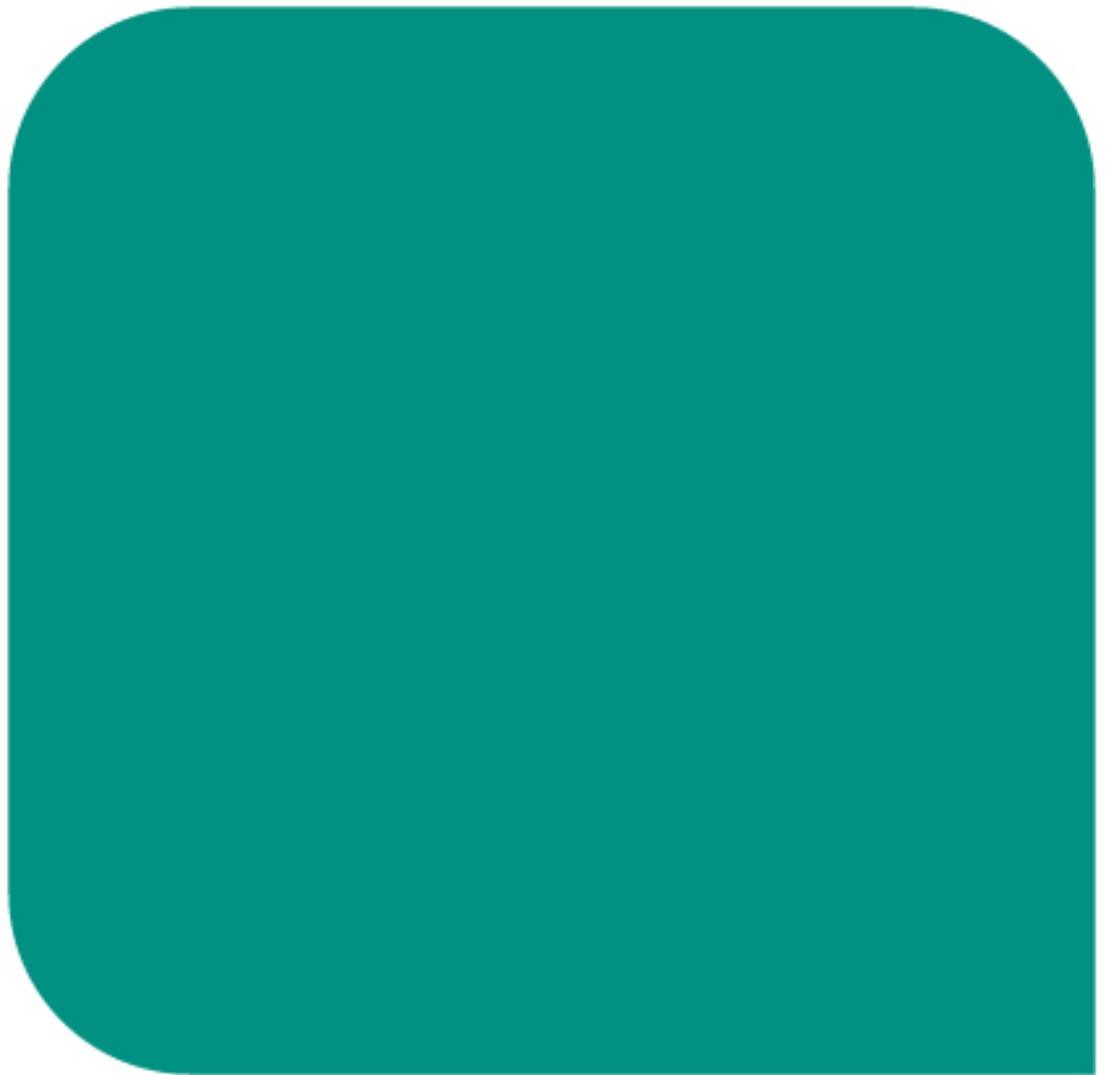




social care
institute for excellence

**Models of care and care pathways to support mental health and wellbeing of looked after children:
Findings of call for evidence**



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Introduction

This document presents the findings of a call for evidence conducted for a Department of Health and Department for Education-funded project to develop models of care and care pathways to support the mental health and wellbeing of looked after children.

Together with an Expert Working Group of professionals, policy makers and young people, the Social Care Institute for Excellence (SCIE) has worked since March 2016 to develop care pathways, models of care and quality principles to help improve access to high quality services to address the mental health and wellbeing needs of children in care, children who have ceased to be looked after under special guardianship orders or through being adopted from care, and care leavers.

Additional input has been sought from a separate young people's advisory group, and stakeholder workshops with professionals and young people.

SCIE would like to thank the individuals and organisations who participated in the call for evidence.

1. Aims

The EWG agreed it was essential that we call for evidence from those who work with the population of young people this project is focused on. The aim of the call for evidence was to identify examples of effective practice in relation to mental health and wellbeing support for looked after children (including unaccompanied asylum seeking children), care leavers, those under a Special Guardianship Order and adopted children. These practice examples will be used to inform the recommendations of the Expert Working group by identifying:

- Good practice within the sector which would not be available via the published research literature
- Examples with published research evidence which had not been identified via a bibliographic database search (conducted separately as part of the project).

Our aim was to identify examples with evidence of any of the following:

- Impact on outcomes for children, young people or carers
- Acceptability to children, young people or carers
- Acceptability to practitioners.

For this reason, the call for evidence template guided contributors only to submit examples supported by evaluation data and/or service user feedback.

The call for evidence is aligned with the aspiration of the EWG to complement its work at a national level with input from local, frontline services. In total we will hear from over 400 stakeholders and 100 young people. This wide consultation will ensure that the recommendations of the EWG will be founded on evidence and informed by key stakeholders, including children and young people themselves.

2. Methods

Areas of interest

We invited contributors to submit examples of good practice across the spectrum of need, including from services for children with complex and high needs, in the following four areas:

1. **Care pathways** - Examples of care pathways for looked after children which have been shown to improve their mental health and wellbeing outcomes.
2. **Models of care** - Examples of how services are configured to support mental health and wellbeing of looked after children.
3. **Prevention and early help** - Examples of effective practice in working with looked after children and/or their carers to promote good mental health and wellbeing, prevent problems from developing, or provide help at an early stage.
4. **Assessment** - Examples of effective practice in assessing the mental health and wellbeing of looked after children, which has led to improved identification of needs.

Dissemination

The call for evidence was open from 20 December 2016 until 31 January 2017.

The call for evidence was published on the SCIE website, and disseminated via the Expert Working Group and a list of stakeholders who had previously expressed an interest in the project.

Analysis

The analysis has aimed to:

- Synthesise the information provided in a way that will support the decision-making of the Expert Working Group
- Be clear about the evidence base supporting each of the submissions, whilst recognizing that many of the examples originate in practice rather than research.

The analysis comprised the following stages:

1. Clustering

Submissions were grouped into clusters of similar practice examples. Where appropriate additional analysis of similarities and differences between examples in each cluster has been conducted. Within these clusters, some of the submissions are examples of service structures whilst others are examples of specific interventions, and some are a combination of the two.

2. Mapping and appraisal of evidence

The evidence reported in the submissions and any supporting documents was categorized in terms the type of evidence provided (outcome data with or without comparator; views of children and young people; views of carers; practitioner views; audit and inspection data).

Where the evidence had been obtained using formal research or evaluation with a reported methodology, evidence was formally critically appraised using a modified version of the appropriate NICE critical appraisal tool. The tool was used to rate the quality of evidence as low, medium or high.

Where no methodology was reported (for example, data gathered as part of routine monitoring) no formal critical appraisal was conducted.

3. Data extraction

Key findings from each of the submissions and any supporting documentation were extracted into a standard Excel template.

4. Synthesis

The evidence for each of the submissions in a cluster was synthesized by evidence type. This was used to generate brief evidence statements for each cluster.

5. Triangulation

The described practice was triangulated with recommendations from relevant NICE guidelines, as an additional source of information about what types of practice are effective. The next stage of the process will involve comparing evidence from the call for evidence with the other data we have gathered through the project.

3. Results of call for evidence

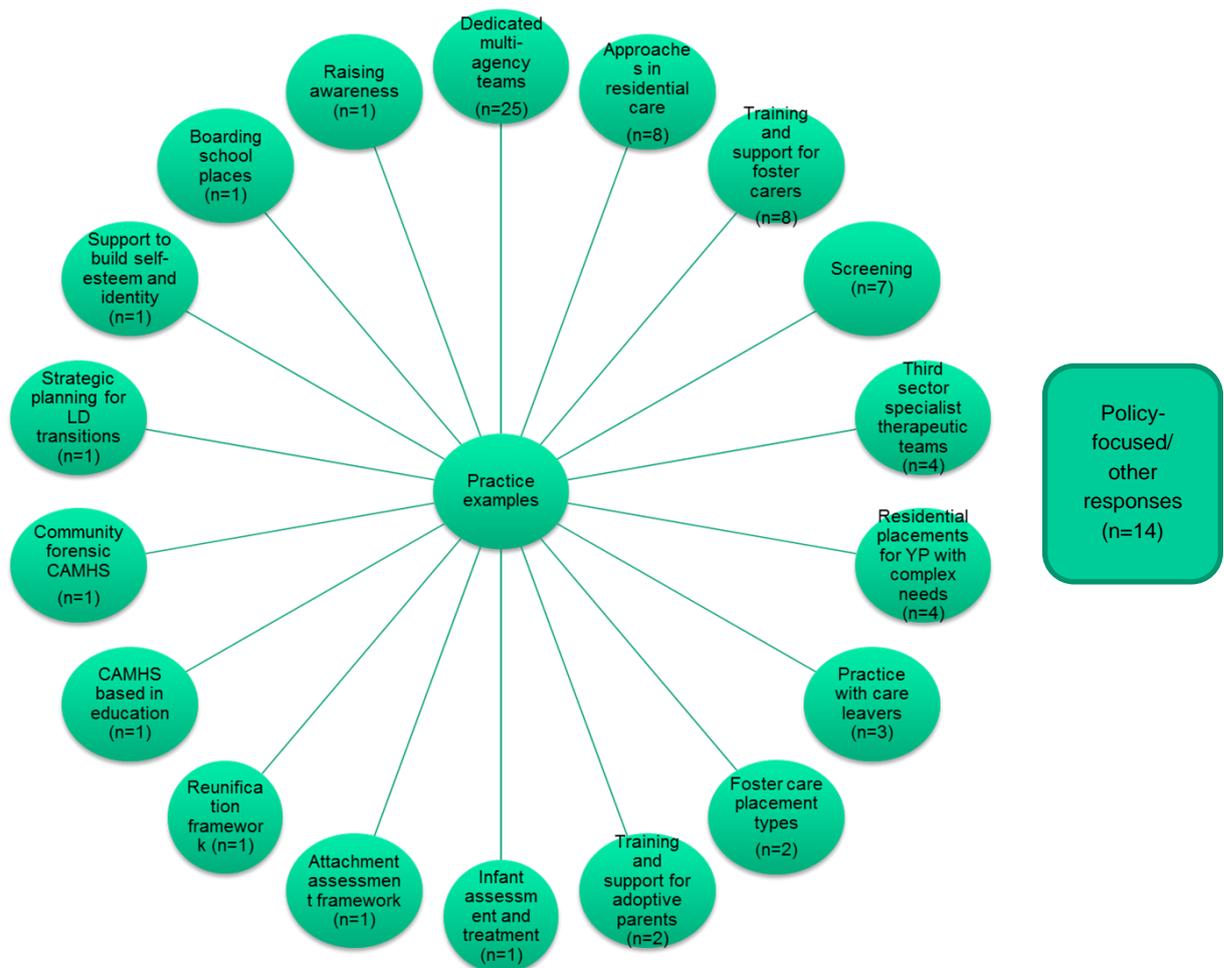
Response rate and overview of clusters

We received 68 practice examples and a further 14 submissions which took the form of a proposal or policy response to the group. The respondents were as follows:

Respondent group	N	Respondent group	N
NHS Trust	29	National body	8
Third sector	17	University	3
Local authority	12	Parents and carers	2
Private providers	11		
Total			82

Responses were placed in the following clusters, which form the basis of the remainder of this report.

