, and Panos Vostanis describe the use of focus groups with various stakeholders – social services staff, foster carers and residential social workers – to inform the development of a specialist mental health team for looked after children. Thirteen focus groups were conducted, comprising 58 participants in total, and all sessions were audio-taped and transcribed. Data were analysed using the constant comparative method and this revealed several emergent themes: difficulties accessing mental health services, the importance of developing a working partnership between child and adolescent mental health services, social services and foster carers, the need for consultation, and the importance of developing a service that is appropriate to the specific needs of looked after children. The newly developed model of mental health provision for looked after children is described, and the ways in which its form was influenced by the issues identified in focus groups are highlighted.

Introduction
The high rates of mental health problems and disorders among children and young people looked after by local authorities have been widely reported (McCann et al, 1996; Brand and Brinich, 1999; Dimigen et al, 1999; Hukkanen et al, 1999; Roy et al, 2000; Minnis and Devine, 2003). Young people are also more likely to experience mental health difficulties after leaving the care system (Cheung and Buchanan, 1997; Buchanan, 1999). Early family experiences which may have led to the young person’s placement in care, together with experiences within the care system (for example, frequent placement breakdowns and moves), have been posited as contributing to this high level of mental health need (Quinton and Rutter, 1984; Minty, 1999).

These needs remain largely unmet, since child and adolescent mental health services (CAMHS) vary considerably in their provision, as do the interventions offered and the disciplines or agencies involved (Harman et al, 2000; Payne, 2000; Richardson and Joughin, 2000; Nicholas et al, 2003). Factors that contribute to young people’s access difficulties include narrow referral criteria, non-detection of mental health problems, referrers’ reluctance to pathologise children’s behaviour, high levels of mobility among children, difficulties in gaining their engagement with therapies and limited resources (Hatfield et al, 1996; Minnis and Del Priore, 2001).

Typically, CAMHS have attempted to provide a service to looked after children by using existing CAMHS staff, who have usually been faced with huge demand and have been able to cover only a proportion of the looked after population (Barrows, 1996; Butler and Vostanis, 1998; Arcelus et al, 1999). Recent policy changes in the UK (Department of Health, 1998) have led to the provision of funding for designated mental health posts or teams for looked after children (Street and Davies, 2002; Kelly et al, 2003).

Looked after children have complex social and educational needs that require the co-ordination of different agencies (Nicol et al, 2000). A high level of cooperation between the different agencies involved in their care is, therefore, a key aspect of developing specialist mental health services for this group. This is important both for the individual young person (Barrows, 1996) and institutionally, to ensure the smooth running of a service working with children with such complex needs. For this reason, when establishing a new mental health service for looked after children, consultation with main stakeholders is an essential component of strategic planning and implementation.
The aims of this study were to describe: a) local authority professionals’ and carers’ perceptions of existing mental health services for looked after children and their recommendations for a new service; and b) how these views were addressed by a new designated service for children looked after by local authorities. (The team also provided a service to homeless families, young offenders and refugee children, but in this paper we will only refer to the service component for looked after children.) Focus groups were used to access the views of local authority professionals and carers.

Methods

Setting

The health district in which this study was conducted 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 is aged under 18 years. The mental health team covers young people accommodated in eight statutory and five private residential units and approximately 700 foster or pre-adoption placements. The total number of children looked after over the period of one year in this district is around 800.

Focus groups

Focus groups were used to allow participants an active role in the research process and, although not exempt from the power relations inherent in the research relationship, they enable participants to have some influence over the agenda of the interview and allow them to ask questions of each other and of the researcher (Kitzinger, 1994; MacDougall and Fudge, 2001). Focus groups are a generative method of interviewing, facilitating the expression of a range of opinions and experiences that might exceed those initially predicted by the researcher. This makes them particularly suited to eliciting the varied perspectives of stakeholders needed to inform the development of a new service.

The focus groups took place before the establishment of the mental health team for looked after children. Participants were interviewed in groups of similar professional backgrounds (eg residential social workers were interviewed together in one group). We attempted to subvert normative pressures within the focus groups by asking for dissenting opinions and directing questions evenly across each group. Focus group discussions were audio-taped and transcribed verbatim. A prompt or topic list was used to guide the interviews. This was initially composed of the key issues identified by the inter-agency steering group but was revised throughout the study as new issues emerged during the focus groups. The sessions were facilitated by the first author (JC).

