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Mental Health and Looked After Children

Time for change not more of the same

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On the 9th January 2017 Theresa May, Prime Minister for the UK, announced new approaches to Mental Health for Children and Young People asking that the Care Quality Commission lead a review of Child and Adolescent Mental Health Services (CAMHS) to ascertain what works well and what does not. Whilst this may be commendable, a review of this nature has been available since 2009. Jackson (2009) was commissioned to conduct a practice mapping exercise on behalf of North East National CAMHS Support Service. This report highlighted areas of what worked well and what did not across 12 local authorities, therefore the need for a further scoping exercise is unclear. Additionally, whilst the parameters of the Care Quality Commission's report includes a range of service provisions, how much inclusion of service users' voice is unclear¹. When this review is completed it will be of little value if it does not include the voices of those service users; the children and young people themselves. This is important given the number of children and young people who have felt that the service provided was unsuitable for them personally, or intrusive in ways that cannot be justified when trying to support those children and young people who access service provision (see for example Stanley, 2007 who also raised this point). Such intrusion is noted by young people to include asking questions at the first meeting that they were uncomfortable answering to a stranger or support that did little to alleviate their position. The Care Quality Commission will undertake the review of provision with partners (in a similar approach to that of Jackson, 2009) and anticipates reporting on this review in 2017/2018. Whilst this is a much needed reflection of service provision, especially at a time when the Centre for Mental Health (2016) has reported a delay of up to 10 years between a young person first experiencing mental health symptoms and receiving help, this does not address the immediate issues for Looked after Children (LAC) with reference to their mental wellbeing now.

Firth (2016 p.5) highlighted within her 'State of the Nation' research report that at present CAMHS are *turning away nearly a quarter (23 per cent) of children referred to them for treatment by concerned parents, GPs, teachers and others. This was often because their condition was not*

¹ This will be completed with OfSTED and with partners including inspectorates and provider agencies

considered serious enough, or not considered suitable for specialist mental health treatment and that the average waiting time from referral to first appointment was 6 months, whilst the duration between referral and 1st treatment or intervention to commence was 10 months. This reinforced the findings of Abdinasir and Pona (2015) in their study of ‘a teenager’s pathway through the mental health system’ highlighting waiting times of between 13 and 140 days and 15% of referrals denied access without further action; equivalent to 30,000 children overall. Indicators reported by the Children’s Commissioner (2016) agree with this estimation overall, noting that on average 28% of referrals were declined; however within this, one CAMHS confirmed that 75% were not allocated a service, whilst in the South East and West Midlands this was 18%. The delay of provision is also noted by Armiger² (2017) who ascertains “*Within every provision I have worked in, we have many children with very complex mental health issues. Many have gone untreated for a very long time and had no access to support, or have been on waiting lists for 12+ months*”. This means that when the report is published by the Care Quality Commission, little will change in real terms for those currently waiting, and for those being refused; many of whom will be LAC. Furthermore during the time the report takes to be published many LAC who are waiting for appointments or treatment may need to move placement out of the catchment area for that CAMHS provision, therefore any outstanding referral may become void requiring a new referral to be made extending the duration of delay.

The negative impact that placement disruption has on LAC mental wellbeing is well documented as a significant factor in high levels of mental health need (see for example Stanley et al, 2004).

Moreover, the NSPCC commissioned Luke et al (2014) to report on ‘What works in preventing and treating poor mental health in Looked After Children?’; therefore reporting on what works well and what does not work has previously been undertaken and is available for consideration now. This is important given that YoungMinds (2017³) indicated that 22.9% of LAC aged 5-15 exhibited emotional problems, 18.9% under 5’s (19.3% of boys and 17.4% of girls) displayed signs of emotional or behavioural problems and these children/ adolescents were 4-5 times more likely to attempt suicide in adulthood. This reflects early findings by the Office of National Statistics that pointed to 45% of 5-17 years olds having a mental health concern compared to their peers (indicators note 10% of children generally have a mental health concern within this age range). Previous concerns have led

² Mike Armiger is a consultant and trainer specialising in safeguarding, behaviour, LAC, trauma, and mental health. His experience includes; head of educational provisions, consultant to police teams (specifically in sexual crime) a foster carer, Looked after children intervention specialist, mainstream primary/secondary teacher and advisory roles within local authorities

³ Detailed in http://www.youngminds.org.uk/about/whats_the_problem/mental_health_statistics

to a range of government actions including collaborative projects and training for carers to support LAC⁴. However what is overlooked within these suggestions is those LAC who have not formally been assessed or diagnosed, in that carers would identify the child or young person having a mental health ‘problem’ rather than the child or young person being identified as having a mental health ‘disorder’. This disparity leads to many children being overlooked by service provision, a scenario previously noted by The Mental Health Foundation (2002) and McAuley and Young (2006).