Figure 1: Clustering of submitted examples¹



¹ Some submissions appear in more than one cluster.

3.1 Multi-disciplinary looked after children's emotional and mental health support services (including CAMHS)

Summary evidence statement 1

We received 25 practice examples relating to multi-disciplinary teams to support the mental health and wellbeing of looked after children. These included health- and social work-led teams, and those based at the interface of health and social care. Key components of these teams included consultation and training for professionals and carers, and therapeutic support for children and young people and their carers as appropriate.

Overall, there was some evidence (based on 8 submissions) to suggest that the activities of the teams were associated with improved outcomes for children and carers, including improved child wellbeing, understanding of children's difficulties, and carer stress. However, it should be noted that none of the submissions included a comparator group, so results should be interpreted with caution. The work of the teams was also multi-faceted, so it is difficult to disaggregate which components or combinations of components were necessary for the improvements.

There was evidence that the teams were valued by children and young people (8 submissions), carers (14 submissions) and other practitioners in the professional network (14 submissions).

Description of practice

We received 25 practice examples relating to multi-disciplinary teams to support the mental health and wellbeing of looked after children.

Structure of services: There were three main types of multi-disciplinary team -

- Health led. Practitioners often involved in these teams included psychologists (clinical, forensic, educational), psychotherapists (child and adolescent, family/systemic, educational), mental health nurses, community mental health practitioners, family therapists, occupational therapists, therapeutic social workers, art therapists, play therapists.
- Social work led. These usually included a range of social workers (looked after children, fostering support, therapeutic), a small number of psychologists, as well as practitioners such as skills workers, education advisors/specialists, youth workers/mentors, youth justice workers, Connexions workers, play therapists.
- Teams at the interface between health and social care.

A summary of the functions described in the three categories of submission is shown below. As illustrated by this table, all services contained multiple elements.

Services/functions provided by multi-disciplinary teams:

	Health led MDT ²	Social work led MDT ³	MDTs at interface of health and social care ⁴
Consultation for professional network involved with a looked after child	Yes	Yes	Yes
Consultation for carers	Yes		
Support and training for carers	Yes	Yes	Yes
Training for social workers, residential staff, etc.	Yes	Yes	Yes
Specialist assessments	Yes		Yes
Individual therapy for children and young people	Yes	Yes	
Support for placement stability	Yes		
Family/dyadic interventions	Yes	Yes	
Support for adoption transitions and post adoption period	Yes		
Supporting multi-agency planning	Yes		Yes
Screening and monitoring of DAWBA or SDQ scores	Yes		Yes
Specialist CAMHS drop in service	Yes		
Access to clinical psychology input/CAMHS		Yes	
Group supervision		Yes	
Support to schools		Yes	
Lead worker		Yes	

Description of evidence

One submission (submission 2) provided an externally commissioned evaluation⁵ that was rated as good (++), although it should be noted that this was an evaluation of a whole model comprising two services only one of which was included in the

² Submissions 1, 4, 6, 8, 10, 17, 22, 30, 31, 32, 35, 40, 43, 50, 53, 55, 61, 64, 66, 68, 71, 72.

³ Submissions 2, 24, 42.

⁴ Submissions 35 and 53.

⁵ Evaluation method included surveys (n=13) and interviews (n=7) with young people who had had contact with the service; surveys (n=6) and interviews with foster carers; focus groups (n=2) and interviews with the service practitioners, and interviews with strategic and operational managers (n=9). It also included a social network analysis to explore working relationships and links between young people, carers and families. Interviews with young people were carried out using a peer researcher methodology, with peer researchers conducting interviews and contributing to the analysis. The authors acknowledge however that the small sample sizes are a limitation.

submission. However, there was sufficient information on this aspect of the model for the evaluation to provide useful evidence, which is reported further below.

The remaining submissions provided data gained through internal evaluation or routine service monitoring. The evidence provided in relation to this cluster is summarised in the table below.

Evidence type	Provided by
Outcome data (no comparator)	Nine submissions (4; 17; 24; 31; 32; 35; 43; 55; 64) ⁶
Children and young people's views	Eight submissions (1; 2; 4; 31; 43; 64; 66; 71)
Carer views	Fourteen submissions (1; 2; 4; 8; 10; 17; 31; 32; 35; 43; 50; 64; 66; 71)
Practitioner views	Fourteen submissions (1; 2; 4; 6; 8; 10; 30; 31; 35; 50; 53; 55; 68; 72).
General views (summarised across groups)	One submission (22)
Audit data	Three submissions (2; 35;43)

It is important to note that no submitted evidence compared the use of a multi-agency dedicated looked after children CAMHS model to a different type of model (e.g. providing services to looked after children as part of a general CAMHS service).

Findings of evidence

Outcome data

Overall, outcome data described positive impacts, although it should be noted that the submissions that included reports of outcome data were either appraised to be of low quality with regard to internal validity, or provided insufficient methodological detail for an appraisal of their validity. None of these used a comparison group.

The table below describes the reporting of outcome data:

Submission	Evaluation validity appraisal	Outcomes data	Findings
4	- Low	Parents and carers complete TAYC (n=19 of 60 possible cases) and PSI Short Form (n=19 of 60	Parents and carers reported improvement in their understanding of child difficulties and the quality of the parent-child relationship following

⁶ Outcomes measures used included Parent Stress Index (PSI); Thinking About Your Child (TAYC); Children's Global Assessment Scale (CGAS); Goal Based Outcomes (GBO); Outcome Rating Scale (ORS)/Child Outcome Rating Scale (CORS) and the Strengths and Difficulties Questionnaire (SDQ).

		possible cases) at assessment and case closure;	therapy, as assessed using the TAYC and reduced stress in the parent-child system following therapy, as assessed using the PSI. The improvement in scores following therapy was statistically significant.
17	No appraisal	Outcomes measured using CGAS (n=46); GBO (n=5); ORS (n=7)	CGAS: data is said to show 'significant progress' from pre to post-intervention (54.87 at T1; 64.76 at T2); GBO: average scores demonstrate move to desired goals (3.6 pre and 7.8 post - scale of 10); ORS: young people show a move toward feeling more positive overall after intervention (19.14 at T1; 26.43 at T2; maximum score of 40)
24	No appraisal	GBO (number in sample not stated)	Goals included themes such as developing understanding, working on difficult feelings, building relationships and managing behaviours. From April 2015-March 2016 the average shift for clients moving towards goals was between 3-4 points (on a scale of 0-10).
31	No appraisal	SDQ is used at the start and end of an intervention (with foster carers and where appropriate young people) (number in sample not stated)	The submission form states that the first 3 years of the model saw a reduction in the number of young people with high SDQ scores and an increase in the number with low scores.
32	- Low	Group members (foster carers) (n=13) complete PSI Short Form and a Carer questionnaire before and after attending group training	Findings include lower stress levels after attending the group, and an improvement in the degree to which foster carers felt they understood their children's difficulties and behaviour.
35	No appraisal	CGAS (n=46) – completed by clinician; GBO (n=5) and ORS (n=7) - completed by children and young people; GBO also completed by foster carers attending the Attachment Focused Caregiving Group (n=5)	CGAS (n=46) shows average improvement of one category from 'some noticeable problems' to 'some problems'; GBO (children and young people) and ORS both show improvements. GBO completed by foster carers showed large increase in average goal rating post-intervention.
43	No appraisal	SDQ and CGAS (number in sample not stated)	Most recent SDQ data is said to show a significant reduction in the overall total difficulties of young people; CGAS data is said to indicate that 62% of young people's scores improved over time.

55	- Low	'Before and After' questionnaire with professionals (n=25)	Data showed significant improvements in professionals' understanding of the child's psychological needs; the child's relationships with other people, and their confidence in making decisions about the child.
64	No appraisal	Data collected using SDQ and CORS/ORS (n=1)	This submission provides evidence in the form of a 'case study' and gives an indication of outcomes for 1 client, which are said to show a significant reduction in experiences of sexual assault/coerced sexual activity and significantly improved family relationships

Views and experiences of children and young people

Only 8 submissions (1; 2; 4; 31; 43; 64; 66; 71) reported the views of children and young people, and one of these provided feedback from a single service user as part of a case study (64). However the descriptions of feedback provided suggest that overall the views and experiences were positive.

- Submission 2 is a multidisciplinary LAC social care team which bases its practice on Dyadic Developmental Psychotherapy (DDP) alongside the framework of Family Partnership Model (FPM). It utilises a Lead Worker model, so that continuity of relationships can be preserved for young people within both a 'team around the child' and 'team around the worker' approach. Findings from interviews (n=7) with young people using the service were mixed, with 3 respondents described as positive about the service, and 4 more ambivalent – for example, some young people were unhappy with the level of their input into decision-making.
- The other submissions reporting feedback from children and young people all reported positive feedback. For example, one specialist CAMHS Team (submission 1) gathered feedback from children and young people (n=17) over a 4 week period using the Experience of Service Questionnaire (ESQ). In 2016 94% responded 'certainly true' to 'I would recommend [the service] to other young people in my situation', showing an increase of 18% since 2014. Qualitative responses to the question 'What was really good about your care?' included "Get listened to when I want to talk"; "I get help and support". Submission 66 reported that feedback from young people via the Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ) indicated that they were not receiving enough information about the service; each child now receives a personalised letter and further feedback indicates that this has encouraged use of the service. Another submission (submission

43) reported that children, young people and their parents/carers who completed the CHI-ESQ demonstrated a 92% rate of satisfaction overall.

Views and experiences of carers

Again, the views and experiences of carers were reported to be positive overall (1; 2; 4; 8; 10; 17; 31; 32; 35; 43; 50; 64; 66; 71).

- Submission 2 included interviews with foster carers. Feedback was reported to be overwhelmingly positive, for example, enhanced support from the team, coupled with training to help them understand and manage behaviour, had been important to prevent crises escalating and resulting in breakdowns; they were also reported to be positive about the nurturing attachments training they had received as part of DDP, and perceived that this had improved their interactions with, and the care they were able to provide, to their foster children;
- Submission 2 also described feedback from carers as 'extremely positive' with themes relating to quality of care, flexibility, feeling listened to without judgement, effectiveness, and improved psychological understanding. Areas identified for improvement mainly related to reducing delays and improving transition between services;
- Submission 10 asked carers attending consultations to complete a feedback questionnaire (n=171), and reported that 99.5% of carers felt listened to and 97% felt they were able to talk about what they wanted to talk about; 99% understood what was talked about in the meeting and 95.5% felt the meeting gave them ideas about what to do;
- Submission 55 undertook interviews with 4 foster carers, which suggested increased confidence and understanding of child and young person emotions and behaviour.

Views and experiences of practitioners

The submissions including views and experiences of practitioners (1; 2; 4; 6; 8; 10; 30; 31; 35; 50; 53; 55; 68; 72) also reported these to be positive.

