



House of Commons
Education Committee

Mental health and well-being of looked-after children

Fourth Report of Session 2015–16



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*Report, together with formal minutes
relating to the report*

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The Education Committee

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Summary

In March 2015 the Department for Education and the Department of Health jointly published new statutory guidance on *Promoting the health and well-being of looked-after children*. The guidance recognised that almost half of children in care have a diagnosable mental health disorder.

Provision for looked-after children with mental health concerns is poor in many areas across England. Some local authorities are providing integrated services with a strong focus on multi-agency working and support for key workers such as foster carers and school staff. However, a significant number are failing to identify mental health issues when children enter care and services are turning away vulnerable young people for not meeting diagnostic thresholds or being without a stable placement. It is important that all children who need access to CAMHS get it in a timely manner. We believe that looked-after children should be viewed as a priority for access to mental health assessments and never refused care based on their placement or severity of their condition.

Co-ordination between health, education and social services at a local level is at the heart of effective support for looked-after children with mental health difficulties. We have seen evidence of local authorities who have co-located their services and are implementing the aims articulated in last year's aspirational *Future in Mind* report. Co-ordination must be driven by strong leadership and we recommend that each local area employ a senior, designated mental health professional to oversee provision.

Children and young people need to be better supported as they enter and leave the care system. We recommend that care leavers should be able to access CAMHS up until the age of 25 if necessary and that initial assessments of those entering care should be more thoroughly and consistently carried out.

Schools and teachers have an important role to play. But, they should not be administering specialist advice or acting as the sole source of support for their students. We advocate a 'whole-school approach' to mental health. Through initial teacher training (ITT) all teachers should be trained in mental health and well-being. Current training and development for foster and residential carers in mental health and well-being is of variable quality, but when done properly is a critical part of providing looked-after children with stability and security in their placement.

Addressing the lack of reliable data about the state of children's and young people's mental health must be a priority for the Government. We are disappointed that it has been 12 years since the last prevalence survey on children's mental health was conducted.

Finally, the voices of the children and young people in the care system must be heard at every stage. Their input into care planning and the services they receive is crucial to ensuring successful placements and the formation of lasting relationships with the many professionals in their life.

1 Introduction

Background

1. The mental health of looked-after children is significantly poorer than that of their peers, with almost half of children and young people in care meeting the criteria for a psychiatric disorder.¹ In comparison one in ten non-looked-after children and young people suffer from a diagnosable mental health disorder.² In November 2014, the Health Committee published a report on Child and Adolescent Mental Health Services (CAMHS).³ The report revealed problems throughout the system from early intervention to the transition to adult services. The Committee concluded that “there are serious and deeply ingrained problems with the commissioning and provision” of CAMHS.⁴

2. Since the publication of the Health Committee’s report the Department of Health (DH) and the Department for Education (DfE) have published new statutory guidance on *Promoting the health and well-being of looked-after children*.⁵ On the same day the Children and Young People’s Mental Health Taskforce released their report *Future in Mind*.⁶ Both of these publications are part of a wider focus on mental health by the Government, most recently demonstrated through the commissioning of a report by the independent Mental Health Taskforce, *The Five Year Forward View for Mental Health*.⁷ The Government has stated that it will invest £1.4 billion in children and young people’s mental health services over the course of the Parliament.⁸

3. Children in care and care leavers are more likely to experience poor health, educational and social outcomes.⁹ Young people leaving care in the UK are five times more likely to attempt suicide than their peers.¹⁰ They are also more likely to enter the criminal justice system. 23% of adult prisoners have been in care, and 40% of prisoners under 21.¹¹ Research by Loughborough University and the NSPCC suggested that the consequences of a lack of support for looked-after children’s mental health and well-being can be more expensive than investing in specialist services.¹² Their analysis showed that:

1 Luke et al, [What works in preventing and treating poor mental health in looked-after children?](#) (August 2014), p 7

2 Office of National Statistics, [Mental health of children and young people in Great Britain, 2004](#) (August 2005), p xxi

3 “CAMHS is used as a term for all services that work with children and young people who have difficulties with their emotional or behavioural well-being. Local areas have a number of different support services available. These might be from the statutory, voluntary or school-based sector, such as an NHS trust, local authority, school or charitable organisation”. NHS Choices, [‘Child and adolescent mental health services \(CAMHS\)’](#), accessed 6 April 2016

4 Health Committee, Third Report of Session 2014-15, [Children’s and adolescents’ mental health and CAMHS](#), HC 342, p 3

5 Department for Education and Department of Health, [Promoting the health and well-being of looked-after children](#), March 2015

6 Department of Health and NHS England, [Future in Mind](#), March 2015

7 Independent Mental Health Taskforce, [The Five Year Forward View for Mental Health](#) (February 2016)

8 Youth Select Committee, [Young People’s Mental Health](#) (November 2016), p 6. The Youth Select Committee is a British Youth Council initiative, supported by the House of Commons. The eleven committee members are aged 13-18 and include two Members of the UK Youth Parliament, two youth councillors, a Young Mayor, one elected representative from each of the devolved nations and three reserved seats.

9 Essex County Council ([MHW 25](#)) para 1.5

10 Children and Young People’s Health Outcomes Forum, [Report of the Children and Young People’s Health Outcomes Forum- Mental Health Sub-Group](#) (July 2012), p 2

11 The Who Cares? Trust, [‘The statistics’](#), accessed 6 April 2016

12 NSPCC, [Achieving emotional well-being for looked-after children](#) (June 2015), p 5

One child's unstable and unsupported experience of care cost £22,415 more per year (including health, social care and criminal justice costs) than another child's stable and well supported care journey.¹³

Our inquiry

4. The work of the Health Committee, and subsequent Government commitments on mental health prompted us to conduct an inquiry focusing specifically on looked-after children.

5. We launched our inquiry on 18 September 2015 with a call for written evidence in respect of the following issues:

- Whether the Department for Education and Department of Health guidance on *Promoting the health and well-being of looked-after children* published in March 2015 is sufficient to ensure that mental health and well-being are prioritised for children in care and care leavers;
- The extent to which the aims articulated in the guidance are being implemented at a local level;
- The extent and quality of dedicated mental health and well-being services provided for looked-after children and care leavers, including training and support for carers and social workers;
- The level of coordination between relevant elements of the education system, the care system and the health system in supporting the mental health and well-being of looked-after children and care leavers, and how this can be improved;
- The contribution that schools make to supporting the mental health and well-being of looked-after children alongside services such as CAMHS;
- How young people and their carers can be more involved in designing mental health and well-being services for looked-after children, including when making the transition to adult services when leaving care;

6. We received 58 written submissions during our inquiry including written evidence submitted jointly by DfE and DH. We took oral evidence on three occasions, including from Rt Hon Alistair Burt MP, Minister of State for Community and Social Care, and Edward Timpson MP, Minister of State for Children and Families. We also held an informal, private meeting with a group of young people in care and care leavers.¹⁴ We are grateful to the NSPCC and The Who Cares? Trust for helping us organise this session and to the young people who attended. In January 2016 we visited Trafford Metropolitan Borough Council as an example of an integrated service for looked-after children. We are grateful to the staff there for accommodating us, and to all whom we met.

¹³ [Achieving emotional well-being for looked-after children](#), p 5

¹⁴ See [Annex 1](#) for further details.

7. During the inquiry we benefited from the advice of Professor David Berridge OBE and Marion Davis CBE as our standing advisers on children's services, as well as Dr Matt Woolgar, a Consultant Clinical Psychologist, who acted as a specialist adviser for this inquiry.¹⁵

15 Professor David Berridge, Professor of Child and Family Welfare, University of Bristol, declared interests as a member of the Bristol City Council Corporate Parenting Panel, research grants from DfE, research councils, trusts, voluntary organisations and others. He declared his involvement at the University of Bristol in educating and training qualifying and advanced social work, and other, students. Marion Davis declared interests as a Trustee of Children and Families across Borders (CFAB), a member of the Improvement Board for Children's Services in Northamptonshire County Council, an external adviser to the Safeguarding Board of Northern Ireland in respect of a thematic review of Child Sexual Exploitation, and author of a Serious Case Review for Sutton local safeguarding children board. Dr Matt Woolgar declared interests as an employee of the National Adoption and Fostering Service at the Maudsley Hospital, SLAM NHS Foundation Trust, and co-author of the Fostering Changes programme. He declared funding from National Institute for Health Research and the Children and Young People's Improving Access to Psychological Therapies Programme.