Analysis

Data analysis was guided by the grounded theory analytic process described by Strauss and Corbin (1990). Each paragraph of the transcript was considered in close detail and concepts relevant to understanding participants’ perceptions of existing mental health services for looked after children were developed and labelled (Pidgeon and Henwood, 1996). Each discrete idea or event was coded and, where appropriate, represented by the participant’s own words (in vivo codes).

Data collection and analysis occurred simultaneously, allowing constant comparison and development of the interviews, and emergent codes were continually compared to discover relations between the data. The sample was determined by practical rather than theoretical considerations and, although themes had begun to recur in the interviews and a high level of consistency was achieved, we would not claim that theoretical saturation was reached (ie additional themes might have emerged if we had interviewed more stakeholders). Field notes were written up after each session, recording reflections on the focus group discussions and initial analytic comments. The process of the analysis was recorded in a set of memos (Pidgeon and Henwood, 1996). No computer package was used. The data analysis was conducted by JC and MR, with assistance from BY and PV. The use of more than one researcher in the analysis helped to validate the assignment of data to the codes and themes and improve the ‘trustworthiness’ of the analysis.
Findings

Thirteen focus groups were held: four with foster carers (n=14), two with residential social workers (n=7), one with residential unit managers (n=7), two with childcare operations workers (n=10), three with link workers (n=14), and one with managers who chair children’s care review meetings (independent chairs, n=6). The emerging themes are presented below.

Accessing mental health services

Difficulties in accessing CAMHS were reported by most participants, particularly for children who are not in stable placements:

*And of course they tell you they can’t see the child until they’re in a stable placement, but how on earth is the child supposed to get stable until they get help?* (Foster carer)

Attempting to provide a stable environment for the young person while receiving little support was a source of considerable frustration, especially for social workers whose accounts indicated that young people’s needs for mental health intervention should be assessed with minimum delay to determine whether referral to CAMHS is appropriate and whether intervention would be helpful:

*There is a need for a rapid response to issues raised. These young people have lives that are changing so much, and a six-month waiting list means that they are in a completely different place from where they were when they were first referred.* (Childcare operations social worker)

Accounts identifying such difficulties were put forward by most participants. Long waiting lists were viewed as effectively blocking looked after children’s access to mental health services by failing to respond to their life circumstances of instability, mobility and rapid change. Placing young people on long waiting lists was considered tantamount to denying them the service outright. Obscure referral criteria for CAMHS was pointed to by several social workers as another major obstacle to accessing services for young people. The likelihood of accessing services was regarded as being influenced not so much by young people’s actual mental health need, but rather by the incidental knowledge and skill of their individual social worker in ‘playing the system’ to get the referral picked up:

*Part of getting them through the gate is about knowing what the referral criteria are, and that is never very clear. And of course, if we don’t know, we can’t refer.* (Childcare operations social worker)

Early response and intervention

To improve access and appropriateness of the service, respondents suggested that there was a need for CAMHS involvement quite early in a young person’s experience of care. Consequently, it was felt that being able to access CAMHS, even for consultancy as part of the care planning process, would assist social workers in particular placement decisions. This was seen as a mechanism to facilitate more appropriate case management and ultimately ease the burden of referrals to CAMHS:

*If you can identify a young person’s needs early on, you can prevent it from developing into a major mental health difficulty.* (Independent chair)

‘I think I’m getting normal now’: mental health and stigmatisation

On the whole, those who worked with looked after children perceived them to have a very high level of mental health need:

*All foster kids are disturbed kids. They might be happier because they’re in foster care, but they’re still disturbed.* (Foster carer)

Foster carer 1: *He said to me, ‘I think I’m getting normal now’.*

Foster carer 2: *But they’re NOT normal, are they? None of them are really normal. Teachers, social workers, they all let them know that they’re not like other children.*
The language of ‘abnormality’ and the differentiation between looked after and other children were viewed as alienating young people from services and were regarded as an important source of young people’s denial of their mental health problems and their resistance to mental health services:

The child, who’s only nine, has actually said ‘I’m not going in there because that’s a place for nutters’. I mean I was quite shocked that a child of, you know, a relatively quite young age, has got this association. (Childcare operations worker)

Young people in care have often had considerable experience of multiple health and social care agencies. As a result, they are often fairly ‘wise’ to the stigma that can be associated with these types of organisations. It is likely that the discourses of abnormality and damage which surround young people are combined with their reflexive constructions of the accounts of mental health services that they hear from other young people, and that these in turn influence their own experience of referrals. Some of the workers we interviewed offered suggestions for helping to dispel the stigma associated with mental health services by reconstructing them as services that simply help people with ‘problems’:

I think it’s dispelling the myths and accessing services in a way that doesn’t make them feel stigmatised, or you know, ‘I’ve got major mental health problems.’ Because I think that you are never going to make the service accessible, and I think they’ve got to understand that people who have, I don’t know, problems, rather than in terms of mental health problems, make them feel less scary. (Residential social worker)

The stigma of having mental health needs appears, according to the accounts of some social workers, to be linked to perceptions of the actual building or environment in which the service is offered. Focus group participants (particularly in the social worker groups) felt that it was very important to find strategies to deal with this stigmatisation. Some suggested that there be more flexibility in the location in which services are offered. Others indicated the need for better information to offer to young people, using education as a means of tackling the stigma:

I think they need to look at providing services, either within the foster home itself, if that’s the most appropriate place, or wherever kids find it easier to access, in the initial stages of that sort of service. (Childcare operations social worker)

Working in partnership

In all focus groups, there was some discussion about the need for good working partnerships between CAMHS, social services, residential social workers and foster carers. Historically, the relationship between CAMHS and social services is a tense one, often with competing targets and pressures as well as ill-defined and overlapping boundaries. There is also a perception within social services that their involvement with a young person may block rather than facilitate access to CAMHS. These concerns indicate a need for better inter-agency working relationships and more open and clearly defined channels of communication. Some participants suggested that there needed to be a better understanding of the way in which the various agencies operated and the language that was used:

One thing I’m really aware of is the need to develop a common language. For example, when you do get a service, what you get as a typical outcome is a letter in psychiatric jargon, summarising everything you already know. There’s no indication of how to manage the problem, of what should be done, and there’s often no involvement of social services in the whole process. (Independent chair)

Participants pointed to a need for an awareness of the type of language used in communicating with other agencies, as jargon can be quite alienating and act as a barrier to partnership building. More significantly, participants highlighted a
need for greater clarity in mental health reports and the consideration of the needs of the person to whom they are addressed, so that practitioners are not merely following a standard format but rather answering the questions of the person for whom they are writing. The nature and quality of feedback from CAMHS to social services, foster carers and residential social workers were highlighted as a particular source of frustration for carers and several felt that poor communication in this area actively prevented them from providing the best possible care to the young person:

We’ve got to work with that person all the time, so when we come to actually set up a therapeutic programme, you’ve got to be able to understand what’s happening, through dialogue with the mental health professional who’s working with that young person. So not only do we have to work with the young person, but we’ve also got to understand what the therapist’s ideas are and how to implement and support those. (Childcare operations worker)

Participants highlighted the need for close working relationships between CAMHS professionals and the person providing day-to-day care for the child. Foster carers perceived receiving little support from social services or CAMHS; indeed, foster carers emerged as a particularly isolated and stressed group:

Because of what I’m trying to cope with at the moment, I’m not at all sure I’m doing right. In fact, I know, I’m pretty sure, I’m doing it all wrong. (Foster carer)

Although foster carers recognised that social services were under considerable strain and that resources within the service were stretched, accounts suggest that they experienced the support systems as unreliable:

Foster Carer 5: It depends which way the wind’s blowing and who’s on duty, I think.
Foster Carer 1: The support is very patchy. On a good day, if you ring up, you’ll get someone supportive, but on a bad day . . .