Historically Child and Adolescent Mental Health Service (CAMHS) provision has been based on a 4 tier approach whereby Tier 1 is a broad provision for all children and may be provided by the child’s GP, Children’s Centres or Health Visitors for example. However Armiger (2017) highlights difficulties within the current system, particularly when a ‘crisis’ arises whilst waiting for support, he claims

In terms of provision, there are many organisations doing great work but even charitable organisations are in need of finance and funding, so finding a provision without incurring cost is nearly impossible. Many of my school colleagues have reported having to take children to hospital emergency departments because they have arrived at school in crisis and no one is available from mental health services to attend. It’s early intervention that all professionals are screaming for and trying to access before a child’s mental health deteriorates. In Wales we now have the social services and wellbeing act. This law places a legal duty on local authorities, schools, social care etc to refer an adult or child if they believe that the child or adults wellbeing will be impaired unless the local authority provides them with support. This act is exactly what we need in terms of early intervention. However with this has come with limited finance or extension of provision. This is placing increasing strain on an already overstretched provision. It’s a step but it doesn’t address the real issue.

Such intervention, if available, would reflect Tier 2 CAMHS support. Tier 2 reflects more targeted services which can include CAMHS joint working with education and health care focusing on children vulnerable to mental health difficulties. With this provision available it would seem logical that all LAC are identified as Tier 2 at the point of becoming Looked After as evidence demonstrates and supports that these children are vulnerable to mental health difficulties. This raises questions over provision and identification, when reflecting upon the number of LAC who do not receive support or services from CAMHS and are not recognised as requiring prevention intervention due to their high risk status. Irrespective of the reasons for becoming Looked After these children will experience loss and trauma from the transitional process of becoming looked after. Therefore moving into ‘corporate parenting’ in itself impacts upon the child’s mental wellbeing. Whilst it is accepted the degree of loss and trauma these children will experience, and may have experienced to date, is as individual as the child, recognition that coming into care is part of the trauma process for the

⁴ See for example Nicholas, et al. (2003) Looked After Children in residential homes’ and Callaghan et al. (2003) Developing new mental health services for Looked After Children: a focus group study.

majority of children needs addressing. The impact of how disrupted placement and 'moving on' has on the emotional wellbeing of LAC is aptly illustrated by Bazalgette et al (2015), who used individual case studies as journeys through care. These journeys point to a need for early intervention and monitoring of the mental wellbeing of LAC coming into care and during their time in care and hence either Tier 1 or Tier 2 provision. For many of these children it is not within the early days of placement they display indicators of impact upon their mental health wellbeing; for some it may be weeks, months or years following the initial transition. In order to provide timely and early intervention it is important that the mental wellbeing of these children is recognised as equally important to their physical wellbeing. Therefore irrespective of where the LAC resides, Tier 1/2 is a fundamental level and starting point for all mental health wellbeing and support.

CAMHS maintain that those LAC who are yet to be placed 'permanently' are not necessarily eligible for specialist support (Tier 2), arguing that consistency is of the utmost importance therefore any intervention needs to be after the child is in a permanent placement. This stance negates the purpose of Tier 2 intervention in failing to recognise the child's rights (such as ensuring the *best interests* of the child are met whilst in corporate care, and their rights under the United Nations Convention of the Rights of the Child, for example Article 3 and Article 12 and in particular Articles 21, 23, 24, 26 and 39). Refusing support for reasons of permanence also suggests lack of inter-agency partnerships, in that should the child move area geographically after support has been commenced, those receiving CAMHS provision could continue with this support. One argument against transferring support may result from the relationship developed over time with the professional and the Looked After Child which can be instrumental in the success of intervention strategies employed. Further delay has been identified by Abdinasir and Pona (2015 p.5) who noted that the 'Safeguarding' process '*eclipsed*' the need for mental health support. Additionally, they identified a young person (aged 12) at high risk of sexual exploitation who was declined by CAMHS on the basis that this person did not meet their criteria and should be referred to social care provision. Given the increasing concern regarding grooming within the UK and sexual exploitation, it would appear that early indicators are not viewed as a mental health concern in this instance. This is concerning given the higher risk of LAC being sexual exploited, going missing from care or becoming a potential victim of human trafficking. The problem of attempting to access CAMHS is highlighted within the Children's Commissioner's Report (2016) who found that 79% of CAMHS provision across the UK placed restrictions and thresholds on access to services. The argument for ensuring all vulnerable children do have access to the support they require is not new. This was one of the main recommendations within the 'Vulnerable Groups and Inequalities Task and Finish group Report'

from the Children and Young People's Mental Health and Wellbeing Taskforce (2015a); that in turn informed 'Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing'. Whilst the recommendations were not a statement of government policy at that time, they did highlight the inconsistency and lack of provision for vulnerable children and young people (which by definition would include all LAC) and argued that

Children and young people with vulnerabilities that predispose them to mental health problems due to their biological or social history should be able to access and receive high quality support at an early enough stage to prevent entrenchment and escalation of existing problems. This means making changes to referral and access routes where these are known to exclude those with vulnerabilities. (p.2)