2 Access to mental health services

Mental health and well-being assessments

8. According to the joint DfE and DH statutory guidance *on Promoting the health and well-being of looked-after children*, all looked-after children and young people who enter care should have an initial health assessment by a registered medical practitioner.¹⁶ Looked-after child reviews should subsequently take place every six months with an Independent Reviewing Officer (IRO), social workers and foster or residential carers. Health and well-being should form part of these discussions.

9. In addition a Strengths and Difficulties Questionnaire (SDQ), a brief emotional and behavioural screening tool, should be completed annually for every child in care. Despite this Ofsted told us that SDQs are “rarely” used to maximum effect:

Most local authorities inspected since the publication of the revised guidance in March 2015 were unable to complete initial health assessments of children after they enter care within the required timeframe consistently. A small number of local authorities were unable to provide data on this statutory requirement.¹⁷

10. Lisa Harker, Director of Strategy, Policy and Evidence at the NSPCC, told us that the SDQ is just a starting point and that a “fuller” mental health assessment should be undertaken by a mental health professional for those children who receive high scores in the SDQ.¹⁸ The NSPCC’s written evidence stated that:

Although we support a system that uses SDQs in a consistent manner, they are not mental health assessments and they will not provide the overarching mental health insight that is essential upon entry into care.¹⁹

11. The National Children’s Bureau also told us that initial health assessments on entering care are “highly variable and often poor”.²⁰ It recommended that assessments of looked-after children should be completed by a qualified mental health professional when entering care.²¹

12. The regular assessment of looked-after children and young people’s mental health and well-being was raised by Teresa Latham, a foster carer. Ms Latham told us that assessment of mental health needs should take place throughout a child’s time in care rather than just at the beginning.²² She explained that “the child that you have for the first three to six weeks of placement is not the child that you will have after six weeks. They settle in and then you see the real child.”²³

¹⁶ [Promoting the health and well-being of looked-after children](#)

¹⁷ Ofsted ([MHW 64](#)) para 4.11–12

¹⁸ Q3

¹⁹ NSPCC ([MHW 72](#)) para 7

²⁰ National Children’s Bureau ([MHW 36](#)) para 3.3

²¹ National Children’s Bureau ([MHW 36](#)) para 3.5

²² Q5

²³ Q135

13. **Current methods of assessing children and young people’s mental health and well-being as they enter care are inconsistent and too often fail to identify those in need of specialist care and support. Initial assessments are rarely completed by qualified mental health professionals with an appreciation of the varied and complex issues with which looked-after children may present.**

14. *We recommend that the Government amends the statutory guidance to make clear that an SDQ should be completed for every child entering care as a starting point. In addition all looked-after children should have a full mental health assessment by a qualified mental health professional. Where required this should be followed by regular assessment of mental health and well-being as part of existing looked-after children reviews.*

CAMHS and looked-after children

15. CAMHS offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. The services they provide differ depending on the local area. We received a substantial amount of evidence on the capacity of CAMHS to respond and treat looked-after children and young people.

16. In our first evidence session Sarah Brennan spoke of the high numbers of young people being turned away from CAMHS because they did not “fit the medical criteria of having a diagnosed mental health problem”.²⁴ David Graham, National Director of the Care Leavers Association, supported this view by adding that the level of assessment which CAMHS used was “too high”.²⁵ The result of high thresholds for treatment can mean that young people are placed at the end of lengthy waiting lists. One young person we met in our informal meeting told us that “doctors refer young people to CAMHS, and then the young person receives a message saying that you are not a priority”, they added “this is disgusting and a huge self-esteem blow”.²⁶

17. Christine Malone, a foster carer, told us that CAMHS will only see a child when they are in a “permanent settled placement”.²⁷ The young woman in Ms Malone’s care said that she had been waiting for CAMHS for over two and a half years but had been unable to access services because she had moved thirteen times during that time period.²⁸ Despite the statutory guidance stating that should “looked-after children should never be refused a service, including for mental health, on the grounds of their placement”, this refusal of CAMHS to see children without stable placements was described in several pieces of written evidence.²⁹ The National Adoption & Fostering Service said that “CAMHS LAC (looked-after children) services will often want to wait until a child is ‘stable’ before assessing or treating”.³⁰ The reluctance to assess or treat young people without a stable placement largely stems from “uncertainty” as children and young people move between

24 Q2

25 Q2

26 See [Annex 1](#) for further details.

27 Q126

28 Q122

29 [Promoting the health and well-being of looked-after children](#), p 6

30 The National Adoption & Fostering Service ([MHW 66](#)) para 13

foster or residential placements.³¹ CAMHS are unwilling to begin therapeutic treatment until they can ensure that a child will be based in the same location for a significant period of time.³²

18. Written evidence also commented on the budget cuts which CAMHS have faced over recent years.³³ This reduction in funding has taken place across NHS and local authority budgets. In particular, many specialist teams which offered targeted support for looked-after children and young people have been abolished due to financial pressures. The Royal College of Psychiatrists wrote that although dedicated CAMHS for looked-after children had disappeared in some areas, because of pressures on local authority funding, in others they had survived because funding had been ring-fenced.³⁴

19. The extent to which local CAMHS should be wholly responsible for delivering services was challenged by Claire Bethel, Deputy Director for Children and Young People's Mental Health and Well-being at DH. Ms Bethel told us "we need a multi-agency response, that if a looked-after child has a mental health problem it is not just a problem for CAMHS".³⁵ Wendy Lobatto, Service Manager at 'First Step' in Haringey, agreed with Ms Bethel and argued that CAMHS should not be seen as the only source of support:

The point I want to make [...] is that CAMHS should be all of our business and that emotional and mental health needs for looked-after children cannot, I think, be sequestered off into this agency called CAMHS, which then has to manage all of the difficulties, but that they should be the concern of all of us.³⁶

20. A 'multi-agency' response allows looked-after children with complex needs to receive specialist input across services and is advocated in The National Institute for Health and Care Excellence (NICE) guidance:

It is also reported that when multi-agency teams are supported and encouraged to address their way of working, they are better able to collaborate when handling difficult and complex situations, and more readily adopt a non-defensive approach that focuses on the best outcomes.³⁷

21. Looked-after children who need access to mental health services often have numerous and complex issues that require specialist input across multiple agencies. We have heard evidence that CAMHS is often unable to provide this care due to high thresholds and a refusal to see children or young people without a stable placement. The inflexibility of CAMHS is failing looked-after children in too many areas and leaving vulnerable young people without support.

22. CAMHS should not refuse to see children or young people without a stable placement or delay access to their services until a placement becomes permanent.

23. We recognise that CAMHS is not the only, or in many cases the most suitable, source of support for looked-after children. We recommend that where possible CAMHS

31 Research in Practice (MHW 44) para 12

32 The Children's Social Care Department of Portsmouth City Council (MHW 51) para 8

33 The Children's Society and the Church of England (MHW 68) para 4.1

34 The Royal College of Psychiatrists (MHW 33) para 3.3

35 Q70

36 Q110

37 NICE guidelines, *Looked-after children and young people* (October 2010), p 22

should form a part of a multi-agency team in which education, health and social care work in partnership. Looked-after children and young people are best supported when professionals collaborate and services are tailored to the needs of the individual.

Priority access for looked-after children

24. In addition to the challenges which looked-after children face in accessing CAMHS, several witnesses discussed the extent to which mental health services should prioritise those in the care system. Sarah Brennan, Chief Executive of YoungMinds and a member of the Government’s 2014 taskforce, recommended that all looked-after children should have a ‘fast track’ to and within CAMHS because of the increased risk of having experienced childhood neglect, abuse or trauma.³⁸ Essex County Council told us that they had made looked-after children and young people a priority for accessing support in order to ensure that they received a specialist response as “swiftly and effectively as possible”.³⁹

25. Whether or not looked-after children and young people should have priority access to mental health services was a source of disagreement between the two Ministers in their oral evidence to us. Speaking for DH Alistair Burt told us that:

It is important to me that a looked-after child gets access to the service that they need through the system, but not necessarily simply because they are designated a looked-after child [...] But it is important that the clinical mental health needs are assessed in the same way as they would be for any other child, and that a looked-after child has the opportunity to come into CAMH Services that are available to all.⁴⁰

26. In contrast Edward Timpson gave his opinion that looked-after children should be prioritised for services:

On this I am not prepared to break my own rule, irrespective of the fact that there is the clear clinical, constitutional position of the National Health Service that everyone has to access any health service based on clinical need. I think there are things we can do to ensure that children in care, and also children who move on to special guardianship order or on to adoption, have a much better arrangement in place to ensure that they do not lose out by there being insufficient resource for them.⁴¹

27. It is important that all children who need access to CAMHS get it in a timely manner. In recognition of the distinct challenges which looked-after children and young people face, we recommend that they should have priority access to mental health assessments by specialist practitioners but that subsequent treatment should be based on clinical need.