- Submission 2 included focus groups with team members (n=2), and interviews with lead professionals. Feedback was described as positive, for example the role of training in providing confidence in team members and improving practice and the benefits of a multi-disciplinary team and lead worker model. Social Network Analysis, together with interviews and focus groups showed that, although roughly the same number of professionals were involved in cases compared to long-term looked after children, these were more immediately on hand for the team;
- In addition, submission 6 reported on feedback from referrers, for example with 100% reporting that they would use the service again and 90% believing that

the service had benefitted the young person, family or carers; an internal evaluation for a Specialist CAMHS Drop-in service (submission 30) reported on interviews with 9 practitioners, which included positive feedback on the way in which the service had increased knowledge and understanding of when a referral is needed. Comments included: "I think it has been really helpful for the team to learn that some of the emotional difficulties children present with are a normal response and do not necessarily mean they need therapeutic input";

- Submission 53 also used qualitative interviews with social workers (n=10) to evaluate their use and satisfaction with the model. This is reported to have shown that they viewed the resource as valuable, enabling them to reflect and think differently about a case. This in turn had, for example, helped them to feel more supported and to formulate ideas about how to move forward.

Audit

Three submissions (2; 35; 43) refer to audit data in the form of Ofsted or CQC reports. In addition, 1 submission (66) reported improvements in waiting times following referral.

- Submission 43 reports that an Ofsted inspection of the service achieved a 'Good' rating, with Leaving Care rated as 'Outstanding', describing the Clinical Service as 'excellent' in its provision of 'swift access to CAMH support', noting an 'impressive range of therapeutic options' that are 'leading to demonstrable benefits in children's lives';
- Submission 35 has been rated as 'Outstanding' by CQC
- Submission 2 reports that the most recent OFSTED inspection suggests standard practice did not suffer as a result of the model, with the service rated as 'Good'.

Relevant NICE guidance

The examples submitted in this cluster are aligned with recommendation 8 of NICE guidance on the health and wellbeing of looked after children. The recommendation includes guidance to:

'Jointly commission services dedicated to promoting the mental health and emotional wellbeing of children and young people who are looked after or are moving to independent living. These services should be structured as integrated teams (virtually or, ideally, colocated), and have a mix of professionals who will vary according to local circumstances'. (p. 26)

3.2 Screening and identification

Summary evidence statement 2

We received seven practice examples relevant to screening and identification. This included four sites in which SDQ scores were proactively monitored, one site using the Development and Well Being Assessment (DAWBA) and two sites implementing specific screening approaches for under 5s.

None of the examples were able to show that screening had improved identification rates relative to a comparator (although the evaluation of one of the under 5 screening initiatives has not yet been published).

Two sites had indicative evidence of improved outcomes for young people of their service overall, but this was not specifically linked to the screening process. Five examples provided positive feedback from carers or practitioners. None of the examples provided evidence about children and young people's experience of screening.

Description of practice

We received seven examples which included screening and monitoring processes. Four sites made use of existing SDQ data collection⁷. SDQs should be completed for all looked after children. However, in many areas these scores are not used for clinical purposes, or to guide service provision. In the examples we received, mechanisms had been put in place to monitor SDQ scores, and plan services accordingly:

- Submission 4 includes an assessment and intervention service for all looked after children, adopted and Special Guardianship Order (SGO) children, positioned within Health and Social Care. Its services include monitoring high SDQ scores for looked after children, as part of a dedicated looked after children CAMHS team.
- Submission 31 includes examples of SDQ scores used in multi-agency wellbeing meetings to determine which children and young people may be in need of a service from the dedicated looked after children CAMHS team.
- Submission 50 reports on a small multi-disciplinary team with access to the Local Authority database for looked after children. On entering care, an SDQ is routinely sent to the child or young person's foster carer. The results of the SDQ help to inform the subsequent care plan for the child or young person.
- Submission 72 reports on a monthly multi-agency clinic formed to review looked after children's SDQ results, and where there are scores of concern, to decide how best to meet the needs of the person from a health, mental health, care and educational perspective.

⁷ 4, 9, 27, 31, 35, 50, 72

- Submission 35 reports use of the DAWBA for initial screening of all looked after children. This decision to use DAWBA was taken on the basis that the SDQ does not cover areas relevant to looked after children including post-traumatic stress disorder, emotional trauma, attachment issues and ADHD. The DAWBA is completed online by carers, following an introduction to the tool by their social worker. The tool results in a judgement about the probability of the child or young person experiencing difficulties. If a particular cut-off point is reached, this results in a referral to CAMHS.

In two sites, specific interventions were piloted with young children:

- Submission 27 reports on a project in which social and emotional screening of under 5s in care is carried out, including looked after children CAMHS team members observing review health assessments and asking carers to complete SDQ, Ages and Stages Questionnaire, the Carer Questionnaire and How Was This Meeting? questionnaire. Where needed, further observation and intervention was offered. The initiative ran as a pilot from May 2015 to May 2016.
- Submission 9 reports on an intervention for social-emotional screening and intervention for children under 4. This was a clinical feasibility study providing immediate access to assessment and, where indicated, intervention, for children under the age of 4 who become newly looked after.

Description of evidence

The following evidence was provided with the submissions:

Evidence type	Provided by
Outcome data	Two submissions (31, 35).
Children and young people's views	None
Carer views	Two submissions (4, 50)
Practitioner views	Three submissions (9, 27, 72)
Audit data	None

Findings of evidence

Impact on outcomes – identification and longer term outcomes

One example (submission 31) reported that 'the proportion of young people with high SDQ scores increased, and with low scores decreased'. However, no figures were given in support of this.

For submission 35, no data were provided on whether using the DAWBA helped to improve identification compared to other methods. However, overall the CAMHS looked after children service of which this is part showed improved outcomes in terms of improved CGAS and GBO scores (statistical significance of improvement not tested).

Views and experiences of children and young people

None of the examples reported the views and experiences of children and young people.

Views and experiences of carers

Two examples (submissions 4 and 50) included parent and carer feedback. In one example (submission 4), feedback from 19 parents/carers showed improved understanding of child difficulties and reduced stress, with positive qualitative feedback from parents and carers. A second example (submission 50) provided data from two service evaluations. These suggest that practitioners including foster carers find the service helpful to understand the young person's behaviour and develop a care plan.

Views and experiences of practitioners

One example (submission 72) included feedback from 1 looked after children's nurse, who suggests that the clinic has been able to identify gaps in provision.

For submission 27, feedback was provided by Children in Care social workers and looked after children's nurses. Their feedback was positive, particularly in relation to the fact that a psychologist saw 'first hand' the child's behaviour and relationships with others. No data were available on the impact on children and young people's wellbeing.

For submission 9, the research study is not yet finalised but initial evidence suggests good take up of assessment and intervention, and good outcomes where more than 80% of intervention sessions are attended.

Relevant NICE guidance

No relevant NICE recommendations.

3.3 Training and support for foster carers

Summary evidence statement 3

We received nine practice examples relating to interventions and training to support foster carers, which made use of the following interventions: Incredible Years, KEEP, TEND, Nurturing Attachments, Head Heart Hands, Reflective Fostering, Mentalisation Based Treatment for Fostering, Fostering Changes Programme and a specialist foster carer support scheme.

There was strong evidence from two submissions (Incredible Years and KEEP) to suggest that interventions improved outcomes relating to parental sensitivity and quality of parenting compared to a control group. Two further submissions showed improved outcomes in these areas, but did not have a control group (Nurturing Attachments, TEND).

Two interventions showed improved outcomes for children in relation to a control group in areas such as behaviour, emotional distress and prosocial behaviours (Incredible Years, KEEP). One intervention (TEND) showed improved outcomes for child development but did not have a control group.

Five submissions (Incredible Years, Nurturing Attachments, KEEP, TEND, specialist foster carer support) also provided positive feedback from carers. There was no data on the views and experiences of children and young people.

One submission (submission 41) is currently undergoing a scoping study to establish feasibility for conducting an RCT.

Description of practice

We received nine practice examples relating to interventions and training to support foster carers⁸. These were sometimes provided by the multi-disciplinary teams described above, and at other times were provided by third sector organisations commissioned by the local authority.

The eight practice examples were:

- Submission 14 describes a group based training programme using Incredible Years, designed to improve child behaviour and social competence. Sessions focus on the importance of play and support for learning, use of incentives, effective praise and limit-setting, and effective ways of dealing with misbehaviour;
- Submission 18 uses group based parenting programmes (Nurturing Attachments) incorporating attachment and trauma theory. A DDP model is

⁸ 14, 18, 19, 45, 48, 55, 56, 82

used to support carers to emotionally connect with children in order to increase their sense of security and support their behaviour;

- Submission 19 is a programme developed to understand the impact of introducing a social pedagogic approach to fostering in the United Kingdom (Head, Heart, Hands). Carers are supported to understand the needs of young people in their care and to find ways to promote wellbeing within the fostering household. The approach is also thought to have a positive impact on the carer/young person relationship leading to improved trust and a greater sense for the carer of being an advocate for the young person in their care;
- Submission 41 describes a Reflective Fostering programme, aiming to support strong and positive relationships between foster carers and their foster children by promoting the carers' capacity for reflective functioning.
- Submission 45 describes a manualised group based programme (KEEP) to support carers and increase their skills in managing the challenging behaviours. A key component is use of Parental Daily Report – a tool which tracks stressful behaviours over past seven days;
- Submission 48 is a group based, video coaching intervention (TEND) for foster-carers of infants and children aged 0-4 years in the pre-adoption period, based on 'Serve and Return', a US model. The central focus is on the relationship between carer and child as the vehicle to create healthy change and better outcomes;
- Submission 55 reports on a Mentalisation-based treatment for fostering designed to enhance quality of carer – foster child relationships, and enable carers to provide sensitive care that enables better management of emotions. The key focus is on promoting secure attachment;
- Submission 56 is a specialist foster carer support scheme for carers of adolescents with complex needs providing a more intensive level of support and supervision via a clinical psychologist embedded in the fostering service;
- Submission 82 describes an approach for training up foster carers better to be able to maintain children and placements, address behavioural challenges and also to skill them up to thinking about how to collaborate and engage with young people about their mental health well-being and concerns.

Description of evidence

Several of the submission included additional supporting evidence. One of the respondents (submission 14) referred to two journal articles which they had included with their submission. These reported on a trial of the Incredible Years programme conducted in Wales in 2006/7. Outcomes data are included in one of these papers whilst the second reports issues raised by group facilitators regarding the needs of carers. While the quality of the reporting of the outcomes data was of a good standard (++); there was insufficient methodological detail to rate the quality of the qualitative evidence in either paper.

Outcomes data were also provided for the KEEP programme (submission 45) and the pro forma describes improvements in outcomes such as child behaviour and carer stress. The submission also included a link to an evaluation commissioned through the Department for Education Innovation Programme. The evidence for this submission was rated as good (++).

Outcomes data were also provided for the Fostering Changes programme (submission 82) and the submission included a link to an RCT evaluation commissioned through the Department for Education. The evidence for this submission was rated as good (++).

The Nurturing Attachments programme (submission 18) also provided an external evaluation, which was assessed to be of a good standard (++).

One submission (submission 41) is currently undergoing a scoping study to establish feasibility for conducting an RCT.

The evidence submitted with the other examples provided insufficient methodological detail to appraise the quality of the research. The remaining evidence provided in relation to this cluster is summarised in the table below.

Evidence type	Provided by
Outcome data (with comparator)	Three submissions (14; 45; 82) ⁹
Outcome data (no comparator)	Two submissions (18; 48)
Children and young people's views	None
Carer views	Six submissions (14; 18; 45; 48; 56; 82)
Practitioner views	Three submissions (14; 48; 55)
Audit data	None

⁹ Outcomes measures included the Eyberg Child Behaviour Inventory (ECBI) (14); SDQ (14; 18; 45, 82); Assessment Checklist short form (18); Child parent relationship scale (CPRS) (18); Parental reflective functioning questionnaire (PRFQ) (18); The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (18; 45); Parenting scale (45); Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) (48); Parenting Sense of Competence (PSOC) (48); Ages and Stages Questionnaire (48); CSRI (Economic Evaluation (82); Alabama Short Form (82); Carer Efficacy Questionnaire (CEQ) (82); Quality of Attachment Relationship Questionnaire (QUARQ) (82); Carer Coping Strategies (82); Carer-Defined Problems Scale (82).