In addition to the Task Force recommendations (that were endorsed by House of Commons Education Select Committee, 2016), there are a number of NICE guidelines to support professionals in good practice including: 'Looked After Children and Young People' (QS31) (2013) and more recently 'Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care' (NG26) (2015). It therefore appears evident that the Threshold Tier pathway within CAMHS at present does not reflect those indicated by NICE if vulnerable children, including LAC, are refused support for not meeting any threshold designated by CAMHS. Furthermore the Department for Education and the Department of Health (2015) clearly state within their Statutory Guidance for local authorities, clinical commissioning groups and NHS England, with reference to promoting the health and well-being of LAC, that *Looked-after children should never be refused a service, including for mental health, on the grounds of their placement being short-term or unplanned*(p.6) a requirement that CAMHS as part of the NHS provision for LAC appears to ignore without regard for the potential consequence of such action. The Children's Commissioner (2016 p.2) found that of the 3,000 referrals made to CAMHS for concerns around life-threatening conditions (*such as suicide, self-harm, psychosis and anorexia nervosa*), 14% receive no support⁵ and 51% were placed on a waiting list (which as previously discussed could be for several months); some of whom would be in corporate care provision. In addition, whilst it is known that many LAC (along with their peers) may decide not to attend their appointment, this in itself can prevent them from accessing services as 28% of CAMHS providers indicate they would stop any further access, and 35% indicated they would place restrictions on access (ibid).

Reflecting on the discourse around lack of placement permanence preventing access suggests that referral systems need clarifying and should include a maximum time frame. LAC are rarely consulted

⁵ no support is variable across CAMHS ranging between 45% in some areas to 18% in others, (The Children's Commissioner, 2016. p.7)

in terms of who the professional is that they will receive support from, rather this process tends to be the person allocated the case. In this way the potential for the Looked After Child not wishing to meet with the allocated professional or work with that particular professional needs acknowledging, and it is feasible the receiving CAMHS provider (once permanence is established) is more effective in providing interventions. This possibility however should not preclude the LAC being supported in the interim period. The ability to access another professional without additional referrals, delays or repetition of information was outlined by Alistair Burt, the Minister for Community and Social Care on 16th March 2016, in his speech at the Children and Young Peoples Mental Health Conference, when he claimed that the Government would be *giving more support directly to children and young people*.(n.p), acknowledging that children and young people were not only entitled to a voice in their care but also wished to be part of any discussions about them specifically and party to any decisions made about them (as highlighted within the UNCRC). Burt responded to this by stating that

I am pleased to say that we are now giving them that control. Through a new online platform, called CO-OP, backed by £1 million of government funding, young people will be able to tell their story about their mental health history and host notes from the clinicians they encounter. This will mean that whenever they meet a new health professional, young people can give them individual access to their mental health history and the professional will be able to continue that person's care in the most effective way. Young people will be in control of their data at every stage, and can agree exactly what to share, and with whom. Not only will young people give information to the platform, they will also have access to information about local mental health services and useful self-help apps.(n.p)

This suggests any refusal for support provision by CAMHS on the grounds of placement permanency is negated and suggests CAMHS not only disregards policy requirements but also practitioner developments. The ability for LAC to have control over their own mental health support provision or any interventions planned is important and needs to be considered alongside the new school strategy of *offering mental health first aid training for teachers and staff to help them identify and assist children experiencing mental health problems*⁶.

The Prime Minister, Theresa May (2017) stated that *Mental health training for teachers and staff will be rolled out to a third of secondary schools this year (around 1,200 schools), with the remaining two-thirds of secondary schools offered this training in the following 2 years. The training will be run by Mental Health First Aid UK working with the government*⁷. The training offered by Mental Health First Aid UK is charged at £150-£200 per person, this suggests a significant investment by the

⁶ Announced on 9th January 2017 as part of Theresa Mays speech regarding the new strategy and approach.

⁷ Announced on 9th January 2017 as part of Theresa Mays speech regarding the new strategy and approach

government into this approach⁸. The training is provided by quality assured instructors who undertake a 7 day instructor's training programme that is accredited by the Royal Society for Public Health. Whilst it is commendable that support in school will become more widely available overall, there are details for this support network that are less clear. Given the number of children and young people currently being refused support by CAMHS as not meeting the threshold, who the mental health first aider refers children or adolescents to for further help is unclear. If no support is in place to immediately respond to mental health first aider requests from schools then the mental health first aider could feel vulnerable in their ability to actively fulfil the new role they are undertaking. When reflecting upon the position of LAC, particularly those who are adolescents, they are already known to, and should be supported by, the Designated Teacher within school, the Virtual School Head and the team supporting the Virtual School Head who receives the allocated Pupil Premium Plus to help provide support. Therefore should any concerns be noted it could be argued that the Designated Teacher is in the best position to provide 'mental health first aid' in the first instance and best placed to liaise with the VSH and the VSH team, especially given the acknowledged long lasting impact between experience of loss and trauma and mental well-being. More importantly interventions need to recognise the impact of loss and trauma is a fundamental part of any behaviours displayed therefore mental health first aiders need to be well placed in their ability to determine cause rather than effect. This means that mental health first aiders would need to be able to distinguish between a direct consequence of loss and trauma or other factors (such as normative hormonal influences during adolescence) as this will inform any intervention proposed. Moreover, for some LAC part of the impact upon their mental wellbeing could be the school itself, the teacher(s) or the pupils. It is therefore unlikely they will respond to any school based intervention and any attempt to provide this may cause further mental health issues for the LAC.