38 YoungMinds ([MHW 71](#)) para 13

39 Essex County Council ([MHW 25](#)) para 2.8

40 Q194

41 Q196

3 The care system

Placement stability

28. Children in long-term, secure placements are more likely to feel that their mental and emotional health needs are supported.⁴² Matching children and young people to suitable foster and residential settings is crucial to ensuring longevity in a placement and happiness for a child or young person.

29. Kevin Williams, Chief Executive of the Fostering Network, told us that “placement stability will be one of the key factors that helps to improve emotional well-being for looked-after young people”.⁴³ Mr Williams also voiced his support for the ‘Staying Put’ policy which allows young people to stay in foster placements until they are 21.⁴⁴ He added that although ‘Staying Put’ could “reduce involvement in mental health services in the future”, implementation is currently “poor” and “sporadic”.⁴⁵ The Government has recently announced a 50% increase in funding for ‘Staying Put’ in 2016/17.⁴⁶

30. In our private meeting several young people spoke of the disruption that frequent change had on their emotional well-being and mental health.⁴⁷ One care leaver told us “continuity and stability is so important and children in care don’t have any”.⁴⁸ Continuity in care also featured heavily in our discussion with young people and in evidence from Sarah Brennan:

We know the linkage—the continuity of care—is absolutely critical for all parts, but certainly around mental health and well-being it is often the relationship and the consistency of care that is the most therapeutic thing. How those local arrangements can enable continuity of care is certainly challenging, but it is also essential.⁴⁹

31. The National Adoption and Fostering Service commented that placement stability can have a positive impact on looked-after children’s “attachment relationships” and subsequently their mental and emotional health and well-being:

Placement stability in its own right can be a valuable asset for improving children’s well-being, and based on research, their attachment security.⁵⁰

32. Continuity of care in an environment where children and young people are able to form strong, enduring relationships should be at the heart of the care system. We are pleased to see an increase in funding for ‘Staying Put’ and expect to see evidence that this additional investment leads to more young people remaining in secure placements for longer.

42 The Adolescent and Children’s Trust ([MHW 60](#)) para 7

43 Q2

44 Q2

45 Q2

46 Department for Education, [Staying Put Implementation Grant \(2016/17\)\[No.31/2380\], March 2016](#)

47 See [Annex 1](#) for further details.

48 See [Annex 1](#) for further details.

49 Q11

50 The National Adoption and Fostering Service ([MHW 66](#)) para 20

The transition out of care

33. CAMHS are expected to work with young people up until the age of 18. However we were told that CAMHS will see a young person between 16 and 18 only if they are in full time education. The Children’s Services Development Group explained:

There is also a specific problem with a lack of access to CAMHS for looked after children between the ages of 16 and 18 who do not attend school or college. Funding for CAMHS is generally organised through school and colleges. As a result, looked after children who are over 16 and not in education rarely receive CAMHS, even if they require it.⁵¹

34. Once a young person is over the age of 18 they can be referred to adult mental health services. Several pieces of written evidence described the differences between CAMHS and adult services, which they said were in many cases unsuitable for vulnerable young people such as those in care. The Children’s Society and the Church of England expressed particular concern for the mental health of care leavers:

The period of transition for many children can be characterised by confusion, a lack of coordination and participation. It is known that mental health needs become more acute as children progress through adolescent years and when they leave care. Yet it is then that the access to services becomes more difficult.⁵²

35. The NSPCC described the withdrawal of CAMHS at 18 as a “cliff edge” in care.⁵³ Its 2015 report into the emotional well-being of looked-after children recommended that local authorities and health services should work together to provide mental health support for care leavers up to the age of 25.⁵⁴ Extending mental health support for care leavers until the age of 25 was also included in the Alliance for Children in Care and Care Leavers seven key recommendations to this inquiry.⁵⁵

36. NICE guidance recommends that mental health treatment for young people should continue “until a handover with an assessment and completed care plan has been developed with the relevant adult service”. It continues to say that if a young person does not meet the threshold for adult mental health services then other types of support should be identified in a pathway plan.⁵⁶

37. Although the majority of evidence agreed that looked-after young people need better mental health support as they leave the care system, there was some debate over whether providing such support should be mandatory. Claire Bethel told us that:

What I don’t think we want to do is put that on the statute books and make it a mandatory increase in the age from 18 to 25. We want to leave it for local determination but we are very interested and pleased that there a couple of areas in the country [...] that are now commissioning services from 0-25.⁵⁷

51 Children’s Services Development Group (MHW 26) para 28

52 The Children’s Society and the Church of England (MHW 68) para 5

53 *Achieving emotional well-being for looked-after children*, p 8

54 *Achieving emotional well-being for looked-after children*, p 8

55 Alliance for Children in Care and Care Leavers (MHW 62)

56 *Looked-after children and young people*

57 Q73

38. Professor Peter Fonagy, National Clinical Adviser on Children and Young People's Mental Health at NHS England, agreed with Ms Bethel that a 0-25 mental health service for looked-after children should be made possible but not enforced. This argument is very much in line with the recommendations from The Children and Young People's Mental Health Taskforce report *Future in Mind*.

The Taskforce does not wish to be prescriptive about the age of transition, but does recognise that transition at 18 will often not be appropriate. We recommend flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age.⁵⁸

39. Leaving the care system can be a time of significant upheaval and disruption. This is likely to be more acute for care leavers with mental health concerns. Current support for these vulnerable young people is inadequate and based too heavily on inflexible age restrictions.

40. CAMHS should be made available for all looked-after young people up to the age of 25 in recognition of the distinct issues which this vulnerable group of young people face as they leave the care system. Access to services beyond the age of 18 should be offered where appropriate but not made mandatory where an individual would be better suited to moving onto adult mental health services.

Monitoring of looked-after children and care leavers

41. In 2014 the Health Committee's report on CAMHS expressed serious concerns over the lack of reliable data and information on children and young people's mental health.⁵⁹ The Committee described it as "deeply" concerning that the Office of National Statistics (ONS) data on children's and young people's mental health was ten years out of date. It received assurances from the Minister that the study would be repeated:

The Minister agreed that prevalence data was "horribly out of date". During the course of our inquiry, the Government announced that it had identified funding to repeat this survey, and the Minister repeated this commitment in oral evidence to us. Work will begin in the autumn, although the project is not likely to be completed until 2016. While the Minister could not commit future governments to funding the survey on a continuing basis, he told us that in his view a long gap between surveys should in future be avoided, in order to "maintain a current understanding of the scale of the problem".⁶⁰

42. In evidence to us Alistair Burt admitted there had been a "data shortage" and stated that the Government had commissioned a new ONS prevalence survey which will report in 2018; 14 years after the last study.⁶¹ The studies were previously conducted on a five-yearly basis.

43. The paucity of data was acknowledged by Edward Timpson who also admitted that there was a huge variability in the extent to which local authorities support and monitor

58 *Future in Mind*, p 49

59 *Children's and adolescents' mental health and CAMHS*

60 *Children's and adolescents' mental health and CAMHS*, p 13

61 Q199

their care leavers.⁶² Mr Timpson referred to the National Audit Office's (NAO) report entitled *Care leavers' transitions to adulthood*.⁶³ This report recommended that the Government "monitor the lives of care leavers" to get a "better understanding of the social problems care leavers face, such as [...] mental illness".⁶⁴

44. Concerns over the long-term monitoring of care leavers were reflected in evidence from Professor Fonagy:

I would want to state that specifically in the case of looked-after children, long-term outcomes are poorly monitored and if you wanted to consider recommendations for this Committee, better monitoring of long-term outcomes for this population is of great importance.⁶⁵

45. There is an urgent need for comprehensive and up to date data on the mental health and well-being of looked-after children and care leavers. We are disappointed that a new ONS prevalence survey will not report until 2018.

46. We strongly urge the Government to return to funding ONS prevalence surveys on children and young people's mental health on a five-yearly basis. We also recommend that they invest in outcomes monitoring to better understand the challenges that young people face whilst in and when leaving the care system.

62 Q200

63 National Audit Office, *Care leavers' transition to adulthood*, [HC 269](#), July 2015

64 *Care leavers' transition to adulthood*, [HC 269](#), p 11

65 Q72

4 Workforce development

Foster and residential carers

47. We met foster and residential carers as part of our visit to Trafford Metropolitan Borough Council in January 2016. Trafford runs two training programmes on mental health and well-being awareness as a recognition that investment in carers can help ensure placement stability for children and young people.