Findings of evidence

Outcome data

Overall, the outcomes data shows improvements for carers and children.

- The Incredible Years parenting programme (submission 14) collected baseline and 6 month follow-up for carers receiving the intervention and a control group. Results showed a significant reduction in child problem behaviour and improvement in carers' depression levels at follow-up, compared with the control group;
- Foster parents (n=29) attending the Nurturing Attachments programme (submission 18) completed a range of measures of parental and child wellbeing and family functioning pre-training and immediately after completing training and rated how close they were to reaching self-selected goals at each session. There were improvements in for example, confidence for parents. Children's difficulties didn't improve (SDQ scores showed an increase in difficult behaviour), but there was evidence that parents' perceptions had changed, with greater understanding of those difficulties.
- Baseline and follow-up data were collected from carers receiving KEEP training (submission 45) (n=59) and carers who did not (n=26). Taken together, the analysis of quantitative measures found that carers who completed the KEEP Standard showed significant improvements on the Parenting Scale while SDQs completed by those carers showed significant improvements on the sub-scale scores on their child's emotional distress and prosocial behaviours compared with the control group.
- The TEND group based video coaching intervention (submission 48) collected outcomes data using a range of measure indicating that increased parental sensitivity, parental satisfaction and improved child development.
- Baseline and follow-up data were collected from carers receiving Fostering Changes training (submission 82) (n=34) and carers who did not (n=29). The analysis of quantitative measures found that carers who completed the Fostering Changes Programme showed significant improvements on the Carer-defined Problems Scale, QUARQ and Carer's Coping Strategies, and SDQs completed by those carers showed significant improvements on the sub-scale scores on their child's emotional distress and prosocial behaviours compared with the control group. There was no difference between the intervention and control group carers detected by the Alabama Parenting Questionnaire.

Views and experiences of children and young people

None of the examples reported the views and experiences of children and young people.

Views and experiences of carers

The views and experiences of carers were reported to be positive.

- Submission 18 included qualitative interviews with foster parents (n=8), which showed that attending group was a positive experience, resulting in feeling less overwhelmed and more hopeful, with improved emotional regulation for themselves and their children. Those interviewed reported valuing the support of practitioners and other group members.
- Interviews with carers (n=15) pointed to the positive effect the KEEP Standard (submission 45) had on their confidence and well-being as well as their ability to respond to challenging behaviours, which they felt benefited the child in placement and placement stability;
- The submission for TEND group-based video coaching (submission 48) included a link to an article that described feedback from carers and practitioners, with carers describing having been able to use what they learned to positive effect;
- The Specialist foster carer support scheme for carers of adolescents with complex needs (submission 56) described feedback from questionnaires (n=4) as positive, with carers feeling listened to, learning new ideas and developing their confidence
- The Incredible Years Parenting Programme (submission 14) included a journal article that reports benefits of the dedicated foster carer groups, for example ensuring confidentiality and focusing on issues specific to foster care. However, it should be noted that this feedback was gathered through the group leaders during their supervision sessions.
- Submission 82 included a Satisfaction Questionnaire with carers from the intervention group (n=31). Feedback on the training programme was overall positive, with carers reporting that their perception of their child's behavior had improved or changed, and their relationship with their child had significantly improved. It was reported that the training programme improved carers' skills and knowledge, confidence and self-esteem, and was facilitated effectively.

Views and experiences of practitioners

Three submissions provided feedback from practitioners, although this is not extensive and 1 of these (submission 14) reports feedback from practitioners on their perceptions of the foster carers' experiences (reported above).

Qualitative feedback from facilitators involved in the TEND programme (submission 48) suggests that they perceived it to have a positive impact on carers, and on their own practice and learning. The Mentalisation-based Treatment for Fostering programme (submission 55) describes feedback from a small number of feedback questionnaires (n=9) as positive, with practitioners reporting that it had contributed to clinical practice with foster carers.

Audit

None of the examples reported audit data.

Relevant NICE guidance

The examples in this cluster are broadly aligned with recommendations from NICE guidance.

NICE guidance on looked after children and young people (PH28) notes that ‘Evidence indicates that foster and residential care are complex activities that require rehabilitative and therapeutic approaches and skills. Carers who feel supported by their social worker and have ready access to support services are better able to use these skills to encourage healthy relationships and provide a more secure base, and so reduce the risk of placement breakdown. These skills should also be reflected in the recruitment of foster carers and residential staff, and in the training and support they receive.’ (p. 50). Recommendation 36 specifically refers to training for foster and residential carers.

The guideline on attachment (NG26) recommends training and intervention for foster carers and adoptive parents, including attachment-based training for carers of preschool age children, and training in positive behaviour management and conflict resolution for parents of older children.

3.4 Foster care placement types

Summary evidence statement 4

We received three submissions relating to foster care placement types. One related to the Mockingbird Family Model (MFM), which organises a network of 6-10 foster carers organised around a dedicated hub home. The second related to multi-dimensional treatment foster care. The third related to a specialist, long term fostering placement for children.

The evaluation of the MFM was on a small scale and did not include a comparator group, but suggested that the intervention had a positive impact on placement change, and was viewed positively by young people and carers.

The findings relating to multi-dimensional treatment foster care reported in the submission show some evidence of improving children and young people’s behaviour, including conduct and hyperactivity problems. However, it does not appear that a comparator group has been used (methods not reported in detail).

The evaluation of the specialist, long term fostering intervention is in progress.

Description of practice

We received three practice example submissions relating to foster care placement types.¹⁰ Please note that submission 19 included two practice service examples, one is relevant to foster carer training and is reported above.

- Submission 19 describes a network of 6-10 foster carers organised around a dedicated hub home (Mockingbird Family Model). Carers within the hub home are specially recruited and trained and offer emergency and planned respite, foster carer peer support and regular family social activities, creating an extended familial network for the children, young people and foster carers within the constellation.
- Submission 47 is a social learning based programme (multi-dimensional treatment foster care - TFCO) originally developed in the United States as an alternative to custody, more recently used as a programme of care for young people with complex needs and challenging behaviour. The programme is described as a team intervention in which specially trained foster carers provide single placements for between nine and 12 months. Carers and young people are supported by a team who work together to devise strategies to strengthen specific relational and developmental skills in the foster home, but also work on skills and strengths in other contexts such as education, or with the biological or extended family.
- Submission 62 is a Specialist therapeutic, long term fostering program (Focus Fostering), providing solo placements for children aged 5 to 18 who have suffered complex developmental trauma. Focus fostering is a multi-agency team with a dedicated CAMHS practitioner or lead, family placement social workers, support workers and a teacher. The service aims to provide a holistic approach that is psychologically informed, trauma sensitive and attachment focused.

Description of evidence

Submission 19 provided an independent evaluation report produced by the Department for Education in association with Loughborough University. The evaluation of the MFM, published in 2016, was funded by the Children's Social Care Innovation Programme. The evaluation aimed to explore the impact of the MFM on both foster carers and those children and young people they support. A mixed-method approach was adopted which included:

- An analysis of key documents.
- Structured telephone interviews with staff stakeholders (n=23) across all 8 host services.
- In-depth dives into each site which included a focus group of supervising social workers; a survey distributed online to all foster carers (n=135); qualitative

¹⁰ 19, 47, 62.

interviews with participating fostering households (n=37); and an analysis of associated costs and resources with the MFM.

The evidence for submission 19 was rated of good (++) quality due to the robust methodology and large sample group which met the overall aims and outcomes.

Submission 47 refers to ongoing work by the National Implementation Service to determine the effectiveness of the programme across sites around the country. It is unclear from the submission what study design is being used, and whether a comparator group is present. The research team have taken relevant information from the call for evidence template. The findings of the research do not yet appear to have been published.

The evaluation of submission 62 is still in progress,

Findings of evidence

Outcome data

In submission 19:

- As noted in the limitations, the MFM had not been implemented widely at the point of evaluation and the research team commented that some outcomes i.e. improving educational outcomes, supporting birth family relationships and transition to permanence, had not changed significantly.
- The evaluation reported that a total of six children placed in MFM experienced disruption, which is lower than the national average; of these one was a planned placement change and in two cases, the children moved to a different satellite home in the same constellation.

Submission 47 reported the following pre-post data (no comparator group appears to have been used):

For TFCO-A (Adolescent, 12-18 years)

- An overall improvement in global level of functioning in life
- A significant reduction in mean total score of problematic behaviours as rated by the carer and young person (SDQ).
- A significant reduction in mean scores on conduct and hyperactivity scales (SDQ).
- A significant reduction in the mean number of behaviours occurring weekly (Parent Daily Report).
- A sizeable reduction in the occurrence of 7 out of 9 high risk behaviours

For TFCO-P (Prevention, 3-6 years)

- Placement Stability: over 90% of children who complete TFCO-P remain in the same placement at 5 year follow-up.
- Behavioural Improvements: children who successfully complete TFCO-P have significant improvements in a wide range of behaviours between entry and exit from their placement (based on SDQ, Adaptive Behaviour Assessment System, Child Behavioural Checklist and on-line Parent Daily Report)
- Adoptive Placements: between exit and 5 year follow-up from TFCO-P, 42 (40%) children have moved to adoptive placements.

Views and experiences of children and young people

In submission 19, views and experiences of children and young people were collected in reference to the following themes (these have also been reported under views and experiences of carers):

- **Respite** - the evaluation stated that consistency and familiarity with the respite provider was positive. One young person who was interviewed stated that initially it was 'weird' but now he is used to the environment and *"it feels like a second home"*
- **Extended family** – Children and young people reported that they enjoyed going to constellation events as it was a new opportunity to have a wider network and form friendships. However one young person (who was reaching independence) said that the MFM was *"[not] my kind of thing"* because the children in the constellation were younger. Additionally, two young people did report that they did not want to be a part of the MFM as they felt they would be marked out as different because they were looked after.

Views and experiences of carers

In submission 19, views and experiences of foster carers were overall positive about the MFM. In particular, the opportunity to meet in constellation meetings with other foster carers in a non-judgmental environment helped address challenges of looking after children because they could learn from each other. Participants described hub carers – who have lived experience of providing foster care - were described as responsive, supportive and flexible.

Satellite carers commented that it was easier to access respite through MFM, which provided consistency as the same person provided respite each time. The consistency enabled them to feel comfortable as they knew the respite provider. It was reported that prior to the implementation of MFM, satellite carers had not accessed respite.

The MFM was viewed to develop supportive relationships, Participants (n=11) in almost two-thirds (61%) of the interviews with satellite carers described MFM as an extended family, offering a range of practical and emotional support. One satellite carer commented that children and young people often lose wider family connections, and this model can offer a substitute for those extended networks.

Views and experiences of practitioners

Submission 19 reports that the delivery of MFM and implementation outcomes highlight that hub carers are paramount to the success of the model.

Recommendations suggest leaving enough time to recruit and support hub carers when implementing the model. Clear guidance and clarify around care plans of individual children in the constellation is essential. It was noted that recruiting highly experienced foster carers into the hub role might impact on the pool of carers, thus placing a pressure on the wider service.

Cost data

In submission 19, at point of publishing (January 2016), the evaluation stated that 16 constellations with 106 fostering households were operational. The costs associated with running a constellation was estimated to be £30, 491 per annum. The research team note that the estimated figure does not include payments for respite care or the costs for staffing, including the constellation liaison worker.