The need for specialist training has been noted by the House of Commons Education Select Committee (2016, p.8) when discussing the mental health of LAC; they counselled that the procedure for assessing LAC mental wellbeing on becoming a LAC *were inconsistent and too often failed to identify those in need of specialist care and support. Initial assessments were rarely completed by qualified mental health professionals with an appreciation of the varied and complex issues with which looked-after children may present.* (my emphasis). This highlights the complexities facing mental health first aiders in being able to identify children and young people who require mental health support. Mental health concerns are not displayed in the same way as physical health

⁸ Cost as indicated on the company website: <https://mhfaengland.org> initially part of the NHS the company transferred to become a Community Interest Company in 2009

concerns, and there may be a myriad of reasons why any child or young person may appear to be in need. However there are also many children and young people who are adept at not being seen as a cause for concern, or to require any support with their mental health wellbeing, who engage in risk taking behaviour or self-harm or even attempt suicide at a time when self-harm⁹ and suicide attempts are increasingly evident in young people overall. One reason for increasing trends of self-harm has been linked to use of social media platforms by young people, a platform also frequently used by LAC and one where significant amounts of bullying is said to happen. Bullying is a further reason why LAC are in need of support for mental health wellbeing given indicators that point to the number of LAC being bullied is twice that of non LAC (see for example Brewina and Statham, 2011); particularly during the transition to secondary school education. For this reason there needs to be further consideration to ascertain if one day of training will equip teachers to feel confident in providing mental health first Aid, and recognise that some staff may feel ill equipped to support today's young people following their training.

Nevertheless placing staff in school is not a new proposal given that the House of Commons Select Committee (2016) also pointed to the need for school based counsellors who were suitably qualified, to be available in order to identify early indicators for concerns relating to mental health wellbeing and well placed to sign post those requiring support to specialist care. Training mental health first aiders does not appear to meet this more specialist and skilled role proposed by the Select Committee. Conversely, in September 2016 the Secretary of State for Health indicated that the Government did not accept the recommendations set out within the House of Commons Education Select Committee (2016) report (conclusion and recommendation 6) requesting that all "looked-after children should have a full mental health assessment by a qualified mental health professional". Instead of endorsing the recommendation another Expert Working Group, working with NHS England, Health Education England, and sector partners would be established and hold their first meeting in July 2016, to establish pathways for assessment. If this Expert Committee will report to, or work in conjunction with the newly announced Care Quality Committee is unclear at this time. In addition, whilst supporting initial and annual SDQ (Strengths and Difficulties Questionnaire) assessment for LAC the government did not accept the recommendation that the SDQ should lead to further assessment by a qualified professional. It will be important to schools however, that newly trained mental health first aiders are not seen to be best placed to complete these assessments once in post. Ironically despite all of the current discourse around identifying

⁹ It is estimated that as many as 1:15 young people self harm in the UK, one of the highest rates in Europe (Burton, 2014) whilst earlier studies argue self-harm is more prevalent in LAC (Harkess-Murphy, MacDonald and Ramsay, 2013)

mental health concerns impacting upon children and young people, including LAC, evidence reported by Blower et al (2004) claimed this was not the issue, the issue was indeed access to early intervention following identification. They argued that those children and young people who required support with their mental health wellbeing were identified early through a range of sources but were not provided with support once identified and it was delayed intervention that was of prime concern.

Tier 3 and Tier 4 intervention from CAMHS provides specialist intervention and CAMHS support; however evidence points to unsatisfactory responses with reference to this provision for all children including LAC. Armiger (2017) agrees that the process is long and frequently frustrating for all involved, noting that *The common issues we face in terms of the referral cycle for children that require further support are as follows:*

Educational psychologist - *there's very few of them in certain authorities and so trying to get an initial phone call consultation with them never mind a visit, is somewhat difficult. Now there are of course times where the educational psychologist doesn't necessarily need to be involved but when we are looking at children that are on the autistic spectrum and we have concerns about diagnostic overshadowing in terms of their mental health, it is often necessary. Following that we have the issue of payment in many cases. Schools having to use their own money for assessments in order to pay for assessment which rubber stamps referral to other agencies. If that rubber stamp is not in place, very often it doesn't matter what the GP's, paediatricians or other professionals say because it will in my experience, immediately get re referred to the Ed Psych.*