48. Carers in Trafford are given free training in KEEP, an evidence-based programme designed to support foster carers to manage the behaviour of looked-after children with complex and challenging behaviours. Trafford also offer training on the Nurturing Attachment Programme which is based on attachment theory and an understanding of the impact of trauma on children's development and security.⁶⁶ In Trafford approximately 75% of foster carers have taken part in the KEEP programme and roughly half have attended the Nurturing Attachment training.

49. In response to a written question on the training available on mental health awareness for foster carers Mr Timpson stated:

The statutory framework is clear that fostering services must provide carers with the training, information and support necessary in the interests of children placed with them.

The Training, Support and Development (TSD) Standards provide a national post-approval training framework for what foster carers should know and understand. This includes knowing what 'healthy care' means for the mental health of young people, and how children develop relationships. My Department's expectation is that fostering services should ensure that foster carers complete the training within 12-18 months of approval. The TSD Standards form part of the National Minimum Standards for foster care.⁶⁷

50. Despite these standards, evidence to this inquiry has described training for foster and residential carers in mental health and well-being as patchy. Alistair Burt responded to criticism of current training for foster carers by saying that "of course we want to continue to see what more we can do so that the often greater level of specialism that is now needed in foster care is being addressed".⁶⁸

51. Wendy Lobatto, from 'First Step' in Haringey, told us that different areas have varying approaches to training and development and that it would be "good to build on the best of those approaches".⁶⁹ She added that it would be helpful if there was "vigilant oversight" from the Government to ensure that all areas "are putting sufficient resource and attention into the needs of looked-after children and the needs of the workforce that

⁶⁶ The term 'attachment' refers to the physical and emotional support which children depend on from the key adults who take care of them. Attachment theory says that children who are securely attached have higher self-esteem and empathy, and can deal with stress more effectively. Looked-after children are more likely to be affected by attachment difficulties which can have a negative impact on their mental health and subsequent behaviour.

⁶⁷ PQ 26853 [[on Foster Care: Mental Health](#)], 23 February 2016

⁶⁸ Q202

⁶⁹ Q116

support them”.⁷⁰ Dr Antonina Ingrassia, a Consultant Child and Adolescent Psychiatrist and Director of Medical Education at Oxleas NHS Foundation Trust, added that “the Department of Education should commission a scoping exercise to develop a curriculum for a core national training module for professionals working with looked-after children”.⁷¹

52. Training and support for foster and residential carers is highly variable and in many local authorities fails to equip carers with the knowledge and skills needed to support looked-after children with mental health difficulties. Foster and residential carers are professionals who need comprehensive and regular training in how to properly support children and young people in their care.

53. *The current Training, Support and Development standards should be supplemented with specific modules which focus on mental health and emotional well-being. The Department for Education and the Department of Health should fund and develop these learning modules, building on best practice and those existing programmes with clear evidence of success. We recommend that the Government creates a curriculum development committee to oversee the formation of these modules.*

Teacher training

54. Training for teachers on mental health and well-being was highlighted in the January 2015 Carter review of initial teacher training (ITT):

ITT should provide new teachers with a grounding in child and adolescent development, including emotional and social development, which will underpin their understanding of other issues such as pedagogy, assessment, behaviour, mental health and special educational needs and disabilities (SEND). ITT should also introduce new teachers to strategies for character education and supporting pupil well-being.⁷²

55. The report claims that although teachers “believe they have a duty to help identify and support pupils with mental health problems, they feel inadequately prepared to do so”.⁷³ This echoed the evidence we received from the Association of School and College Leaders (ASCL) which argued that instead of supporting and promoting good mental health and well-being, schools are delivering “emotional first aid”.⁷⁴ ASCL wrote that long waiting lists for CAMHS means that schools are forced to call emergency services in severe cases.

56. The Youth Select Committee recently recommended that “there should be a mandatory minimum training for teachers on young people’s mental health” which includes training on “how to spot problems and where to refer”.⁷⁵

57. *We support the recent recommendation made by the Youth Select Committee on the inclusion of mental health training in the core content of initial teacher training. We see this as a minimum requirement. Training on emotional well-being and mental health should also be included in continuous professional development for current teachers.*

70 Q116

71 Dr Antonina Ingrassia ([MHW 70](#)) para 23

72 Andrew Carter, [Carter review of initial teacher training \(ITT\)](#) (January 2015)

73 Andrew Carter, [Carter review of initial teacher training \(ITT\)](#) (January 2015), p 56

74 Association of School and College Leaders ([MHW 34](#)) para 7

75 [Young People’s Mental Health](#)

5 School provision

A ‘whole school approach’ to mental health and well-being

58. Several submissions spoke of the importance of a “whole school approach” to mental health and well-being within schools. The Children and Young People’s Mental Health Coalition (CYPMHC), a coalition of charities campaigning together on the mental health and well-being of children and young people, has worked with Public Health England to design a framework for this approach. It said:

There is evidence that suggests that a whole school approach is important as it ensures that mental health and well-being is embedded within the culture and processes of the school, and also ensures that they work with partners in health, the voluntary sector etc. to provide mental health support for those most in need.⁷⁶

59. The Government’s *Future in Mind* report also referred to the development of “whole school approaches” and cited Personal, Social, Health and Economic education (PSHE), counselling services and “work on character and resilience” as crucial aspects of this approach.⁷⁷ *Future in Mind* recommended that all schools should have in place a “specific individual responsible for mental health in schools”. This person would be able to provide a link to medical expertise and “make effective referrals”.⁷⁸ This recommendation is reflected in the Government’s current ‘Mental Health Services and Schools Link Pilots Scheme’. This £3 million pilot will train a single point of contact in 255 schools who will be responsible for developing relationships with local CAMHS. This role is not unlike that of a special educational needs coordinator (SENCO), a designated teacher who is responsible for special educational needs policy. Grants of up to £50,000 are available per clinical commissioning group (CCG) taking part in the pilot and each school taking part will also be given £3,500 for training.

Counselling services within schools

60. Numerous pieces of written evidence spoke of the benefits of school based counselling for looked-after children. The charity Place2Be told us:

Outcomes for children, including LAC, following Place2Be interventions demonstrate the effectiveness of school-based mental health services: at a national level, of those children who had severe difficulties before Place2Be’s counselling, 80% showed improvement in well-being according to their parents, and 64% showed an improvement in attitudes to learning according to their teachers.⁷⁹

61. The Children’s Society and Church of England recommended that “the Government should explore the effectiveness of making school-based counselling a statutory provision

76 The Children and Young People’s Mental Health Coalition ([MHW 11](#)) para 10.2

77 *Future in Mind*, p 36

78 *Future in Mind*, p 42

79 Place2Be ([MHW 65](#)) para 15

as is the case in Wales and Northern Ireland.”⁸⁰ However the National Association of Independent Schools and Non-Maintained Special Schools (NASS) shed some doubt on the effectiveness of on-site counselling in schools:

Whilst this is helpful for the individual children attending that service – as they get access to the support they need - it can mean that areas of specialism develop outside of clinical commissioning groups or the local authority with no clear route to feed back.⁸¹

62. Professor Fonagy told us that recommending “blanket counselling” as a solution to “substantive mental health disorders” was not advisable.⁸² He stated that counselling was not evidence-based and that looked-after children required more tailored treatment.

63. School based counsellors should be available to identify early potential problems and signpost children and young people with more acute mental health difficulties to specialist care. Schools have a clear role in teaching about mental health and well-being, and should work with partners in health and local authorities to direct students to further support.

64. The interface between schools and health services needs to be strengthened to ensure that teachers and schools are better equipped to identify, assess and support children and young people with mental health difficulties. However, schools must not be relied on to provide specialist care and treatment. We recommend that, if successful, the current schools link pilot be extended across all clinical commissioning groups with funding for all schools to train a mental health coordinator.

80 The Children’s Society and Church of England ([MHW 68](#)) para 5.2

81 National Association of Independent Schools and Non-Maintained Special Schools ([MHW 8](#)) para 14

82 Q88

6 Service integration, leadership and local implementation

Revision of the Government's statutory guidance

65. The DfE and DH new statutory guidance says that local authorities, CCGs, NHS England and Public Health England must cooperate to commission health services for all children in their area. On the same day The Children and Young People's Mental Health Taskforce published its report *Future in Mind*.⁸³ The taskforce was co-chaired by NHS England and DH. It provided a broad range of recommendations across the education, health and social care sectors aimed at improving the mental health of children and young people.