Relevant NICE guidance

The NICE guideline on antisocial personality disorder (CG77) makes reference to multidimensional treatment foster care as a form of psychological therapy.

NICE guidance on looked after children and young people (PH28) recommends that commissioners ensure a variety of placement types are available.

3.5 Approaches and models in residential care

Summary evidence statement 5

We received eight practice examples relating to residential care approaches and models. Key features included providing comprehensive training to staff based on a common conceptual or therapeutic model, and provision of therapeutic interventions to children and young people.

One example (RESuLT) provided an evaluation report. However, insufficient time had elapsed to demonstrate impact on outcomes for children and young people. A second example (integrated residential care – No Wrong Door) reported a reduction in SDQ scores, which was correlated with input from the service's life coaches. However, it is unclear what methods were used to determine this.

Two submissions (RESuLT, INTEGRATE) received positive feedback from children and young people and staff in the residential homes.

Description of practice

We received eight practice examples relating to residential care approaches and models¹¹. There were three instances in which two people had sent in very similar information regarding a specific approach or placement type¹² and these have been combined in the table summary below¹³.

The characteristics of the residential care approaches and models are shown in the table below.

		Submission 7 (Integrated residential care service – No Wrong Door)	Submission 33/46 (Multisystemic Therapy Family-Integrated Transitions)	Submission 49/63 (RESuLT)	Submission 49/63 (Needs-led therapeutic model)	Submission 60 (INTEGRATE model)
Model	Consultation for professional network involved with a looked after child	Yes	Yes	Not Relevant	Yes	Yes
	Supporting multi-agency planning	Yes	Not reported	Not Relevant	Yes	Not reported
	Multi-agency model i.e. 'Hub'	Yes	Not reported	Yes	Yes	Yes
Approach	Co-production model that consults young people with experience of care	Yes	Not reported	Not reported	Not reported	Yes
	Peer support workers	Yes	Not reported			Yes
	Outcome measure i.e. BERRI	Not reported	Not reported	Not reported	Yes	Not reported
	Systems approach	Yes	Yes	Yes	Yes	Yes
Open	Age group supported	Up to 25	Not reported	Not relevant	Not reported	Not reported

¹¹ 7, 20, 33/46, 39, 49, 52/70, 60, 63, 74, 75

¹² Submissions 33 and 46, submissions 49 and 63; and submissions 52 and 70.

¹³ Data for table has been extracted from information provided in the call for evidence only.

	Training for social workers, residential staff, etc.	Not reported	Not reported	Yes	Yes	Not reported
	Data sharing with partners	Yes	Not reported	Not reported	Not reported	Not reported
	Joint working arrangements	Yes	Not reported	Not reported	Yes	Yes
	Co-location with agencies	Yes	Not reported	Not reported	Not reported	Not reported
Support provided	Specialist assessments	Yes	Yes	Not relevant	Yes	Not reported
	Individual therapy for children and young people	Yes	Yes		Not reported	
	Placement planning	Yes	Yes		Not reported	
	Accommodation placement offered	Yes	Not reported		Yes	
	Support and training for carers	Not reported	Yes		Not reported	
	Support for placement stability	Yes	Yes		Not reported	
	Family/dyadic interventions		Yes		Not reported	
	Support for transitions	Yes	Yes		Not reported	
	Providing practical support i.e. education, training and employment	Yes	Yes		Not reported	
	Support and information to access specialist support i.e. speech and language therapy	Yes	Not reported		Not reported	

Description of evidence

The research team has extracted findings from one additional report, an independent evaluation which is of good (++) quality (submission 49/63)¹⁴. One example

¹⁴ Submissions 49/63 rated high (++) because the study had rich data from a comprehensive mixed-methodology with multiple data collection sources. Through the comparison and intervention site, the research collected a significant amount of data to enable implications and recommendations for policy and practice. The researchers note the limitations: due to being a short-term evaluation (9 months) it has been problematic to demonstrate

(submission 7) is currently being externally evaluated but the results have not yet been published.

Two submissions included outcomes data (7, 49/63). Two submissions included feedback from children and young people, and from practitioners (49/63, 60). Submission 49/63 also included feedback from carers.

Findings of evidence

Outcome data

Submission 7 sought to evaluate and evidence the impact of an integrated residential care service including an onsite multi-agency hub and reports the following outcomes:

- Reduction in SDQ scores for those accessing the service
- A statistical correlation between the input of life coaches and social workers and a reduction in SDQ scores.

However, it is unclear what methods were used to ascertain this.

In submission 49/63, a nine-month evaluation sought to understand the impact of RESuLT training. The evaluation was carried out in 6 intervention homes (which had undertaken the training) in 6 locations, and in 4 comparison homes (homes where training had not been undertaken).

The evaluation noted that insufficient time has elapsed to demonstrate impact on children's behaviour and outcomes. Data on outcomes for the young people by the end of the training had a low number of responses (n=14) resulting in challenges in comparing mean Time 1 and Time 2 changes. However the evaluation notes that 'it seems possible that the young people's social behaviour in the Intervention Homes showed more stability or improvement than for the young people in the Comparison Homes'.

Views and experiences of children and young people

In submission 49/63, 10 young people who lived in the intervention homes were interviewed by the research team. Overall the children and young people consensus suggests that the training was being used in the residential home and had led to some improvements, as suggested by the following: "They never used to sit down with us because they were too busy doing work all the time. But they sit down with us now, so it's good".

In submission 60, internal qualitative interviews were conducted by an Assistant Psychologist (who was not involved in the delivery of the initiative) with young people

whether RESuLT training programme has had an impact on children's behaviour and outcomes. An additional limitation would be that it is not clear how the data were analysed.

(numbers unclear). The four main themes that emerged relating to the effectiveness of the initiative were:

- Feeling understood and expressing feelings;
- Feeling included and valued;
- Importance of youth-led fun activities;
- Legacy and hopeful futures.

The young people reported feeling listened to and that they enjoyed engaging with the Peer Support Workers who they felt they could relate to. The youth-led activities were important to them, bringing a sense of fun and ownership, whilst giving them a chance to talk to the staff team in a less formal way.

Views and experiences of carers

Submission 49/63 included the views and experiences of carers; however, the results are not clear.

Views and experiences of practitioners

In submission 49/63, a mixed method approach enabled the collection of qualitative data from eighty-two staff who participated in the training. Additional data were collected through interviews with forty-two staff members (including 6 heads of home) who were partaking in the intervention homes. Findings suggest that participants who attended the RESuLT training were very positive about all the elements of the course, such as cross-sectional participants, good facilitators, and the link between theory and practice. Since training, it was noted across all 6 settings that the training was being used with the young people daily and has led to changes in how the homes are operating. Staff had acknowledged their own individual changes in practice. One recalls: "There seem to be less sanctions, definitely less. There weren't many anyway, but there's a lot less and certainly more praise, a lot more praise going on".

In submission 60, qualitative interviews were conducted by an Assistant Psychologist (who was not involved in the delivery of the initiative) with practitioners (numbers unclear). The five main themes that emerged relating to the effectiveness of the initiative were improved:

- Role modelling and relating
- Reflective practice
- Developing a new perspective and team cohesion
- Positive engagement
- Staff confidence and resilience (self-care).

Audit

None of the examples reported audit data.

Relevant NICE guidance

NICE guidance on looked after children and young people (PH28) notes that 'Evidence indicates that foster and residential care are complex activities that require rehabilitative and therapeutic approaches and skills. Carers who feel supported by their social worker and have ready access to support services are better able to use these skills to encourage healthy relationships and provide a more secure base, and so reduce the risk of placement breakdown. These skills should also be reflected in the recruitment of foster carers and residential staff, and in the training and support they receive.' (p. 50)

3.6 Residential placements for children and young people with complex needs

Summary evidence statement 6

We received four practice examples relating to residential placements for children and young people with complex needs.

One submission relating to placements for young women at risk of child sexual exploitation (CSE) was at an early stage of evaluation, with a relatively small number of participants, making it difficult to draw conclusions about outcomes.

A submission relating to placements for young people with complex mental health needs suggested that young people's mental health and behaviour improved during the service, however no comparison group was included in the research.

A submission relating to placements for young people with multiple and complex needs found some evidence of reduced self harm, although this should be interpreted with caution as there was limited information about the methods used to determine this.

One submission relating to a secure unit reported positive feedback from young people and referring practitioners.

Description of practice

We received four practice examples relating to residential placements for children and young people with complex needs¹⁵. These are described in the following table:

¹⁵ 20, 39, 74, 75

	Submission 20	Submission 39	Submission 74	Submission 75
Age Supported	10-17	12 – 17	Not reported	10-18+
Target group	Secure unit/Offenders and YP cared for by Welfare provision	Young women at risk of CSE	Complex mental health with diagnosis	Multiple and complex needs.
Sex	All	Female only	All	All
Main funder	Offender Health Commissioning	Department for Education Innovation	Independent	Tri-partite arrangement
Assessment	Yes	Yes	Yes	Yes
Intended length of stay	Not reported.	6-9 months	Not reported.	Not reported.
In-house therapy	Yes	Yes	Yes	Yes
Crisis intervention	Not reported.	Not reported.	Not reported.	Yes
Approach	Wraparound	Trauma-based/Social pedagogy	Therapeutic Spectrum	DBT/DDP ¹⁶
Multi-disciplinary team	Yes	Not reported.	Not reported.	Yes
Consultation for professionals working with looked after children	Yes	Yes	Yes	Yes
Outreach	Yes	Yes	Yes	Yes
Pathway to CAMHS	Yes	Yes	Yes	Yes

Description of evidence

Submission 39 included an internally produced interim evaluation of the pilot service rated medium (+) quality¹⁷.

The evidence provided in relation to this cluster is summarised in the table below

Evidence type	Provided by
Outcome data (with comparator)	None

¹⁶ A combination of Dialectical Behavioural Therapy (DBT) (with good evidence in meeting young people's mental health needs) and DDP (with good evidence in meeting attachment needs of looked after young people).

¹⁷ Submission 39 rated of moderate (+) quality because the report has a comprehensive mixed-methodology with multiple data collection sources. A limitation is that it is not clear how the data was analysed, and because it was internally produced, it is unclear if there is research bias. The authors' note that there were challenges encountered interviewing the young people, hence the small sample (n=3), which have been clearly detailed in the research paper.

Outcome data (no comparator)	Three submissions (20; 39; 75)
Children and young people's views	Two submissions (20; 39)
Carer views	None
Practitioner views	Two submissions (20; 39)
Audit data	One submission (39)

Findings of evidence

Outcome data

The following outcomes for young people were reported in relation to submission 39:

Outcome area	Finding
Young women are making more decisions for themselves with fewer mishaps	It has been reported that there has been little time for the project to demonstrate its efficiency in this respect. The findings suggest that there has not been a significant change between T1 and T2.
Young women have greater understanding of CSE and its impact; young women believe they deserve to be valued not exploited in relationships	As reported through self-reporting (n=3) using the measurement tool Teenage Attitudes to Sex and Relationships (TASAR), saw slight improvements.
Young women have greater understanding of the impact of trauma on their lives and have reduced symptoms	The SDQ and Trauma Symptom Checklist for Children (TSCC) were used as measurement tools to evaluate the young women through self-reporting (n=3). At T2 there were slight improvements which could be seen as encouraging.

In submission 74, an internal clinical audit in January 2016 of 50 young people's admission to the service and care pathway demonstrated positive improvements. The audit found that a wide range of young people, with some complex mental health, emotional and behavioural difficulties, used the service, and that a significant number of these young people have made improvements from admission through to their discharge.