CAMHS – *Quite often as their caseload is so vast and regional CAMHS teams are overwhelmed, we have a very long waiting list in many areas. Having spoken to many practitioners they are treating children who should have been receiving support years previously. Although initial assessments can sometimes take place within 30 days, the waiting list is still just as long. This is disproportionate geographically too. Some authorities have seen good responses and provision from CAMHS others report very little access. Many children in my schools have been assessed and given some indication of diagnosis and then placed on the waiting list after being given the news that they may have ADHD, depression, PTSD or many other complex mental health issues. They are left to ponder this without being given the tools to do anything about it.*

School based counselling – *Quite often our school based counsellors work brilliantly to support children. However we are seeing a huge increase in their caseload and quite often they are working closely with children that are actually in need of tier 3 support services. Another challenge these teams face is that of confidentiality. There have been many times where sharing information in a school setting has become challenging because of the clinical approach often needed with supporting these vulnerable young people. Many school based counsellors are also under huge pressure to keep children on their caseload because they are so reliant on the service to keep them mentally well. This is often because school systems and interventions of wave 1 support are not adequate or available*

Current research points to a whole school approach being effective in helping to support the mental wellbeing of all pupils, including LAC. However any real progress will only be made if those organisations involved provide information and a range of potential strategies to schools about LAC,

specifically the increased risk of mental health concerns, including the impact of loss and trauma and the increased risk of engaging in self-harm risk behaviour. Furthermore adopting a whole school approach appears to reflect OfSTED indicators, and those of Public Health England (2016) who have produced an evidence based practice unit toolkit for professionals on measuring and monitoring children and young people's mental wellbeing; indicative of a whole school approach. Armiger advocates a whole school approach suggesting that

A whole school approach is effective if you have the access to well trained and experience staff within your own provision. Having been head of both mainstream and specialist educational provisions, I have been able to call on my own expertise and my staff to implement models that focus on keeping children healthy and well. School approaches are often outdated with sanction systems in place that don't focus on rehabilitation but only focus on punitive measures They have their place but many children with poor mental health end up in this punative system with no way out and no effective intervention that seeks to support their wellbeing and improve their coping strategies. Many schools use restorative approaches and focused interventions when a child appears in distress, but this needs to be advocated more in order to keep our children healthy and well in school and at home.

The main issue of course comes down to lack of provision and funding. Sadly this is a political issue. We want to support every single child in our care and many schools make that very clear. Often these young people require specific intervention quickly and to avoid long waiting lists the only available option is financing interventions in school. This can be effective however most local authorities have cut back on interventions previously financed and accessed by schools. This means if we want to access the service we have to pay for it. We have no issue in doing this but I know from my own experience, that we are forever trying to find money in our own already decimated budgets to do this. Sadly this is only going to get worse. With school budgets facing a very real attack and welsh schools facing the possible loss of European deprivation grants the finance is going to get tighter. We are not managing to meet the demand currently and I must say that I am really concerned for our children's mental health in the near future.

'Who pays' seems to dominate support and intervention provision, a factor not lost on the Children and Young People's Mental Health and Wellbeing Taskforce (2015b) during their discussion and report when recommending adopting a joint commission approach. Adopting a joint commission approach would address concerns raised by one of the Social Workers contributing to the report, who argued that "*Serious consideration should be given to joint commissioning arrangements between social care and health... to promote better understanding, better allocation of resource and reduce the futile arguments about „is it social care or mental health?“ - which is really about who will pay and rarely about the needs of the child.*" (Ibid. p.12). Place2be¹⁰ have provided training for schools within the UK and advocate school counsellors who are fully trained and registered to provide mental health support in schools. This strategy could be more meaningful to LAC in

¹⁰ Place2be is a registered charity and can be accessed at: <https://www.place2be.org.uk/> the inclusion of Place2be is not an endorsement of their service provision over any other charitable provision, rather it is to highlight alternative options to that proposed under Mental Health First Aiders for consideration

providing them with an independent advocate rather than a member of the teaching team. To be effective mental health support and interventions need to be founded in a level of trust between those receiving support and those providing support. This in itself could create conflict for school teaching staff if they also have a professional responsibility within the classroom for teaching or as a head of year/ tutor and involved in any behaviour policy consequences. It is therefore essential that Mental Health First Aiders are not used or seen as part of the Tier 2 provision of support in place of more specialist support and that for those children who are LAC, the designated Teacher and Virtual School Team may be the best point of providing mental health first aid rather than an allocated teacher.

One of the most frequent concerns raised by LAC revolves around confidentiality and sharing of personal information; this may also present a barrier between the LAC seeking advice, guidance or support from the Mental Health First Aider or even the Designated Teacher. Concerns around confidentiality and sharing information were also highlighted by Stanley (2007). Within his study Lisa argued that confidentiality was extremely important for LAC and pointed to an issue she had experienced *'I said something to my social worker once . . . and then a couple of months later you get like review report things don't you, and it fucking had all of it in, didn't it... And then I called my social worker and said "what do you think you're playing at, it was like confidential, talking to you confidentially and you go away, you fucking put it on paper.* (ibid. p.261). The issue of confidentiality would need careful consideration for Mental Health First Aiders, for example if a LAC were to disclose risk taking behaviour believing they could trust the first aider, and this information was then disclosed to others without any consent, the potential for future support will be lost. Alternatively if the first aider does not share information relating to risk taking behaviours, this could compromise them professionally given their legal obligation to uphold child protection.