Foster Carer 5: I personally would say, to be fair to the fostering team, they do their utmost. And if you have a child who has a good child ops worker, it helps a lot and it’s great. If you’ve got a lousy care ops worker, then you’ve got problems.

They reported poor communication with social services and a sense that vital information about the young person in their care was often withheld, especially for the more needy children:

I went into his room, and he had a glass over his arm, and I thought, oh, great, I didn’t know he was a self-harmer. And when I called the social worker, she said, ‘Oh yes, he does that sometimes’. And I just thought, you know, it would have been nice to know that, because then I would have given him plastic, not glass! (Foster carer)

Within this context, foster carers also did not perceive a great deal of support from existing CAMHS:

I don’t think the psychiatrist has spoken to me once about him. I mean I drop him off, wait for him and take him home. The psychiatrist treats me like a taxi! But at the end of the day, it’s me who has to deal with him every day. I need a bit of input. (Foster carer)

Consultation
One of the ways in which participants felt that partnership between CAMHS, social services and carers could be improved was through the development of consultation. This was viewed as helping to ensure stronger channels of communication by giving carers and social workers more direct support in dealing with children’s difficulties. It was also seen as a way of improving access to mental health services and providing support to those involved in therapeutic work with looked after children. Participants favoured both individual and group consultation. Foster carers recommended a group model, since they felt it would help them to deal with their own sense of isolation by putting them in contact with other foster carers. Social workers, in particular, pointed out
that at times, speedy and appropriate consultation might prevent the need for referral to the specialist service:

One of the things I feel is crucial is that you have some consultation fairly quickly from CAMHS. Nobody needs to get involved straight away but, you know, someone to ask 'What are your views on this? Is there anything else we could do? . . . ' just for some sort of consultation because things are maybe going to need managing fairly quickly. You cannot wait for a referral to go, be processed and then get an appointment. I think that to access maybe in a consultational sort of role would be excellent. (Link social worker)

Training

A range of training needs was identified by participants, including understanding trauma and the psychological impact of abuse and neglect, working with behavioural problems and basic counselling skills. Participants expressed a specific need for training in the identification of mental health difficulties among children and young people:

What is mental health? I mean I know it's sort of a vast span, sort of rejection and stuff like that could come into all of us really, but I wouldn't necessarily say that I suffer from a mental health problem. So how would you define . . . I know it goes from one extreme to the other. But things like self-esteem and stuff like that, that's just building one's system up really, but I wouldn't necessarily say that someone had a mental health problem. You wouldn't necessarily go to address it, you know for outside help. So how do you decide when someone needs help? (Residential social worker)

Participants also felt it would be useful to receive feedback about what happens after a referral is made, and to receive information about CAMHS and interventions being offered. Information on how best to support a child in therapy was also seen as important. A particular issue was identifying and responding to those with less overt behaviours and internalising (emotional) problems:

Yeah, if it's a problem for the unit and the staff group, they will identify those before they identify the quiet one that has nightmares at night. When alarm bells are ringing, the ones that ring loudest get the fires put out. (Residential social worker)

What sorts of mental health difficulties have you encountered?

Foster carer 6: Swearing
Foster carer 2: I think one of the most common problems is strops.
Foster carer 1: Violence
Foster carer 4: Defecating
Foster carer 6: Self-harm
Foster carer 5: Sexualised behaviour
Foster carer 3: Attacking the foster carer

However, participants also indicated a need for CAMHS staff to be trained, to ensure that they had a thorough understanding of social services and its procedures. This would include an understanding of the way in which foster care and residential units operate, the limitations of these facilities and an awareness of the services they are able to provide:

I don't know how familiar CAMHS are with the procedure in terms of when children are accommodated. I had a young person released back to the residential unit by a psychiatrist, who recommended that they be placed on 24-hour observation. Now that is impossible in a residential unit. Maybe they don't understand it at all, you know. I think definitely there's a need for some education about how social services work and the facilities we have. (Childcare operations social worker)

Appropriateness of mental health services for looked after children

It is not surprising that many participants felt there was a clear need for a mental health service that was sensitive and appropriate to the needs of looked after children. Services should be flexible, with staff who have a clear understanding of the young people's difficulties and who are able to engage them and their carers. They explained that many young people had difficult backgrounds and that in
Many cases had drawn a veil of secrecy around their difficult experiences, making it very difficult for them to talk to professionals:

*Bits, now and again. He'll say something, you ask him about it, and then he changes the subject, so you don't really know.* (Foster carer)

Lots of young people are very, not actually secretive, but they're very [clicks fingers] like this with their families, with their background, and you know it's something that has to be, and I know that we find it, that when they initially come in, they don’t want to talk. It’s hard to talk about their experiences. (Residential social worker)

In many cases, this 'secrecy' was viewed as a coping strategy which required a skilful and sensitive response. Participants' accounts also suggested that young people’s difficulties in engaging with services needed to be understood within the context of their experience of the care system. They pointed to how most of the young people will have had multiple contacts with various professionals and agencies, which can be confusing and frightening. Furthermore, these services can be perceived by young people as making no difference to their lives. One implication of these accounts, though not one that was explicitly drawn out by participants, is the need for mental health professionals to define clear boundaries of confidentiality and thoroughly discuss these with the young people. In particular, issues of confidentiality, note-taking and accountability should be established and agreed as a prelude to any mental health contact:

*I think that, unfortunately, in the residential care system, you get young people, where there are review of arrangement meetings, case conferences, 72-hour meetings, and they get all these people involved who are there to help. But I can understand, from their point of view, how I'd feel if I was at that age, and I had been disaffected through a number of years.* (Residential social worker)
them. I wonder maybe if somewhere outside [the residential unit] might do that. (Residential social worker)

**Consideration of the CAMHS perspective**
While we were unable to include focus groups with CAMHS professionals, and acknowledge this as a limitation of our study, it is important to consider some of the previous issues in the light of a ‘CAMHS perspective’, thus highlighting the different pressures, priorities and ‘cultures’ of local authority and health services.

For CAMHS, a priority of central importance is to ensure that limited resources are employed to maximum effect and, in this context, the priorities of CAMHS do not always match with those of other stakeholders. For example, distinctions between concepts such as ‘mental health’, ‘mental health problems’ and ‘mental illness’ become crucial in deciding how best to allocate service provision, with specialist CAMHS targeting the more severe problems and disorders. Also, in distinguishing between different levels of therapeutic interventions, it is important for CAMHS to consider what degree of input is going to make the most effective use of limited resources and to resist pressures to offer psychotherapy as a panacea for all problems, particularly in response to serious environmental deficits or externalising (aggressive) behaviours. For example, there needs to be a distinction between psychotherapy for emotional difficulties and therapeutic work for all children who have suffered loss. Also, there should be consideration that not all children (or adults to that effect) can make use of or engage with this approach: male adolescents with behavioural difficulties may respond better to cognitive techniques.

Requests from CAMHS for a young person to be in a relatively stable placement prior to input often stem from experience of how children’s difficulties in making sense of their inner world, in the middle of major (and often unsafe) life changes, can often compromise the effectiveness of psychotherapy. CAMHS also have to resist pressures to provide therapy because ‘nothing else has worked’, as this is also unlikely to have a positive impact. These are some of the issues we considered during the development and evolution of the new service. Although the findings of this study arise from local authority stakeholders, the ideal basis for the development of services for looked after children is one of negotiation and balanced change between local authority and CAMHS ‘cultures’.

**Developing the looked after children’s team: responding to carers’ and professionals’ suggestions**
In the following sections, we will give a broad overview of the team structure and then discuss how each of the major concerns highlighted by focus group participants was addressed in the team’s structure and working practices.

**Background**
The funding for the development of the designated mental health service had been secured through health and local partnership at the time of conducting and analysing the focus groups. The service was specifically set up for different groups of vulnerable children, ie looked after children, homeless families and young offenders (Vostanis, 2002; Callaghan et al., 2003a, 2003b). (It has since expanded to include asylum seeker and refugee children.) The team consists of two primary mental health workers (PMHWs) for looked after children, four PMHWs for young offenders, five family support workers for homeless children and their parents (these posts have been brought on stream and developed gradually), two psychologists and one psychiatrist (both disciplines working across all groups of children).