Using a likert-type scale to evaluate the results, 30 (60%) of these young people were found 'Significantly improved or Improved at discharge', defined as, at discharge, having evidence of improved mental health/wellbeing; a move into full-time education,

employment or training; having developed community support networks; and a move to home/semi-independence/foster care.

Submission 75 a number of indicators of effectiveness:

- Reduction in A&E visits from the young person's first month in placement to the current month.
- Reduction in risk levels when using daily assessments of self harm and suicide risk.
- Reduction in the amount of self harm incidents from the first month of placement to the current month.
- Reduction in the amount of overall incidents notifiable to the local authority from first month of placement to current month.

Views and experiences of children and young people

Submission 20 reported positive responses to the service user questionnaire:

- 92% of young people were happy with service they received
- 96% reported having felt listened to
- 92% reported they had matters explained to them
- 84% reported that their ideas or worries were taken seriously

Focus group participants requested that the service provide them with more information, support and contact.

Submission 75 provided feedback from young people in placements:

- One young person indicated a supportive and well planned transition, the other was unable to recall their transition from hospital. Both described a welcoming atmosphere and clear information about the home. They described having people to talk to for support, and feeling safe.
- Comments from young people included: *"they included me in the everyday running of the house and made me feel part of the home", "I definitely felt supported by the team", "[in my transition] I had had regular visits 2-3 times a week for about 3 weeks, I had 1-2 overnight visits and I have the manager and 3 different members of the care team visit", "I can tell anyone at [name of home] if I am not happy", "I've had birds painted on the walls and my head board painted with black glitter, I chose my bedding and I am happy with my room and feel it is mine".*

Views and experiences of carers

None of the examples reported the views and experiences of carers.

Views and experiences of practitioners

In submission **20**, referrer and unit management feedback was very supportive of the service model:

- 97% of staff reported no difficulties in accessing the service
- 94% rated care plans as useful
- 86% rated consultations as useful.

Audit

Submission 39 incorporated two Ofsted reports dated 12 January 2016. One house is identified as 'requires improvement' and the other 'good'.

Relevant NICE guidelines

NICE guidance on looked after children and young people (PH28) recommends that commissioners ensure a variety of placement types are available. However, no specific models of residential care are recommended.

3.7 Training and support for adoptive parents

Summary evidence statement 7

We received two practice examples about training and support for adoptive parents.

The AdOpt parenting programme had an associated high quality evaluation with a (non-randomised) control group. The evaluation reported effectiveness in reducing total problems and conduct problems, but not emotional, hyperactivity or peer problems, or prosocial behaviours. It received positive feedback from adoptive parents.

There was some evidence for a neurophysiological psychiatry model, which showed statistically significant changes from pre to post treatment in behavioural regulation, metacognitive executive functioning, alongside an improvement in thought and social problems. However, it should be noted the study did not have a control group. It received positive feedback from children and young people and adoptive parents.

Description of practice

We received two practice example submissions relating to training and support for adoptive parents¹⁸.

- Submission 13 is a neurophysiological psychiatry (NPP) model (Family Futures). NPP is a multidisciplinary, brain-based, developmental and attachment-focussed intervention for children who have experienced significant trauma in their early life.
- Submission 44 describes a group-based parenting programme, developed from the KEEP fostering programme, for adoptive parents (AdOpt). AdOpt includes

¹⁸ 13; 44

an adoptive parent as facilitator, and the programme targets parents and children post legal order, a time when parents have historically received limited support and which is critical for future family cohesion, child development and wellbeing. The overall programme has been designed for adoptive parents to help facilitate parenting techniques and supports that address specific difficulties which adopted children may experience.

Description of evidence

Submission 13 included an evaluation of the effectiveness of NPP, which was appraised to be of moderate quality¹⁹. Submission 44 included a Department for Education research report, which was appraised to be of a good standard.

Submission 44 included outcomes data with a comparison group; Submission 13 included outcomes data, but without a comparison group.

Submissions 13 and 44 included views and experiences of carers; Submission 13 included views and experiences of children and young people; Submission 44 included feedback from practitioners.

Findings of evidence

Outcome data

Submission	Evaluation validity appraisal	Outcomes data	Findings
13	+ moderate	CBCL ²⁰ , TRF ²¹ , BRIEF ²² , ACC ²³ <u>Baseline and follow up:</u> Children (n=31) of families (n=21)	Overall the evaluation found positive outcomes for families who have participated in the NPP programme. The study found statistically significant changes from pre to post treatment in behavioural regulation, metacognitive and executive functioning, and an improvement in thought and social problems.

¹⁹ + Moderate quality empirical study that sought to evaluate the effectiveness of NPP. The methodology and approach is thoroughly detailed, as is data collection points and sample. The limitations of the study is attributed to the absence of a comparison control group.

²⁰ CBCL is a self-report questionnaire distributed to primary caregivers of children aged 6-18 years, where first section evaluates the child's social and academic competencies, and second section evaluates behavioural and emotional problems of the last 6 months.

²¹ Teacher Report Form is a teacher-completed version of the CBCL and reflects the child's functioning in school.

²² BRIEF is a paper questionnaire completed by parents and teachers of children aged 5-18 years and is a measure of the child's executive functioning and regulation.

²³ Assessment Checklist for Children is a questionnaire designed specifically for children in care to be completed by child's caregiver.

44	++ good	Child wellbeing, and Parenting measures ²⁴ Parents (n=101) Facilitators ²⁵ (n=12)	Overall the evaluation found varied results when reporting outcomes for children: Effective in reducing total problems and conduct problems; Not effective in reducing emotional problems, hyperactivity problems, or peer problems, nor did it evidence improvements in prosocial behaviours (based on SDQ scores).
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Views and experiences of children and young people

For submission 13, the call for evidence noted:

- 13 out of the 25 young people described improvements in their peer relationships; 10 felt there had not been a change but many of these young people felt that there had not been a difficulty with their relationships with their peers prior to the treatment programme. No young people described deteriorations in their peer relationships.
- Of the 17 young people asked about how school has been since their treatment programme, 13 described improvements.

However, it should be noted that the source of this data was not clear.

Views and experiences of carers

In submission 13, the evaluation conducted qualitative interviews with a total of thirty-one caregivers. An analysis of the interviews provided positive results in terms of the children's engagement in education, an absence of further mental health diagnosis or involvement in the criminal justice system.

Submission 13 further reported that 19 of the 33 parents/couples asked about positive changes in their children since beginning treatment said that they felt these changes were due, at least in part, to the work done with the service (and thus, the NPP model).

In submission 44, overall the evaluation found positive results based on focus groups and telephone interviews with participating parents. The AdOpt parenting programme:

- Was reported to have had a positive effect on child outcomes and parenting practices as well as parenting satisfaction. Additionally, adoptive parents

²⁴ Measures included 3 questionnaires that assessed emotional, behavioural and social well-being: Strengths and Difficulties Questionnaire (SDQ, Goodman, 2001); Assessment Checklist for Children Plus (ACC+; Assessment Checklist for Children- Short Form (ACC-SF). Three parenting measures assessed: Parenting Sense of Competence (PSOC); Parenting Style and Parent-Child Relations (Iowa Youth and Families Project (IYFP) – Parental Monitoring and Discipline Subscale and Time Spent with Child - Parent-Child Affiliation Style were also included.

²⁵ Facilitators were all social workers, primarily from the adoption support team.

reported feeling more supported, understood and connected to others, thus reducing their isolation.

- One parent commented about their experiences of being part of a network as appealing and invaluable: *“I wanted to feel supported and learn something that would help. Being part of a community and being with people going through the same thing is really helpful. I wanted techniques and tools as well as emotional support – I wanted to feel like I wasn’t drowning or being overwhelmed by the challenges”*.
- Parents identified areas for development of the parenting course: additional time spent discussing topics – *“sometimes we are rushing too quickly for a certain topic”*– and some would like specialist topics to explore their personal self-care and management.

Views and experiences of practitioners

For submission 44, facilitators were largely positive about the training and felt it could be used in other areas of their work:

Audit

None of the examples reported audit data.

Relevant NICE guidelines

The guideline on attachment (NG26) recommends training and intervention for foster carers and adoptive parents, including attachment-based training for carers of preschool age children, and training in positive behaviour management and conflict resolution for parents of older children.

3.8 Independent/third sector specialist therapeutic teams

Summary evidence statement 8

We received four practice examples relating to specialist therapeutic teams. These provided a range of interventions and services, including attachment-, trauma- and solution-focused therapies.

Two of the services reported improvements (identified via internal monitoring) in outcomes for children and young people as a result of therapeutic intervention (attachment/trauma-based and solution-focused respectively), including reduction in trauma symptoms, an improvement in emotional and behavioural difficulties and self-control and problem solving. However, no comparator groups were used.

Three examples reported positive feedback from children and young people and carers.

Description of practice

We received four practice examples relating to specialist therapeutic teams²⁶ (submissions). Submissions were from third sector organisations or the independent sector. The four practice examples are detailed in the table below:

	Submission 12	Submission 28	Submission 36	Submission 41
Age Supported	Not reported	Not reported	?	5-18
Target group	Foster and Adoptive families	Looked after children	Looked after children	Looked after children
Multi-disciplinary team	Yes	Yes	Not reported	Not relevant
Independent	Yes	Yes	Yes	Third sector
Assessment	Yes	Yes	Yes	Yes
In-house therapy	Tailored dyadic intervention	Yes	Bespoke intervention	Not relevant
Frequency of Sessions	Weekly two hour 10 month period	Not reported	Not reported	Not relevant – training for practitioners
Dyadic	Yes	Not reported	Yes	No
One-to-one therapy	Yes	Yes	?	Not relevant

²⁶ 12, 28, 36, 41

Group therapy with other YP	Not reported	Yes	Not reported	Not relevant
Outreach	Not reported	Yes	Yes	Not relevant
Approach	Attachment/ Trauma	User-Led	Not reported	Solution-focused
Training for practitioners	Yes	Not reported	Not reported	Yes

Description of evidence

Evidence type	Provided by
Outcome data (no comparator)	Two submissions (12 ²⁷ ; 41 ²⁸)
Children and young people's views	Three submissions (12; 28; 41)
Carer views	Three submission (12, 28, 41)
Practitioner views	One submission (41)
Audit data	None

Findings of evidence

Outcome data

The data reported for submissions 12 and 41 show an improvement in children and young people's mental health and wellbeing after the intervention each service provides.

²⁷ Submission 12 outcomes data monitored families (n= 43) who had an average of 25 sessions each on psychological assessments measures before and after their therapy. There was not enough information on data collection methods to complete an appraisal.

²⁸ Submission 41 included a mixed-method internal evaluation and adopted an outcomes measurement scale to measure the change in wellbeing for children and young people at the end of the service, and three months later. The moderate quality rating (+) was because the methodology is appropriate and thorough. The study included a large sample group of 611 children and young people who had completed the Face to Face work. They were administered the Outcome Rating Scale, then a follow up with 103 children and young people 3 months after they had completed the intervention. The purposive sample was intended to be representative and inclusive of all users of service. The limitations of the study are detailed in the research paper: outcomes data does not include comparison group; children and young people were followed up three months later but research would be needed to understand if the service sustained benefits long-term; (CORS was administered to 6+ years therefore excluded the 5 year group (2% of service participants)).