66. Several pieces of evidence told us that the current statutory guidance should be reviewed in light of the more ambitious proposals contained in the *Future in Mind* report. Dr Ingrassia stated:

The presence of a statutory guidance is helpful and a useful starting point. The guidance needs to be strengthened to ensure that its aspirational aim to prioritise the mental health needs and well-being of children in care and care leavers becomes a reality, particularly in the current financial climate. In light of the *Future in Mind* report and the plans for CAMHS transformation, a review of the guidance or the publication of additional guidelines to help prioritise resources and investment at a local level would be highly beneficial.⁸⁴

67. In written evidence Sarah Brennan spoke of the *Future in Mind* report as creating a "new vision" for children's mental health.⁸⁵ CYPMHC similarly told us that the *Future in Mind* proposals which focus on vulnerable children should be incorporated into the statutory guidance.

68. Alistair Burt confirmed that they would be revising the statutory guidance in the light of the *Future in Mind* proposals.⁸⁶ However, in follow up written evidence, Mr Burt clarified:

We are waiting for the outcome of your inquiry before making any firm decision on amending the statutory guidance and I am sorry if that was not clear in my response.⁸⁷

69. *We recommend that the statutory guidance on promoting the health and well-being of looked-after children be revised and strengthened to incorporate the recommendations made in The Children and Young People's Mental Health Taskforce report Future in Mind.*

83 [Future in Mind](#)

84 Dr Antonina Ingrassia ([MHW 70](#)) para 6

85 YoungMinds ([MHW 71](#)) para 9

86 Q213

87 Department of Health ([MHW 73](#)) para 10

Local Transformation Plans

70. One of the clearest proposals from the *Future in Mind* report was that all local areas should develop Local Transformation Plans:

These Plans should cover the whole spectrum of services for children and young people’s mental health and well-being from health promotion and prevention work to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.⁸⁸

71. According to *Future in Mind* the plans should be created locally by the CCG, working with the Health and Well-being Board and local authorities. Lead commissioners should also work with schools to contribute to the development of the plans. *Future in Mind* proposes that during 2015/16 every area should develop a Local Transformation Plan which outlines their local offer for children and young people’s mental health and well-being.⁸⁹ Professor Fonagy told us:

We have at the moment, with *Future in Mind*, a real opportunity for bringing services together because the principles that *Future in Mind* sets out are the integration of education, social care and health at the level of clinical commissioning groups and their key partners. This creates an absolutely ideal platform for dealing in a coherent way with the needs of children who are in care.⁹⁰

72. The extent to which Local Transformation Plans will focus on looked-after children and young people is yet to be established. Lisa Harker from the NSPCC commented:

They are very variable in terms of their understanding of and focus on looked-after children. Some are excellent and have really innovative ideas in them, but some of them barely mention looked-after children at all.⁹¹

73. Alistair Burt confirmed that the plans varied in the extent to which they focus on looked-after children:

Clearly what we have seen is that some plans are better and stronger in those areas than others, so the process that we are going through now to evaluate these—and by March we will have done a study that will be qualitative as well as quantitative—will enable us to identify precisely, as a theme, what has been done right through the country with these local transformation plans in terms of looked-after children.⁹²

74. Ms Bethel also told us that NHS England had commissioned an analysis of the Local Transformation Plans, including an examination of how well they covered the needs of looked-after children.⁹³ A quantitative report which provides an analysis of data on spend, and number of referrals for 2014–15 has been published and qualitative analysis is due to

88 *Future in Mind*, p 18

89 *Future in Mind*, p 71

90 Q70

91 Q11

92 Q212

93 Q81

follow in spring 2016.⁹⁴ Ms Bethel added that she “very much hope[d]” that some of the £1.4 billion funding which has been allocated for Local Transformation Plans will “be used to improve outcomes for looked-after children”.⁹⁵

75. The Children and Young People’s Mental Health Taskforce *Vulnerable Groups and Inequalities Task and Finish group* report was published in conjunction with *Future in Mind*.⁹⁶ It set out specific proposals for vulnerable children and young people, including those who are looked-after. The report recognised failures in joint commissioning and the need for clearer pathways to services and support.⁹⁷

76. In addition to this taskforce report and *Future in Mind* the DH have announced an expert group to take forward its proposals for looked-after children:

The aim of the expert group will be to design care pathways and flexible integrated models of care that can be used by all bodies and individuals involved in meeting the mental health needs of looked-after children.⁹⁸

77. **Since the publication of the Children and Young People’s Mental Health Taskforce report last year, and the more recent independent Mental Health Taskforce report, the Government has committed to both a qualitative analysis of Local Transformation Plans and the creation of an expert working group on the mental health needs of looked-after children. We look forward to seeing both pieces of work.**

78. *Looked-after children will only benefit from Local Transformation Plans if their needs are addressed and funding allocated for their care. We recommend that all plans state the services they provide specifically for looked-after children and the funding assigned for them.*

Implementing integration in local authority areas

79. We heard descriptions of the failures of social care, health, and education services to work together in local authorities to jointly commission integrated services. The NSPCC told us that effective support for looked-after children could only take place where “institutions operate in a co-ordinated manner”.⁹⁹ NICE guidance recommends that Directors of Children’s Services and commissioners of health services should:

Jointly commission services dedicated to promoting the mental health and emotional well-being of children and young people who are looked-after [...] These services should be structured as integrated teams (virtually or, ideally, co-located), and have a mix of professionals who will vary according to local

94 NHS England sent us the following comment: A quantitative report of Local Transformation Plans which provides an analysis of data on spend, and number of referrals for 2014-15 has been published by NHS England. This will form the baseline by which progress will be measured. This report does not include information on outcomes and effectiveness of treatment. This will come, in time, from the Mental Health Services Dataset. A qualitative analysis against agreed themes will follow later in the spring. These will provide information taken from all the Local Transformation Plans and will highlight interesting practice and examples of particular services or groups that local areas have prioritised. One of the themes will look at “vulnerable groups”, which includes looked-after children, children adopted from care and care leavers.

95 Q71

96 [Vulnerable Groups and Inequalities Task and Finish group Report](#)

97 [Vulnerable Groups and Inequalities Task and Finish group Report](#), p 20

98 Department of Health ([MHW 73](#)) para 4

99 NSPCC ([MHW 43](#)) para 24

circumstances [...] As a minimum, ensure these services have local authority children’s specialists, dedicated health and mental health (including CAMHS) professionals, and education specialists working with looked-after children and young people.¹⁰⁰

80. We received evidence from several local authorities who are successfully offering an integrated service for looked-after children with strong links between health, social care and education. Barbara Herts, Director for Integrated Commissioning and Vulnerable People at Essex County Council, described the process by which Essex County Council set up a “collaborative commissioning agreement across seven CCGs and three local authorities” in 2014.¹⁰¹ Ms Herts said:

We have very successfully pooled budgets with our clinical commissioning group colleagues and I oversee that budget, which means that we can operate flexibly and meet the needs of vulnerable children and young people in Essex. I think the previous system of having a lot of fragmentation and different organisational boundaries let our vulnerable children and young people down.¹⁰²

Box 1: Case study: Trafford Metropolitan Borough Council

We visited Trafford Council as part of our inquiry, as an example of a local authority that has developed a fully integrated children’s social care and health service.^A We met senior council officers, CAMHS practitioners and psychologists, heads of services, the Virtual School Head and a group of foster carers. We also visited a children’s home.

In December 2014, 338 children were being looked-after by Trafford Council, which is a rate of 63.8 per 10,000. This is above the national average of 60 per 10,000. Ofsted rated children’s services in Trafford as ‘good’ overall, with ‘outstanding’ ratings for its leadership and the experiences of its care leavers. Since November 2013 76% of local authority children’s services have been rated as inadequate or requires improvement. Ofsted’s 2015 inspection of Trafford’s children’s services noted:

The success of the local authority is characterised by the highly effective partnership work and in particular the joint working arrangements between the local authority and the health service provider. This is underpinned by a fully integrated children’s social care and health service; a delivery model which provides a highly effective response for children and families.^B

On the subject of co-location Ofsted reported that:

The co-location of social workers with health staff and child and adolescent mental health service (CAMHS) workers supports good access to services for children with complex needs. These arrangements and the authority’s long-standing commitment to innovative and evidence-based practice have resulted in continual improvements and better outcomes for children.^C

¹⁰⁰ [Looked-after children and young people](#), p 24

¹⁰¹ Q99

¹⁰² Q99

During our visit we were impressed with the level of integration Trafford had achieved through co-location. Their open plan office accommodates a large number of front-line staff meaning that many teams and individuals are within sight of each other. Senior managers are located in the same building.

The council is also coterminous with the police command unit and the clinical commissioning group. Greater Manchester (GM) Police has operational boundaries which are aligned with the metropolitan local authorities within GM. The Pennine Care Health Trust, which covers six local authorities, also has a Trafford division which is coterminous with the local authority.

The Committee met staff in the Multi-Agency Referral and Assessment Team (MARAT). They are the ‘front door’ to Trafford’s services and complete initial assessments once referrals have been made. MARAT seeks to identify problems early and conduct suitable interventions.