**Team structure**
The service adopted the tiered-model as its guiding framework (Health Advisory Service, 1995; Street and Davies, 2002). Primary mental health workers (Tier 2) cover the interface between Tier 1 (predominantly local authority staff and foster carers) and Tier 3 staff (psychologists and psychiatrist) (Gale and Vostanis, 2003).
The team roles include assessment and treatment; consultation with foster carers, pre-adoption carers, residential staff, social workers and foster carers’ link workers; and ongoing training to the same agencies.

Mutual understanding of the various professional roles and systems is also facilitated by ensuring that PMHWs working in CAMHS tend to have a social work background.

Improving access
The team takes referrals regardless of the stability of the child’s placement. Staff aim to forge strong working relationships with social workers and carers involved with a particular child, as a way of ensuring continuity of work if the placement changes. To deal with concerns that the referral route to CAMHS was unclear, a single route of referrals through childcare operations managers was initially piloted. However, the logistics of this quickly became unmanageable and it appeared that this system would only further slow down the processing of referrals. Therefore referrals are now processed directly from social workers, link workers and residential social workers. Primary mental health workers receive the referrals and usually discuss the child in detail with the referrer. A referral form has been developed and is completed at this point. The standardisation of this procedure ensures consistency and appropriateness of referrals.

Depending on the referral, PMHWs may provide telephone or face-to-face consultation, joint assessment or intervention with the referrer, individual assessment or brief intervention (behavioural, cognitive, psychodynamic or systemic) or refer to the psychologist or psychiatrist (Figure 1). These pathways are flexible but children with serious presentations and psychopathology, such as self-harm, depression or eating disorders, are prioritised by the Tier 3 staff. The contact between PMHW and referrer is itself seen as an intervention, facilitating the development of greater skill in the identification of mental health need in individual social workers. The team aims to see young people accepted

*Figure 1*
Levels of mental health service input and process of referrals

| Care operations social worker | Residential social worker |
| Foster carer | Link worker |
| Primary mental health worker |
| Consultation (telephone or face-to-face) | Joint assessment or intervention with referrer | Assessment and brief intervention |
| Psychologists – psychiatrist |
| Joint assessment with PMHW | Assessment and intervention |

| Psychiatric emergency |
for direct work within a month and there is no waiting list for the service. If a young person's difficulties are such that they require longer-term therapy (usually post-abuse psychotherapy), this is provided by a therapeutic social work team placed across the two local authorities. In residential units, a PMHW provides regular input, developing an ongoing consultative role. The consultative role of the PMHW gives social workers access to a mental health professional for assistance in making assessments and placement decisions early in a young person's care history. However, the team does not have the staffing capacity to offer mental health screening for every child who enters the care system, as this was not considered a cost-effective way of using its resources. Instead the team has tried to improve the detection of children at high risk of mental health problems by providing consultation and training on mental health awareness to local authority staff and by responding immediately to referrals without placing children on a waiting list.

Engaging children and young people

The issues of the stigmatisation of mental health and of working with disengaged and disaffected young people are difficult to address. However, steps can be taken to help ensure that CAMHS staff have good understanding of the care system and the way in which it impacts on young people's engagement services. These include a joint forum with social services and training sessions. Several practical steps have also been taken in the development of the service. The team operates as flexibly as possible with young people and their carers, working in different environments (residential units, foster homes and CAMHS clinics). For example, adolescents in residential units often prefer to attend CAMHS for confidentiality reasons and in order to protect their therapeutic space. If the young person is not willing to have direct contact, consultation is offered to other professionals and carers. These adults continue their efforts to engage the young person, who may then decide to see a mental health professional at a later stage, without further delay in the referral process.

At a theoretical level, a focus on resilience and protective factors, in addition to more traditional therapeutic interaction, may begin to dismantle the discourse of damage surrounding looked after children and some of the stigma associated with mental health difficulties. The consultation role of the PMHW provides a powerful position from which they can influence the language used by other professionals and carers and wider attitudes about mental health (Bolton, 2003).