- Submission 12 provided data that demonstrates a significant reduction in trauma symptoms, an improvement in emotional and behavioural difficulties and self-control and problem solving (Executive Functioning). Trauma symptoms were reported using the Trauma Symptom Checklist for Young Children Before therapy children were exhibiting high trauma symptoms such as avoidance, intrusion and arousal. After the intervention, it was reported that children were found to be less avoidant of their traumatic past, and their 'fight or flight' response had been reduced. Overall, children's emotional wellbeing and behaviour monitored through the use of the Child Behaviour Checklist/4-18 showed significant improvement where children's levels of depression and anxiety reduced.
- Submission 41 measured the change in wellbeing for children and young people at the end of service as well as three months after finish. The key finding is that prior to children and young people receiving the service, 58% of children and young people were presenting with wellbeing scores that indicated clinical levels of distress. After the service, this had reduced to 15%. Of those children and young people that showed clinical levels of distress, 70% showed reliable improvement and ended the service with normal levels of wellbeing. Three months on, it was reported that 84% of children and young people sustained improvements in wellbeing scores.

Views and experiences of children and young people

Three submissions collected views and experiences internally in relation to effectiveness of service and appropriateness of therapist. Overall, feedback was very positive:

- Submission 12 reported that 91% of children and young people liked and enjoyed the time they had with their therapist. Comments to support findings included: "She helps in a way that we never thought of :)", and "He is kind and wants to help me".
- Submission 28 also incorporated extremely positive feedback from children and young people, for example "Service was amazing and very professional with work. Very polite and easy to talk to".
- Submission 41 reported that 73% of children and young people said Face to Face had helped them to solve the immediate concern that was affecting their emotional wellbeing. The service was reported to have helped by listening to them; being confidential; encouraging them to reflect on issues; focus on their strengths; giving them control over processes, and by rehearsing strategies to solve their problems.

Views and experiences of carers

Three submissions (12, 28, 41) collected views and experiences of parents, caregivers and referrers internally in relation to effectiveness of service and appropriateness of therapist. Overall, data collected is very positive about the intervention the child or

young person in their care received. Recommendations were highlighted in submission 12 and 41 for service improvements which were about extending the intervention for a longer period of time, or to include more joint sessions for caregiver and child towards the end of the work in order to sustain changes.

Views and experiences of practitioners

In submission 41 practitioners were positive about the service and felt that it had the potential to improve the wellbeing of young people.

Audit

None of the submissions included audit data.

Relevant NICE guidance

None of the examples reported audit data.

3.9 Assessment and treatment for infants under 5

Summary evidence statement 9

We received one practice example relating to the New Orleans Model in Glasgow (GIFT), delivered by a multi-disciplinary team of mental health professionals and social workers.

A qualitative evaluation provided in the submission found that stakeholders regarded the mental health focus was seen as GIFT's key contribution, and explored benefits and challenges of the new approach.

Description of practice

We received one practice example relating to the implementation of the New Orleans Model for infants in care in Glasgow (submission 41).

This is an assessment and treatment service for families and children under 5 who have been taken in to care due to maltreatment. One of the aims of the service is to assist better decision making about entry to care or assessing the parents' ability to support children safely at home.

A multi-disciplinary team provides assessment and treatment for both birth and foster families. After structured assessment, interventions offered may include:

- Circle of security – an intervention using attachment theory to improve parent-child relationships
- Parent-infant psychotherapy
- Video interaction guidance.

Description of evidence

The submission provides a process evaluation of the model. This was rated by the team as being of good quality, acknowledging the limitations of a qualitative design in terms of understanding effectiveness. The study involved semi-structured interviews and focus groups with key stakeholders, including GIFT team members, social workers, the Family Assessment and Contact Team (FACS) birth parents and children's panel members. An exploratory RCT has been conducted by the results are not reported.

Findings of evidence

Outcome data

No outcome data reported.

Views and experiences of children and young people, carers and practitioners

The evaluation does not report the views of stakeholder groups separately, but instead has analysed them under the following three themes:

- Mental health component of GIFT – the evaluation reports that the mental health focus was seen as GIFT's key contribution. An identified challenge was the potential for disagreement between GIFT and FACS regarding permanency decisions
- GIFT timescales – the GIFT process is reported as being longer than service as usual. Whilst this is seen as necessary to improve accuracy of decision-making, the study reports that there have been barriers to other parts of the system accepting this longer timescale.
- GIFT and foster care – The study reports that foster carers report that value of thorough assessment and high level of support. However, the study also reports challenges in relation to the 'newness' of the methods, and that this can challenge foster carers' accepted ways of working.

3.10 Care leavers

Summary evidence statement 10

We received three examples relevant to practice with care leavers (dedicated leaving care practitioner, BOOST pathway, Shared Lives).

None of the examples were able to provide evidence of impact on outcomes. Two (BOOST and leaving care practitioner) reported positive feedback from young people, although it should be noted that the sample size for the leaving care practitioner was very small (n=3). One example (leaving care practitioner) reported positive feedback from carers who attended their training or received consultation support, but again the sample size was small (n=7).

Description of practice

We received three examples relevant to practice with care leavers²⁹.

- Submission 11 is an individual practitioner providing individual and group therapeutic interventions for care leavers as well as training and consultation for the professionals working with them. The aim of the role is to enable care leavers to access mental health care and to bridge the gap between CAMHS and adult mental health services. The service is offered to care leavers 'open' to the leaving care team until the ages of 21 or 25. The practitioner is employed by CAMHS but line managed by, and located within, the local authority's leaving care service. This enables access to specialist mental health supervision and services including crisis and medical intervention.
- Submission 41 describes the Boost Pathway, provided to care leavers between the ages of 16 and 25 and designed to enable independence, improve confidence, expand and develop skills, and reduce the risk of isolation. Boost staff provide one to one life skills sessions covering issues such as managing money, cooking and job interviews. The service also offers access to therapeutic resilience sessions with a qualified psychologist;
- Submission 65 places young people over the age of 16 into Shared Lives Schemes rather than in a foster care placement or a children's home. The initiative was developed partly in response to comments from commissioners who reported difficulties in placing some young people in traditional models of care.

Description of evidence

Two of the submissions reported collecting outcomes data (11; 51); however, this was not provided in a reportable form. Submission 11 also included examples of feedback from young people, carers and practitioners. However, it should be noted that no context was provided, such as whether this was the total number of completed forms, or selected examples.

Submission 51 included an external evaluation of the year 1 programme pilot that reports feedback from young people in the form of a satisfaction survey (n=8) and qualitative interviews (n=10), and from 1 member of staff. It also includes some audit data, assessing the extent to which Key Performance Indicators (KPIs) were met. This was accompanied by a draft article analysing the qualitative interviews using discourse analysis. The evaluation was appraised to be of a low standard with regard to the validity of the findings.

²⁹ 11, 41, 65

Findings of evidence

Outcome data

None of the examples included reportable outcomes data.

Views and experiences of children and young people

- Submission 51 reported positive feedback from young people using the service, concluding that the BOOST programme is a valuable source of support for young people, although there is a need for more targeted support and input on mental health;
- Submission 11 included some examples of completed feedback forms (n=3), which all gave very positive feedback, for example with one respondent stating that they had learned about different methods of coping with anxiety.

Views and experiences of carers

Submission 11 included examples of completed feedback forms from carers who had completed training on caring for teenagers (n=4), and following consultations (n=3). Again these were all very positive, including comments that the consultations had helped with understanding the young person's behaviour and had helped the carer to feel supported.

Views and experiences of practitioners

- The evaluation for submission 51 included a qualitative interview with 1 member of staff. This was mainly used to provide context for the service, but also identified a need for further training on mental health.
- Submission 11 included evaluation of training for practitioners working with care leavers, including training in Reducing Risk (self-harm) (n=4). Feedback was positive, for example, responses to 'Do you feel you have gained a better understanding of the topic' were rated at 4 or 5 (5='Very much so') and all answering 'Yes' to 'Do you feel more confident to talk to young people on the topic?'. The Nurturing Attachments training evaluation forms (n=2) both rated each of 3 training sessions as 'Very useful', with comments including "it was all helpful for my job role".

Audit

The BOOST evaluation reported on data collected by the service to measure outcomes against KPIs, for example:

- Young people who were NEETs at referral accessing education, employment or training (target = 50%; achieved = 58.3%);
- Young people referred actively engaging with BOOST centre (target = 90%; achieved = 85%)
- Engaged young people living in safe and suitable accommodation that meets their needs (target = 90%; achieved = 100%)

- Engaged young people managing their physical and mental health needs. (target = 90%; achieved = 78.4%).

Relevant NICE guidance

No relevant NICE recommendations.

3.11 Attachment Assessment Framework

Summary evidence statement 11

We received one practice example relating to an assessment attachment framework – a method for assessing and monitoring emotional wellbeing of young people. The supporting evidence suggested that the framework can be used effectively in residential care.

Description of practice

We received one practice example relating to an assessment attachment framework (submission 5).

A residential care provider, in partnership with the Centre for Abuse and Trauma Studies (CATS) at Middlesex University have developed an attachment based assessment tool specifically for children and young people in residential care called Q Pack. This aims to give greater insight and understanding of the emotional wellbeing and attachment of the child or young person. This helps to identify the appropriate interventions and services the child or young person may require.

Description of evidence

The Q pack uses standardised and tested self-report questionnaires, which are used on a repeated basis to assess the progress of young people in care, as reported by the young person, carer and social worker. The submission provided a report of how the questionnaire had been put into practice.

Findings of evidence

The evidence submitted found that Q packs are increasingly being utilized across the provider's services since the initial report Baseline Q packs with 167 baseline now completed. Most (82%) were completed by young people and carers, 18% were from carers alone with some teachers also included. .

This initial pilot work shows that the Q pack can be used successfully in residential care and foster care services and that indications of this pilot suggest positive change over a 6-month period as reported by Foster Carers and young people. Longer periods in stable placements seem to be needed to show positive change in residential care.

Relevant NICE guidance

The NICE guideline on attachment (NG26) recommends a range of tools for assessing attachment. This includes the Q sort tool – whilst this has a common theoretical base with the tool above, it appears to be a different tool.

3.12 Reunification practice framework

Summary evidence statement 12

We received one practice example relating to a practice framework to support reunification.

A study following up cases in which the framework was used showed that nearly all children remained at home 6 months after reunification. However, it should be noted that a comparator does not appear to have been used. The framework had received positive feedback from practitioners who had used it, and from children and young people.

Description of practice

We received one practice example relating to a practice framework to support reunification (submission 41). This is a practical guide based on reunification research to support planning for children who cease to be looked after. The guide follows five stages: assessment of risk and protective factors, risk classification, goal setting, reclassification of risk following reunification, return home.

Description of evidence

The submission draws on three evaluations of the framework.

Findings of evidence

Outcome data

The submission reports that the latest evaluation found that 46 of 47 children in the study remained at home 6 months after reunification. One further reunification broke down after 6 months. However, a comparator group does not appear to have been used to compare rates of sustained reunification if the tool was not used. The submission also reports that child protection concerns for the cohort were reduced using the tool.

Views and experiences of children and young people, carers and practitioners

The evaluations found that practitioners valued the approach in the framework. They further found that children and young people responded positively to the tools used.

Relevant NICE guidance

No relevant NICE recommendations.

3.13 CAMHS based in education

Summary evidence statement 13

We received one practice example relating to a CAMHS service embedded within an educational context.

The service had received positive feedback from practitioners who had received consultation and training. No data were provided at this stage relating to the impact on outcomes for young people, or young people's experience of the service.

Description of practice

We received one practice example relating to a model in which CAMHS are embedded in an educational context (submission 25).

The Virtual School CAMHS Team is a joint venture between CAMHS and the local authority's virtual school. The team is described as being embedded within the virtual school and its aim is to incorporate a CAMHS perspective into the work of the virtual school. This is seen as way of providing a flexible and responsive service to looked after children and young people placed both in and outside the borough.

The team focuses on the systems around the child or young person in order to identify barriers to their education and to develop strategies to address these. Components of the model are as follows:

- consultations with practitioners both in and outside the virtual school;
- provision of training to schools;
- assessment and direct interventions to address educational difficulties (including the young person and their carer);
- signposting to other services where appropriate.