What is apparent is that the new agenda for supporting children and young people's mental wellbeing reflects little of what they themselves have indicated as their choice. Young people seek support with any concerns they may have from a variety of sources but for this generation there is a reliance and preference for digitally accessed support. According to Young Minds (2014) young people, which may include LAC, accessed *Mental health apps or websites, and friends were the two sources most frequently used by young people to access mental health information. Online information resources were also considered useful by 68% of those that used them.* (2014¹¹, p.4) In addition, *Information provided by charities was thought to be most useful with 73% of young people*

¹¹ Young Minds (2014) Report on Children, Young People and Family Engagement. Young Minds December 2014.

who had used it saying it was helpful.(ibid). This therefore suggests that even if a LAC were to be concerned there are other forums where they will seek advice, support, information and help that are outside of school. The importance of this in relation to the new Mental Health First Aider approach within school and how young people feel in that *Digital services are popular for the speed, ease of access and preserving anonymity.* (ibid) a factor that would be negated in any approach made in person by teachers to young people, including LAC, if they feel their anonymity is lost. This factor has been highlighted by ‘Voices Making Choices’¹² an advocacy service for LAC in Northumberland, who discussed how useful simple contact was for them and how this was preferred over formal ‘support’ such as counselling. They point to an either or system currently existing, whereby for many whilst they acknowledged they were anxious or stressed, they did not feel one hour a week sessions with a stranger worked. What they felt was more appropriate was to be able to send a quick message via a text, email or chat room to someone who would respond with a short reply at the time of need. This type of provision reflects much of what is offered by voluntary organisations, suggesting that the more statutory service provisions are not meeting the needs of their service users, particularly LAC. For example, StreetWise¹³ in Newcastle upon Tyne offers counselling to anyone aged 11-25. The counselling is made in agreement with the young person accessing the service, irrespective of how the referral is made (for example by parents, teachers or the adolescent themselves) and can be provided during the day, at weekends or on evenings. This provision is also offered onsite or offsite via online support including Skype, email or chat room approaches. The ability to offer a flexible service outside of school hours, in a confidential manner both onsite and offsite, caters to the needs of young people today, by recognising young people’s technological preferences. Agencies such as this may be more attractive to LAC when seeking help, as the individual does not ‘see’ the counsellor everyday in their home or school environment, allowing for a clear distinction between the adolescent’s day to day life and the support provision.

More concerning when attempting direct intervention or a direct approach in person would be the risk of any child, including LAC, making every attempt to hide further their mental health needs, particularly if they feel the mental health first aider is not someone they wish to discuss their needs with. Recognising the LAC’s right to discuss their mental health wellbeing with a person of their choosing is fundamental to any intervention or support success (as previously stated by Davies and Wright, 2008). This relationship is not one that can be chosen for children or adolescents with an expectation of conformity. YoungMinds (n.d) highlighted this fundamental need within their report

¹² Further information about this advocacy group is available at:

<http://www.northumberland.gov.uk/Campaigns/Voices-Making-Choices/VMC-Children-in-Care-Council.aspx>

¹³ Further information about StreetWise services is available at: <https://www.streetwisenorth.org.uk/>

'Improving the mental health of Looked After Young People: An exploration of mental health stigma'. Their report reflected the views of LAC and clearly demonstrated that some of these children and adolescents believed teachers had little appreciation of what it was like to be 'looked after', live in a 'system' with uncertainty of placement permanence, have little say in what happens to them overall and viewed as a behaviour problem. For these reasons some LAC indicated that they could not speak to staff about their mental health wellbeing because they felt judged, 'singled out', misunderstood or because they wanted clear boundaries between school and home life. What is clearly evident throughout the report (ibid) is how LAC feel and what they believe would improve mental health service provision for children and young people, not only LAC. Within this report (ibid) and highlighted throughout is a need to be heard, have a choice and anonymity/ confidentiality as advocated by Public Health England with reference to 'Person Centred Care'¹⁴ and the individual's right to choose.

The impact upon LAC without a voice in their support for mental wellbeing is highlighted by Stanley (2007 p.261) in his study where Rachel stated *'It's like I'll get mad if a social worker turned round to me and says: 'Right you've got to talk to this person, you've got to sort your problems out, you've got to do this, you've got to do that'. They'll wind me up and I'll get mad and then I'll just flip on 'em.'* This is further supported if considering young people's opinions of what helps them, whereby school teaching staff support was not highly regarded; rather they felt that *The two forms of support provided by schools that children and young people find the most helpful – lessons about mental health run by an outside organisation and on-line counselling for pupils – are rarely provided. Online counselling is popular as it alleviates concerns about confidentiality.* (Young Minds, 2014, p.5 my emphasis). This suggests the approach adopted by Place2be¹⁵ to more useful and effective than appointing Mental Health First Aiders in schools, which would then acknowledge the *full-time dedicated trained staff*, young people recommended. Whilst a full-time member of staff could be a full time teacher who has received the mental health first aid one day training, they may not always be available to all pupils unless they undertake this position full-time and relinquish their classroom commitments, particularly in larger secondary schools which have over 1000 pupils onsite. The need to listen to LAC and what works for them was noted by Stanley (2007 p.266) who argued that *Listening to looked-after young people's views on their mental health needs is instructive. The lens shifts and looked-after young people emerge less as a challenge for practitioners and policy makers*