Working in partnership: encouraging good relations between CAMHS, social services and foster carers

The involvement of a multi-agency steering group in the broad development and monitoring of the team also helps to promote the maintenance of strong links between CAMHS and social services and encourages good working relationships. The role of the PMHW as an interface between Tiers 1 and 2 ensures that a clear channel of communication is open between CAMHS and social services. The role of the PMHW in providing supportive communication and feedback to social services and foster carers helps to ensure that improved relationships develop between CAMHS, social services and carers. Team members engage foster carers as far as possible and foster carers are seen as active and involved in the therapeutic process. However, a specialist 24-hour helpline, other than that available for the whole mental health service, is not yet available.

Training

The team provides training to residential, link and childcare operations social workers and to foster carers. An ongoing training course aims at building mental health awareness and empowering carers and professionals in strengthening young people's coping strategies and increasing protective factors (Minnis et al., 2001; Sebuliba and Vostanis, 2001). The attempt to build relationships between CAMHS, social services and foster carers began as an integrated training programme in which different groups of professionals and carers were mixed together. However, foster carers reported that they felt
overwhelmed by this structure and that their concerns were often drowned out. In view of these difficulties the two groups are now trained separately. A second training programme has recently been initiated for foster carers and their link workers to provide a framework for the understanding of the impact of trauma and attachment difficulties on children’s behaviour (Golding, 2003).

In addition to this formal training, the consultative role of the PMHW is intended to empower frontline staff and carers with basic mental health skills. It is hypothesised that the aggregated effect of these consultations over time will help to improve their ability to identify children and young people at risk and increase their skills in building resilience.

**Conclusions**

This paper has described the process of establishing a mental health service for looked after children, in particular the impact of foster carers’ and social workers’ views at the outset of the service. The evaluation of the changes will be published later (Callaghan et al., in press), but it was initially clear that an obvious gap in this process was the lack of consultation with children and young people (Heptinstall et al., 2001; Stanley, 2002) as well as with CAMHS professionals, who are equally important stakeholders. However, young users were included in a subsequent evaluation of the service and, to a large extent, their views were consistent with those of the adults in pointing to the need for a sensitive and engaging approach by the mental health staff, and for clarity and feedback on their difficulties (Callaghan et al., in press). The non-inclusion of CAMHS views does not imply in any way that ‘CAMHS have got it wrong’. On the contrary, there are numerous examples of good inter-agency practice throughout the history of CAMHS, notably during its child guidance phase.

Looked after children’s complex social, developmental, mental health and educational needs can only be met by a co-ordinated and multi-level response and a constantly evolving mutual exchange between social services and CAMHS, with the cultural styles and operational practices of both systems needing to be addressed (Street and Davies, 2002; Valios, 2002). The implementation of policies requires constant dialogue, as the two organisations have overlapping and changing priorities and resource pressures. Organisational links between social services and CAMHS are necessary and these were conditional in the joint planning, commissioning and development of this mental health team.

The roles and needs of different carers and professionals should be actively considered in this dialogue. Although common themes emerged from the focus groups in relation to the provision of mental health supervision for looked after children, there were also specific issues for each participant group. Foster carers expressed the wish for more support, involvement in decision-making and training from both social services and CAMHS. Social workers stated the importance of clear and consistent operational criteria by CAMHS, as well as the need for direct access and prompt responses irrespective of children’s stability. These views were shared by residential social workers who, in addition, highlighted the constraints of their role and how these may sometimes be poorly understood by CAMHS or other external agencies. Policy, practice and research can usefully complement each other, while independent exploration of key stakeholders’ service expectations is essential in facilitating further service planning and commissioning, as well as informing mental health and social work practice.

**Acknowledgements**

We are grateful to all foster carers and social workers who participated in this study. Also, to Jeanette Allen, Daniela Gravili, Anita Kelly, Smita Patel and Micky Foster of the Young People’s Team; Helen Millar, Flick Schofield and Penny Hajek from Leicestershire Social Services; Pat Pollock, Bridget Pudepha, Val Cootes and Hilal Barwany from Leicester Social Services; and Bob Foster from Leicestershire Health Authority. The study was funded by the Leicestershire Health Authority.
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