Leadership appeared to be strong throughout the service, with clear accountability, and continuity of key staff through low turnover. The Chief Executive was able to confidently articulate the benefits of a fully integrated service and she was well supported by a strong management team. At least one member of the management team attends every corporate parenting board and this personal involvement in the lives of looked-after children is considered to be very important.

A Since we visited Trafford Council they have announced that the Pennine Care NHS Foundation Trust will take responsibility for the day-to-day provision of children’s services. They sent us a statement describing how this new arrangement will operate ([MHW 75](#)).

B Ofsted, *Inspection of services for children in need of help and protection, children looked-after and care leavers and review of the effectiveness of the local safeguarding children board* (May 2015), p 6

C *Inspection of services for children in need of help and protection, children looked-after and care leavers and review of the effectiveness of the local safeguarding children board*, p 20

Out of area placements and movement of looked-after children

81. The Children’s Services Development Group (CSDG) told us that there are particular problems in service commissioning for looked-after children and young people who have been moved outside their local authority.¹⁰³ They state that “a child placed ‘out of area’ is often unable to access services, as neither local authority will accept responsibility for the commissioning and funding of the service”.¹⁰⁴ This can lead to a looked-after child being without care for extended periods of time and often being placed on the end of a waiting list. CSDG considered the joint DfE and DH statutory guidance to be “unclear” on this topic and advised that it should be revised to provide clarity on who is responsible for a child or young person who has moved area.

82. Dr Ingrassia told us that agreements on funding can delay access to care for children in out of area placements.¹⁰⁵ She and others emphasised that children placed out of their area were particularly vulnerable and required more support rather than less:

103 The Children’s Services Development Group ([MHW 26](#)) para 2

104 The Children’s Services Development Group ([MHW 26](#)) para 4

105 Dr Antonina Ingrassia ([MHW 70](#)) para 7

Ofsted's 2014 thematic inspection looking at children living out of area found that delays receiving CAMHS support could be most often attributed to a lack of local capacity, poor liaison between different local authorities and clinical commissioning groups, and lengthy disputes about funding. The varying cost of CAMHS provision across health boundaries often contributed to these funding disputes.¹⁰⁶

83. NICE guidelines also address the specific problem of looked-after children moving out of the local authority area:

Children and young people placed out of the local authority area are less likely to receive services from CAMHS in their new location. Looked-after children and young people should be regarded as a priority group for specialist mental health services, especially when moving from one area to another.¹⁰⁷

84. ***No looked-after child should face a delay in accessing services after moving local authority area. We recommend that the Government amend its joint statutory guidance to clarify the balance of responsibility between local authorities when looked-after children and young people are placed out of area.***

The role of local leadership in service commissioning

85. During our visit to Trafford Council we witnessed the effectiveness of strong, local leadership. The vision of an integrated service articulated by the Chief Executive and Directors was compelling and well implemented by front line teams. Edward Timpson told us that he saw local leadership as a key part of effective service provision:

Leadership. This is going to require people at the top telling others, "This is something that we have to all play our part" and where we see that happening, places like Croydon, places like Essex, places like Haringey where they have co-located or they have integrated services, it is because there is leadership saying, "this matters".¹⁰⁸

86. According to the statutory guidance, the Health and Well-being Board should play a leading role in considering the needs of looked-after children. Every Health and Well-being Board should comprise "a representative from each CCG whose area falls within or coincides with the local authority area, the Director of Children's Services, the Director of Public Health, the Director of Adult Social Services and a representative from the local Healthwatch organisation".¹⁰⁹

87. The role of the Health and Well-being Board in local leadership is described in the *Future in Mind* report:

The local plan itself should be derived from the local Health and Well-being Strategy which places an onus on Health and Well-being Boards to demonstrate the highest level of local senior leadership commitment to child mental health.

¹⁰⁶ Ofsted (MHW 64) para 4.4

¹⁰⁷ *Looked-after children and young people*, p 73

¹⁰⁸ Q218

¹⁰⁹ [Promoting the health and well-being of looked-after children](#)

Health and Well-being Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people’s mental health and well-being.¹¹⁰

88. Alison O’Sullivan, President of the Association of Directors of Children’s Services (ADCS), told us that Health and Well-being Boards “are where the leadership across the local system sits”.¹¹¹ Barbara Herts agreed and stated that Health and Well-being Boards are “absolutely critical for holding the Local Transformation Plan to account”.¹¹² She added that their role should be strengthened. Essex’s written evidence said that Health and Well-Being Boards are “well placed to provide co-ordination and leadership locally”.¹¹³

89. Several pieces of written evidence told us that aside from existing leadership structures, there should also be a role for “a designated mental health professional for looked-after children and young people” Professor Fonagy said:

We currently have designated doctors, who are usually paediatricians; we have designated nurses for looked-after children. We do not have a designated mental health professional. I think maybe we could consider having someone in the system who is there to co-ordinate mental health input for looked-after children, who can identify genuine mental health needs, who is aware of alternative care pathways, who can oversee mental health literacy and training and has a perspective of mental health and holds that perspective in a powerful way.¹¹⁴

90. Ms Herts responded to Professor Fonagy’s proposal, agreeing that every area should have a specialist “that could be that sort of systems leader for mental health and well-being to identify appropriate pathways”.¹¹⁵ She described the approach which Essex County Council had taken:

Part of our system is having a specialist mental health professional that can provide on pathways, the evidence base and bringing that together across social care, health and education.¹¹⁶

91. *Integration of education, social care and health services should be driven by strong local leadership. The Health and Well-being Board should have ownership of this agenda and strategic oversight of the commissioning of services for children and young people in their care. We recommend that each local area employ a senior, designated mental health professional with expertise in the diagnosis and treatment of mental illness and awareness of the broader risk factors common in looked-after children.*

110 *Future in Mind*, p 58

111 Q105

112 Q105

113 Essex County Council ([MHW 25](#)) para 2.6

114 Q97

115 Q117

116 Q101

7 The participation of looked-after children in decision making

Incorporating the views of looked-after children into decision making

92. The Government’s statutory guidance recommends that CCGs and local authorities should “take into account the views of looked-after children, their parents and carers, to inform, influence and shape service provision, including through Children in Care Councils and local Healthwatch where they are undertaking work in this area”.¹¹⁷

93. The importance of playing a “meaningful part” in decisions was reinforced in evidence from YoungMinds:

Our own experience has demonstrated that children must play a meaningful part in decisions making, which is also reflected in the new statutory guidance. [...] It is essential to young people’s psychological and emotional development and significantly contributes to building the resilience they will need for the remainder of their childhood and adult lives.¹¹⁸

94. Lisa Harker told us that children and young people need to “have a voice through the whole process”.¹¹⁹ Ms Harker added that mental health professionals should focus on working from problems to solutions together with the children concerned, rather than making interventions “which see the child as the subject of that intervention”.¹²⁰ Ofsted advised that based on their inspection findings local authorities could do more “to maximise opportunities to gather and learn extensively from the views of looked-after children, care leavers and their carers when designing and evaluating the impact of services”.¹²¹ They commented that Children in Care councils often fail to be representative of those in care and care leavers and are too frequently used as the only source of engagement. Ofsted argued that Independent Reviewing Officers (IROs) are in a “unique” position to take a leading role in listening to the views of children and young people.¹²²

Private session with looked-after children and young people

95. During our private session in November 2015, several of the young people spoke about feeling that they didn’t know why decisions were being made. One care leaver told us that they felt they did not have a voice and could not understand “what was going on”.¹²³ These feelings of isolation were most acute when they had moved foster placement and were given little explanation for the move or opportunity to decide where their next placement would be. One young person told us that it was out of their control who looked-after them and for how long.¹²⁴

117 *Promoting the health and well-being of looked-after children*, p 10

118 YoungMinds ([MHW 71](#)) para 18

119 Q36

120 Q36

121 Ofsted ([MHW 64](#)) para 7.2

122 Ofsted ([MHW 64](#)) para 7.3

123 See [Annex 1](#) for further details.

124 See [Annex 1](#) for further details.

96. Several of the young people we met said that this failure to communicate could make the success of a placement less likely and led to problems with their emotional and mental health. One young person told us that isolation and not having someone to trust could have an enormous impact on mental health.¹²⁵ The Care Leavers Association said:

Involving young people in the design of services is key. It is their life. They must have a voice and a sense of ownership. The CLA is a user-led charity and fully promotes the user led approach. We can see success when a care leaver finds their voice and becomes fully engaged in all the decisions that are happening to them.¹²⁶

97. These sentiments are echoed in recommendation 13 of the NICE guidance, which says:

When making decisions about moving children or young people from existing placements: fully take into account the wishes and feelings of a child or young person.¹²⁷

98. All looked-after children should play a meaningful part in the decisions made about their mental health care. They should also be empowered to have a more active role in decisions about their placements to increase the likelihood that they will be stable and successful.