¹⁴ For full details of Person Centred Care see: The Health Foundation-
<http://www.health.org.uk/sites/health/files/PersonCentredCareMadeSimple.pdf>

¹⁵ This is not an endorsement of Place2be rather it is an illustration of where the provision already exists for schools and as such widening this provision may provide an effective alternative

and more as a group whose frustrations and demands reflect the shortcomings of their environment. This is an important argument when asking mental health first aiders to identify those in school. It is crucially important that any concerns are contextualised to the individual's life circumstance and therefore may not be a mental health concern, but a system concern, one in which LAC have very little control. Stanley (ibid) highlighted the need for contextualising concerns felt by adults, suggesting that *Angry and disturbed behaviour seems an understandable response in the light of frustrated expectations of support from their mothers, experience of change and disruption, stigma and lack of privacy.* If support for the mental wellbeing is to be effective it needs those involved to recognise and take responsibility for the detrimental impact the 'system' has had upon LAC individually and collectively. Furthermore it would be prudent to recognise the risk and initiate early intervention.

Early intervention could be met within current systems by establishing an Educational Health Care Plan (EHCP) for LAC from the outset. There are many advantages to allocating and establishing an EHCP for LAC as detailed within proposed recommendations by Taskforce reviews (also see Thorley, 2016) which recognises that all LAC have Health plans and Care Plans as part of their service provision. Providing an EHCP to all LAC would foster multi-agency collaboration as well as enabling them to have a voice in service provision via personal payment into their EHCP, and would also support the Five Year Forward View for Mental Health (Independent Mental Health Taskforce, 2016) recommendations. Armiger (2017) agrees a new approach is required if the mental health is to be addressed successfully this time, suggesting that

Mental health and mental illness are different beings to a certain extent. If you have poor mental health and it goes untreated then it is possible it will transition into a mental illness such as depression or anxiety. Keeping children mentally healthy and well is where we want to be in schools. In my previous school we introduced meditation and mindfulness practices in all our lessons, ensured that behaviour systems encouraged interventions that kept children at baseline as much as possible and reformed the curriculum to teach children how their brain worked. However I was able to do this because of the specialist nature of the school. Many schools want to do this but because of the pressures of data and achievement across core subjects such as Maths, English and science, we are hard pressed to make the space in the curriculum without sacrificing time from another subject. This creates a problem in terms of expectation and data because if data is impacted negatively the implications can often be huge. It's this negative culture that many schools have to engage in and this reflects onto students mental health and wellbeing. A few months ago a 15 year old asked me; "How is it that PHSE pretty much stops when we get to year 10 sir? That's when we need it the most." I couldn't agree more. What works is when we give young people the information, strategies, resources and opportunities to keep themselves mentally well and healthy alongside effective support structures. We are currently working too much at the crisis stage, trying to identify signs of mental illness when the very real stresses and pressures young people are experiencing are overlooked. Many point towards 'resilience' as the way forward. I would agree to a certain extent but

I would remind them that resilience is actually collaboration. A child will feel more able to explore the world and their own emotions if they have an emotionally available adult and safe base to return to. There are also those children who's traumatic experiences have moulded their emotional responses to be completely resilient and not able to depend on adults. So I would argue that resilience is part of the solution but certainly not in the form of expecting children to 'toughen up' or 'get on with it'. The issue is much more complex than this and I think we have had enough attempts at simple fixes.

Armiger continues and provides insight into how schools are in untenable positions now, in trying to maintain the mental wellbeing of their pupils, including LAC; that provides a portrayal of Mental Health: the uncomfortable truth

Let me tell you about a child I taught less than 6 months ago. We will call him Ben.

Ben, aged 14 had recently been struggling with low mood and isolating behaviours over the course of the term. That month he displayed many characteristics of depression. He had very little support at home and socially but we had managed to engage him in a few school based interventions. However we could see that nothing seemed to be working. After further conversations with Ben he explained that his thoughts had become quite dark. Despite numerous calls and referrals concerning his suicidal thoughts we could get no further support than the current school based counselling he was accessing. His parents weren't particularly supportive of his mental health and dismissed it as teenage angst.

I was off site facilitating training one day. It came to lunch and I began doing what any other person does during two minutes spare time they are granted – Checking emails. At the top of my inbox I had received an email from Ben. Many children often email their teachers for the sake of assignments or work set in school for qualifications. I had been Ben's mentor for most of my time in the school and still kept this role even as head teacher. Within this email he had attached his assignment but also outlined some of the difficulties he was having emotionally. But his last paragraph made me go cold. 'I know there might be a way out eventually and someday things may seem brighter, but right now, being alive is just too painful.'

I picked up the phone immediately. Knowing Ben's history of suicidal thoughts, I asked my deputy to get in touch with his parents, police and crisis provision. No one was free to attend within 15 minutes. Ben lived 5 minutes away from the school so my deputy went round with another member of staff. My deputy managed to climb up a drainpipe to Ben's window and talk to him and eventually persuade him to talk with her and not harm himself further.

Fortunately they got there just in time and managed to ensure Ben was safe. I won't lie, it was very close. We almost lost him.

What would have happened if he hadn't emailed me? Or if I wasn't on lunch?

Those words stayed with me all night. He must have been in a really dark place and experiencing so much pain to believe that taking his own life was the easier option.

The good news is that because of my own experience and training I could invest some time and resources in Ben. A few hours a week alongside some further support that explained what was going on in his brain and how to decipher what is rational and what isn't was what he needed at that time. And guess what? That very short and inexpensive intervention worked. There is a long way to go but

he is doing really well and running a group to help other young men talk about their mental health. It is these school based interventions that seem to work positively along side long term external interventions.

But this case is not unique. This is happening regularly. Too many young people feeling unsupported and in crisis and no agencies with available resources to pick Ben up and give him the help and expertise that he needs. I have dealt with similar circumstances in my time, but in the past 2 years of my school career, I have had to deal with these scenarios weekly and I am not alone. It would be no exaggeration to state that educators are going above and beyond in order to plug gaps in provision to literally keep children alive.

We have so much work to do in schools, health, specialist services and our homes for our children's mental health. Things are getting better slowly in terms of awareness and stigma however as we begin to talk about it more and ask young people to discuss their thoughts and health openly, we must equip them with the right tools to navigate through this process; Language, specialist support and education. Rhetoric is not enough.

Such reflection highlights the fundamental difficulties currently existing with mental health provision for all children including LAC at this time within the UK. Additionally, whilst investment into service provision has been highlighted as the main barrier in providing support or intervention for children or adolescents, there appears to be little regard for the longer term costs of not providing support or intervention. This includes a deterioration in the individual's mental wellbeing, that may require Tier 4 intervention following crisis which could have been averted had suitable Tier 2 or Tier 3 support been provided earlier (an issue not lost on the Children and Young People's Mental Health and Wellbeing Taskforce, 2015b). Moreover, it is also recognised that there is an economic cost for the child or adolescent as they progress into adulthood if suitable early intervention is not provided in terms of overall health and wellbeing (for example this is well portrayed within the ACE¹⁶ study) that directly impacts upon any future employment and adult service need. More concerning are the wider impact indicators for LAC as they progress throughout adolescence. It is well documented that LAC individually and collectively achieve less academically than their peers, and are more likely to be excluded within behaviour policies for schools in addition to being identified as having SEN compared to their peers. Within the Youth Justice system there are proportionally more LAC than their non LAC peers and higher levels of substance misuse. These factors have led to a wide range of policy initiatives and research findings and report, for example Lord Laming presented his 'In Care,

¹⁶ The Adverse Childhood Experiences Study (**ACE Study**) is a research **study** conducted by the American health maintenance organization Kaiser Permanente and the Centers for Disease Control and Prevention (1995-1997) leading to a wide range of publications which are listed at: <http://www.theannainstitute.org/ACE%20STUDY%20FINDINGS.html>. This study has been replicated internationally and is widely recognised for predicting future indicators for children as they progress to adulthood, for example see the The Public Health Wales NHS Report (2015) at: <http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf> ; and Liverpool Johns Moore University (2016) in their study from Hertfordshire, Luton and Northhamptonshire available at: http://www.cph.org.uk/wp-content/uploads/2016/05/Adverse-Childhood-Experiences-in-Hertfordshire-Luton-and-Northamptonshire-FINAL_compressed.pdf

Out of Trouble' findings in May 2016. Throughout the majority of these discussions, spanning over 20 years, is the mental wellbeing of children and young people including LAC. All recommendations addressing early intervention for the mental wellbeing of not only LAC but all children, highlight the positive outcomes in economic terms for the Government (both short and long term), and for the individual child or adolescent's short and long term health (see for example Richardson and Lelliott, 2003; Her Majesty's Government, 2011; Department for Education, 2014, Children and Young People's Mental Health and Wellbeing Taskforce, 2015b, Parkin, 2016). Additionally, whilst a review of current provision may appear to be urgently required at this time, this appears to be a repetition of what is already known. As detailed within this discussion reports previously published and research studies to date have continuously highlighted the issues preventing access to gaining mental wellbeing support for children and adolescents, and particularly LAC. They also provide similar recommendations that are yet to be enacted. Following this argument it is difficult to determine what additional findings the Care Quality Commission will discover or how their recommendations will differ from those previously made.

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