125 See [Annex 1](#) for further details.

126 Care Leavers Association ([MHW 55](#)) para 6

127 [Looked-after children and young people](#), p 29

Conclusions and recommendations

Access to mental health services

1. Current methods of assessing children and young people's mental health and well-being as they enter care are inconsistent and too often fail to identify those in need of specialist care and support. Initial assessments are rarely completed by qualified mental health professionals with an appreciation of the varied and complex issues with which looked-after children may present. (Paragraph 13)
2. *We recommend that the Government amends the statutory guidance to make clear that an SDQ should be completed for every child entering care as a starting point. In addition all looked-after children should have a full mental health assessment by a qualified mental health professional. Where required this should be followed by regular assessment of mental health and well-being as part of existing looked-after children reviews.* (Paragraph 14)
3. Looked-after children who need access to mental health services often have numerous and complex issues that require specialist input across multiple agencies. We have heard evidence that CAMHS is often unable to provide this care due to high thresholds and a refusal to see children or young people without a stable placement. The inflexibility of CAMHS is failing looked-after children in too many areas and leaving vulnerable young people without support. (Paragraph 21)
4. *CAMHS should not refuse to see children or young people without a stable placement or delay access to their services until a placement becomes permanent.* (Paragraph 22)
5. *We recognise that CAMHS is not the only, or in many cases the most suitable, source of support for looked-after children. We recommend that where possible CAMHS should form a part of a multi-agency team in which education, health and social care work in partnership. Looked-after children and young people are best supported when professionals collaborate and services are tailored to the needs of the individual.* (Paragraph 23)
6. *It is important that all children who need access to CAMHS get it in a timely manner. In recognition of the distinct challenges which looked-after children and young people face, we recommend that they should have priority access to mental health assessments by specialist practitioners but that subsequent treatment should be based on clinical need.* (Paragraph 27)

The care system

7. Continuity of care in an environment where children and young people are able to form strong, enduring relationships should be at the heart of the care system. We are pleased to see an increase in funding for 'Staying Put' and expect to see evidence that this additional investment leads to more young people remaining in secure placements for longer. (Paragraph 32)

8. Leaving the care system can be a time of significant upheaval and disruption. This is likely to be more acute for care leavers with mental health concerns. Current support for these vulnerable young people is inadequate and based too heavily on inflexible age restrictions. (Paragraph 39)
9. *CAMHS should be made available for all looked-after young people up to the age of 25 in recognition of the distinct issues which this vulnerable group of young people face as they leave the care system. Access to services beyond the age of 18 should be offered where appropriate but not made mandatory where an individual would be better suited to moving onto adult mental health services.* (Paragraph 40)
10. There is an urgent need for comprehensive and up to date data on the mental health and well-being of looked-after children and care leavers. We are disappointed that a new ONS prevalence survey will not report until 2018. (Paragraph 45)
11. *We strongly urge the Government to return to funding ONS prevalence surveys on children and young people's mental health on a five-yearly basis. We also recommend that they invest in outcomes monitoring to better understand the challenges that young people face whilst in and when leaving the care system.* (Paragraph 46)

Workforce development

12. Training and support for foster and residential carers is highly variable and in many local authorities fails to equip carers with the knowledge and skills needed to support looked-after children with mental health difficulties. Foster and residential carers are professionals who need comprehensive and regular training in how to properly support children and young people in their care. (Paragraph 52)
13. The current Training, Support and Development standards should be supplemented with specific modules which focus on mental health and emotional well-being. The Department for Education and the Department of Health should fund and develop these learning modules, building on best practice and those existing programmes with clear evidence of success. We recommend that the Government creates a curriculum development committee to oversee the formation of these modules. (Paragraph 53)
14. *We support the recent recommendation made by the Youth Select Committee on the inclusion of mental health training in the core content of initial teacher training. We see this as a minimum requirement. Training on emotional well-being and mental health should also be included in continuous professional development for current teachers.* (Paragraph 57)

School provision

15. School based counsellors should be available to identify early potential problems and signpost children and young people with more acute mental health difficulties to specialist care. Schools have a clear role in teaching about mental health and well-being, and should work with partners in health and local authorities to direct students to further support. (Paragraph 63)

16. *The interface between schools and health services needs to be strengthened to ensure that teachers and schools are better equipped to identify, assess and support children and young people with mental health difficulties. However, schools must not be relied on to provide specialist care and treatment. We recommend that, if successful, the current schools link pilot be extended across all clinical commissioning groups with funding for all schools to train a mental health coordinator. (Paragraph 64)*

Service integration, leadership and local implementation

17. *We recommend that the statutory guidance on promoting the health and well-being of looked-after children be revised and strengthened to incorporate the recommendations made in The Children and Young People's Mental Health Taskforce report Future in Mind. (Paragraph 69)*
18. *Since the publication of the Children and Young People's Mental Health Taskforce report last year, and the more recent independent Mental Health Taskforce report, the Government has committed to both a qualitative analysis of Local Transformation Plans and the creation of an expert working group on the mental health needs of looked-after children. We look forward to seeing both pieces of work. (Paragraph 77)*
19. *Looked-after children will only benefit from Local Transformation Plans if their needs are addressed and funding allocated for their care. We recommend that all plans state the services they provide specifically for looked-after children and the funding assigned for them. (Paragraph 78)*
20. *No looked-after child should face a delay in accessing services after moving local authority area. We recommend that the Government amend its joint statutory guidance to clarify the balance of responsibility between local authorities when looked-after children and young people are placed out of area. (Paragraph 84)*
21. *Integration of education, social care and health services should be driven by strong local leadership. The Health and Well-being Board should have ownership of this agenda and strategic oversight of the commissioning of services for children and young people in their care. We recommend that each local area employ a senior, designated mental health professional with expertise in the diagnosis and treatment of mental illness and awareness of the broader risk factors common in looked-after children. (Paragraph 91)*

The participation of looked-after children in decision making

22. *All looked-after children should play a meaningful part in the decisions made about their mental health care. They should also be empowered to have a more active role in decisions about their placements to increase the likelihood that they will be stable and successful. (Paragraph 98)*

Annex 1: Informal session with looked-after young people and care leavers

The following is a summary of a discussion between young people in care, care leavers and members of the Committee. The discussion was facilitated by staff from the NSPCC and The Who Cares? Trust and took place in Parliament on 25 November 2015. As much as possible the notes are written in the words that the young people used to describe their experiences and views.

Challenges in the care system

- It's hard to know what's going on, you feel different and you feel like you are the only one in care.
- There are lots of professionals in your life to deal with.
- Foster carers sometimes don't focus on love and nurture. They just focus on the practical stuff and if you need emotional support they just refer you to CAMHS.
- Social workers change too much and you're constantly changing schools, areas and carers.
- It's so intimidating, you feel like you can't say anything bad about social workers and foster carers.
- If you come into care for mental health in family reasons but no one explains it to you then you can spend a long time worrying that you're going to 'get' the same mental health issues as your parents.
- Children are not being told the real reason they've been brought into care.
- Young people don't feel like they have a voice, they're not involved in the process and as things progress they feel less and less like they understand or know what is going on.
- A feeling of isolation and not having someone you trust is very hard. Foster carers are strangers when you meet them and social workers don't have enough time for you. You feel different from everyone else and if you're seen as a clinical case it impacts on your mental health.

School

- If you're moving schools suddenly it's hard for schools to get involved in supporting you.
- My school was great. I did well at school because my school cared.
- PSHE lessons should be giving out information. Even just a half-hour session once a week on mental health or self-harm and where the right resources are or people to speak to are.

- There is counselling, but it isn't pushed. It's a hidden thing.
- People ask questions, is that your Mum/Auntie? I don't like that. It adds to the stigma. You feel like something is wrong with you being in care, it puts a label on your forehead and singles you out.

Carers and support

- Continuity is an issue. If there is a problem in your placement, you just get moved.
- There needs to be better processes in place to end relationships. I had a social worker and I rang up and they said they'd left, then you end up with a duty social worker. You could get a really good one but you just assume they're going to leave.
- There should be more emphasis on how foster carers nurture children. There's lots of focus on CAMHS and therapy. But you wouldn't expect birth parents to send children to CAMHS without emotional support. Carers don't know how to give emotional support.
- Foster carers need to get better. Young people shouldn't have lots of professionals in a young person's life. Social workers only come round every 6 weeks.
- We need better recruitment and training of foster carers. I had 47 placements and only about three I would put through a foster care panel. They don't want to invest in a child emotionally. There's great training out there but it's not mandatory.
- In the short term I had lots of social workers. If I had one social worker they might have tried to solve problems instead of just moving me. Every time I got a new social worker I seemed to move.

Experience of CAMHS

- Therapists are not always trained in care, so you spend lots of time in sessions explaining the care system. Some local authorities have CAMHS just for looked-after children.
- Doctors refer young people to CAMHS, and then the young person receives a message saying "you are not a priority". This is disgusting and a huge self-esteem blow.
- CAMHS is patchy across the country. Different local authorities have very different service levels.

What makes good support for mental health care?

- Young person led training for foster carers and all professionals within the care system so that they get to hear directly from young people and in turn they get to ask questions directly to the young people.
- I had a good CAMHS worker, she stuck up for me. She wasn't focussed on ticking boxes, she cared about me.

- There should be a focus on relationships, there is someone at my local authority who has been there since I was in care but I didn't go to her because I didn't bond with her. A good system responds to that.
- Health and social services need to talk. My hospital placement ended but no one told social services so I had to stay in hospital even though I didn't want to be there because they couldn't find me anywhere to go.

What makes bad support for mental health care?

- Foster placements are out of your control. Because I was a 'good' child, I wasn't placed with specialist foster carers.
- Continuity and stability is so important and children in care don't have any.
- I had 28 foster parents, I wanted to be in residential care. When I did move to a children's home and I had one placement.
- The state took us away from our parents, the Government are now our parents. Parents will do anything for you but the state doesn't provide that.
- When I was at home I understood what was going on but when I was in care I didn't know and I still don't know what's going on.
- Access to services if you live out of area is difficult, if I want to access services I have to go back to my local authority but I don't live there.

Formal Minutes

Wednesday 20 April 2016

Members present:

Neil Carmichael in the Chair

Lucy Allan	Catherine McKinnell
Ian Austin	Ian Mearns
Marion Fellows	Stephen Timms
Lucy Frazer	William Wragg

Draft Report (*Mental health and well-being of looked-after children*) proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 98 read and agreed to.

Annex and Summary agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

The written evidence from Trafford Metropolitan Borough Council was ordered to be reported to the House for publication.

[Adjourned till Wednesday 27 April at 2.00 pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry page](#) of the Committee's website.

Wednesday 16 December 2015

Question number

Sarah Brennan, Chief Executive, Young Minds, **David Graham**, National Director, the Care Leavers' Association, **Lisa Harker**, Director of Strategy, Policy and Evidence, NSPCC, and **Kevin Williams**, Chief Executive, the Fostering Network

[Q1-40](#)

Tony Clifford, Head of Virtual School for Children in Care, City of Stoke-on-Trent, **Carol Jones**, Specialist for Leadership and Teacher Professionalism, Association of School and College Leaders, and **Natasha Devon**, founder, Self-Esteem Team

[Q41-67](#)

Wednesday 13 January 2016

Professor Peter Fonagy, National Clinical Adviser on Children and Young People's Mental Health, NHS England, **Claire Bethel**, Deputy Director, Department of Health, **Dr Ananta Dave**, Consultant Child and Adolescent Psychiatrist Dudley and Walsall Mental Health Partnership NHS Trust, and **Matthew Brazier**, National Lead for Looked-After Children, Ofsted

[Q68-97](#)

Barbara Herts, Director for Integrated Commissioning and Vulnerable People, Essex County Council, **Wendy Lobatto**, Service Manager, First Step, Tavistock and Portman NHS Foundation Trust, and **Alison O'Sullivan**, President, Association of Directors of Children's Services

[Q98-120](#)

Wednesday 3 February 2016

Christine Malone, foster carer, **Teresa Latham**, foster carer, and **Shankly Monksfield**, looked-after young person

[Q121-188](#)

Rt Hon Alistair Burt MP, Minister for Community and Social Care, Department of Health, and **Edward Timpson MP**, Minister for Children and Families, Department for Education

[Q189-218](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry page](#) of the Committee's website.

MWH numbers are generated by the evidence processing system and so may not be complete.

- 1 Agenda ([MHW0048](#))
- 2 Alliance for Children in Care and Care Leavers ([MHW0062](#))
- 3 Association of Child Psychotherapists ([MHW0010](#))
- 4 Association of Directors of Children's Services ([MHW0042](#))
- 5 Association of School and College Leaders ([MHW0034](#))
- 6 Barnardo's ([MHW0028](#))
- 7 Bath Spa University ([MHW0041](#))
- 8 British Association for Counselling and Psychotherapy ([MHW0035](#))
- 9 British Psychological Society ([MHW0015](#))
- 10 Catch22 ([MHW0058](#))
- 11 Centrepont ([MHW0031](#))
- 12 Children & Young People's Mental Health Coalition ([MHW0011](#))
- 13 Children England ([MHW0052](#))
- 14 Children's Commissioner for England ([MHW0038](#))
- 15 Children's Services Development Group ([MHW0026](#))
- 16 Coram ([MHW0020](#))
- 17 Coram Voice ([MHW0023](#))
- 18 CoramBAAF ([MHW0022](#))
- 19 Department for Education ([MHW0074](#))
- 20 Department for Education and the Department of Health ([MHW0050](#))
- 21 Department of Health ([MHW0073](#))
- 22 Dr Antonina Ingrassia ([MHW0070](#))
- 23 Essex County Council ([MHW0025](#))
- 24 First Step, Tavistock & Portman NHS Foundation Trust ([MHW0027](#))
- 25 Fostering, Adoption and Kinship Care Team, Tavistock and Portman NHS Foundation Trust ([MHW0047](#))
- 26 Haringey Clinical Commissioning Group ([MHW0017](#))
- 27 Healthwatch Norfolk ([MHW0007](#))
- 28 London Fire and Emergency Planning Authority ([MHW0037](#))
- 29 Mr Jon Harris ([MHW0063](#))
- 30 Mr Michael Owen ([MHW0009](#))
- 31 Mrs Dee Whitrow ([MHW0002](#))
- 32 NASUWT ([MHW0046](#))

- 33 National Adoption & Fostering Service ([MHW0066](#))
- 34 National Association of Head Teachers ([MHW0012](#))
- 35 National Association of Independent Schools & Non-Maintained Special Schools ([MHW0008](#))
- 36 National Children's Bureau ([MHW0036](#))
- 37 National IRO Manager Partnership ([MHW0057](#))
- 38 National Youth Advocacy Service ([MHW0045](#))
- 39 Now Unlimited ([MHW0054](#))
- 40 NSPCC ([MHW0043](#))
- 41 NSPCC ([MHW0072](#))
- 42 Ofsted ([MHW0064](#))
- 43 Parent Infant Partnerships UK ([MHW0006](#))
- 44 Place2be ([MHW0065](#))
- 45 Portsmouth City Council, Solent NHS and CAMHS ([MHW0051](#))
- 46 Prison Reform Trust ([MHW0059](#))
- 47 Research In Practice ([MHW0044](#))
- 48 Royal College of Nursing ([MHW0053](#))
- 49 Royal College of Psychiatrists ([MHW0033](#))
- 50 St Christopher's Fellowship ([MHW0016](#))
- 51 The Adolescent and Children's Trust ([MHW0060](#))
- 52 The Care Leavers Association ([MHW0055](#))
- 53 The Children's Society and the Church Of England ([MHW0068](#))
- 54 The Fostering Network ([MHW0019](#))
- 55 The Springboard Bursary Foundation ([MHW0013](#))
- 56 The Who Cares? Trust ([MHW0014](#))
- 57 Trafford Metropolitan Borough Council ([MHW0075](#))
- 58 YoungMinds ([MHW0067](#))
- 59 YoungMinds ([MHW0071](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2015–16

First Report	The role of Regional Schools Commissioners	HC 401 (HC 975)
Second Report	Holocaust education	HC 480 (HC 974)
Third Report	Appointment of the Chief Regulator of Ofqual	HC 822
First Joint Special Report	Education, skills and productivity: commissioned research	HC 565
First Special Report	Apprenticeships and traineeships for 16 to 19 year olds: Government Response to the Committee's Sixth Report of Session 2014-15	HC 317
Second Special Report	Extremism in schools: the Trojan Horse affair: Ofsted Response to the Committee's Seventh Report of Session 2014-15	HC 324
Fourth Special Report	Holocaust education: Government Response to the Committee's Second Report of Session 2015-16	HC 974
Fifth Special Report	The Role of Regional Schools Commissioners: Government Response to the Committee's First Report of Session 2015-16	HC 975