Description of evidence

The submission summarises a sample of data collected internally in relation to responsiveness of the service; feedback using the CORC consultation feedback form from practitioners who have received consultations (n=24); and feedback from school staff who had received training from the team (1 school training completed so far). There was insufficient information to appraise the validity of the findings.

The submission also reports that feedback on the initiative has been sought from looked after children themselves, however this is not summarised or included with the submission.

Findings of evidence

Outcome data

The submission did not report outcome data

Views and experiences of children and young people

The submission did not report views and experiences of young people

Views and experiences of carers

The submission did not report views and experiences of carers.

Views and experiences of practitioners

- All practitioners who provided feedback on their consultations reported that they were happy with the service, found the consultation easy to arrange and that their concerns were reduced following the consultation;
- Staff receiving school training reported that the training increased their understanding of how early experiences impact on development, how prepared they felt to support the emotional wellbeing of looked after children, their ability to help other colleagues understand the behaviour of a looked after child and their confidence in managing challenging behaviour.

Audit

Data collected internally showed that between February 2015 and June 2016, in 82% of 92 cases brought to the attention of the virtual school CAMHS team initial contact with the referrer took place within 24 hours.

Relevant NICE guidance

No relevant NICE recommendations.

3.14 Strategic planning for transitions for children with a learning disability

Summary evidence statement 14

We received one practice example relating to strategic planning for transitions to adult services of children with a learning disability who are being looked after away from home and are subject to 'significant restrictions'.

Only preliminary evidence was available, based on four young people. This suggested that the practice had reduced the time for transition planning, reduced restriction and increased family contact. No information was provided on how these outcomes were measured.

Description of practice

We received one practice example (submission 21) relating to strategic planning for transitions to adult services of children with a learning disability who are being looked after away from home and are subject to 'significant restrictions'.

The piece of work involved the development of a project team working across children's, adults' and third sector services, and linking with the Directors of Children's and Adults' Services and commissioners in the Clinical Commissioning Group. The project worked to plan transitions for four young people with complex learning disability and autism in out of area placements for education, care, or both. The project had a particular focus on the development of positive behaviour, communication and active support plans.

Description of evidence

The submission provided a narrative description of early outcomes of the project, but notes that this is on a small scale (n=4).

Findings of evidence

The submission reports that:

- The time for transition planning was reduced from approximately two years to nine months
- There was a reduction in restriction and an increase in family contact for the four young people involved.

Relevant NICE guidance

This practice example relates to NICE guidance on children's to adults' transitions (NG43), which recommends that 'Service managers in both adults' and children's services, across health, social care and education, should proactively identify and plan for young people in their locality with transition support needs' (p.7).

3.15 Forensic CAMHS services

Summary evidence statement 15

We received one practice example relating to a forensic CAMHS service.

The service had received positive feedback from practitioners who had accessed the team. No data were provided at this stage relating to the impact on outcomes for young people, or young people's experience of the service.

Description of practice

We received one practice example relating to a forensic CAMHS service (Submission 38). This was not specifically for looked after children, but had a significant overlap with the looked-after population, particularly those in custodial settings.

Components of the services are as follows:

- Support for practitioners from all agencies who are already in contact with a young person
- Providing assessment and intervention as appropriate
- Strategic functions such as identifying and responding to gaps in service provision and providing training to the children's work force.

The team responds to professional or family concern about children or young people with complex, high risk presentations and where there may be mental health or neurodevelopmental difficulties, rather than access depending on clinical diagnosis. A graded model of access follows referral, described as a 'liaison' model in which advice, consultation and assessment/intervention are provided as appropriate.

The team has a regional rather than local catchment area and is able to support young people who have moved 'out of area'.

Description of evidence

Although the submission included a number of supporting documents, only one of these was an evaluation of the FCAMHS (formerly referred to as Child and Adolescent Forensic Mental Health Service (CAF)). This dated from 2005 (the service has been running since 2003) and was primarily a review of service activity, but also included feedback from practitioners (n=12). There was insufficient information for an appraisal of the quality of the evaluation.

Findings

Outcome data

The submission did not report outcome data

Views and experiences of children and young people

The submission did not report views and experiences of young people

Views and experiences of carers

The submission did not report views and experiences of carers

Views and experiences of practitioners

For the 2005 evaluation of the CAF team, questionnaires were circulated to local CAMHS and YOT teams, with 12 responses. Respondents highlighted the role the CAF team played in facilitating access to service provision, in providing strategic advice, in educating local clinicians, and in providing assessments of complex cases.

Relevant NICE guidance

No relevant NICE recommendations.

3.16 Boarding school places

Summary evidence statement 16

We received one practice example in which disadvantaged young people, including looked after children, are offered fully funded bursaries to attend state boarding schools.

Broadly, the evaluation has found that the initiative had positive impact on pupils' academic progress, aspirations, social skills and wellbeing. However, it was not reported what proportion of respondents were looked after children. We are therefore unable to draw any conclusions about the effectiveness of this intervention for looked after children.

Description of practice

We received one practice example (submission 3) in which disadvantaged young people, including looked after children, are offered fully funded bursaries to attend state boarding schools.

The organisation works with local partners including virtual schools to identify children who may benefit from a boarding school place. Boarding schools receive training and accreditation to ensure that they can meet the needs of the children and young people.

Description of evidence

The submission refers to an evaluation by the National Foundation for Educational Research. This included surveys with children and young people at baseline (starting school) and follow up (end of each academic year); telephone interviews with a sample of young people; analysis of attainment and progression data and qualitative data from staff in member schools.

Findings of evidence

Broadly, the evaluation has found that the initiative had positive impact on pupils' academic progress, aspirations, social skills and wellbeing. However, it was not reported what proportion of respondents were looked after children. We are therefore unable to draw any conclusions about the effectiveness of this intervention for looked after children.

Relevant NICE guidance

No relevant NICE guidance.

3.17 Building self-esteem and identity

Summary evidence statement 17

We received one practice example relating to an intervention building self-esteem and identity.

The evidence provided suggested that this had improved outcomes for young people and their carers in relation to outcomes such as independence. These data are based on internal monitoring data, rather than formal research with a comparator group and standardised measures, so should be interpreted with caution.

Description of practice

We received one practice example relating to an intervention to build self-esteem and identity (submission 54). This described a narrative-focused group intervention for looked after children which is adapted from the 'Therapeutic Story Groups Model'. It is described as a preventive intervention addressing learning needs, social skills and emotional difficulties through an achievement based activity. Groups are run over 10 to 12 sessions by two trained facilitators. The group use metaphors to create a shared story over these sessions and the end 'product' is a printed book for the young person to keep. The intervention is provided jointly by CAMHS and the local virtual school and is made available to looked after children and young people (school years 3-5) for whom other forms of treatment may not be accessible or who may not be known to CAMHS. The group can be used as a diagnostic 'tool' to identify young people who may need further support.

Description of evidence

Submission 54 includes feedback from children and young people suggesting that the sessions were enjoyable. The submission also includes a selection of outcomes data showing improvements using, for example, Goal Based Outcomes. However, only limited details are provided regarding how these data were collected.

Findings of evidence

Outcome data

The summary of evidence provided in the submission form suggests that children have benefitted in a number of ways:

- Mean progress of 31% using goal-based outcomes set with carers of 3 children in the first year of the project (2014), including reduced anxiety, growing maturity and ability to share attention, greater capacity to express emotions and improved handwriting and comprehension.
- Mean improvement of 16% for scores relating to goals set by children before the second group (2015), around friendships, school work, teacher relations

and feelings about self. Children reported gains in areas like learning, confidence, feeling calm and getting on with others.

- Between 10 and 49% increase on resilience scores for 6 children from the most recent two groups (2016) for whom before and after questionnaires were completed and returned by teachers.

Views and experiences of children and young people

The submission did not report additional views and experiences of young people

Views and experiences of carers

The submission did not report additional views and experiences of carers

Views and experiences of practitioners

The submission did not report views and experiences of practitioners

Audit

No audit data were reported.

Relevant NICE guidance

The NICE guidance on looked-after children and young people (PH28) recommends that children and young people be supported to explore personal identity through ongoing life-story activities.

3.18 Raising awareness – Children in Care Council

Summary evidence statement 18

We received one practice example regarding the work of a children in care council.

At the time of the submission, the innovation was still in development, with the launch of the film and worksheet in March 2017 and the collation of feedback from young people and partner agencies from March-May 2017.

Description of practice

Having identified the need for improved mental health support for looked after children, Council members have worked with colleagues from a national charity and a local university to create a short animation and worksheet aimed at increasing awareness among health, social care and education professionals of looked after children's mental health, and their experiences and feelings (Submission 58). As well as informing their own understanding, the young people want to increase others' understanding of the needs of looked after children, encouraging professionals to think about how they currently support the mental health needs of children and young people, and how they could improve.

Description of evidence

At the time of the submission, the innovation was still in development, with the launch of the film and worksheet in March 2017 and the collation of feedback from young people and partner agencies from March-May 2017.

Findings of evidence

Outcome data

Views and experiences of children and young people

The submission did not report views and experiences of children and young people were reported

Views and experiences of carers

The submission did not report views and experiences of carers were reported

Views and experiences of practitioners

The submission did not report views and experiences of practitioners were reported

Audit

No audit data were reported

Relevant NICE guidelines

NICE guidance on looked after children recommends that the views of children and young people should inform service development, via structures such as children in care councils (p. 19).

3.19 Policy and other submissions

The following 14 submissions were based on the experience and practice of national bodies, parents and carers and researchers, but did not refer to specific practice examples and their underpinning evidence.

Policy submissions from national bodies

The **Association of Directors of Children's Services' (ADCS)** submission (submission 20) expressed concern about the difficulties that children and young people have in accessing mental health services, and the additional impact of this on children in care or leaving care, who often have higher levels of need for support. ADCS members pointed to the ways in which the criteria for accessing CAMHS services – having a diagnosed mental illness and being in a stable placement – made it difficult for children and young people in care and leaving care to receive support, particularly early support. The submission made a number of recommendations, including using new technology and a greater offer in schools, and upskilling foster carers and carers in residential homes to support children and young people who are experiencing mental ill health.

Public Health England's National Health and Justice Team note in their submission, based on a review of published research, that over 50% of children in young offender institutions are, or have been, looked after. This requires a response in terms of preventative measures and addressing the health needs, including mental health needs, of looked after children who are in or leaving custody. Stable placements, for example, can mitigate the instability that is linked to an increased risk of offending and the undermining of a child's wellbeing and feelings of self-worth. It is also suggested that multi-agency working and support from social services is required where a child does become involved with the criminal justice system, so that their situation is understood and they are treated fairly.

The submission from the **National Association of Virtual School Heads** (submission 76) reported the following activities of, and learning from, the Association:

- Promotion of the use of SDQ in schools
- Use of pupil premium plus to provide additional emotional support to looked after children
- The initiative to make schools attachment aware and trauma informed – early findings from Bath Spa University on a small cohort sample have demonstrated improvements in attendance, behaviour and educational progress.
- Development of a database to integrate care and education data for looked after children (NEXUS) database.

A submission from **Barnardo's** (submission 26) reports on the set-up and development of the Local Government Association (LGA) National FGM Centre. The centre is funded by the Department for Education and aims to address the physical and mental consequences of FGM (female genital mutilation). Staff are embedded in participating local authorities but are employed and managed by the centre. A key focus of the work is prevention and the centre has developed a risk assessment tool to identify girls at imminent risk. Practitioners are also able to provide a twelve session intervention programme that empowers young people to identify risk and protect themselves.

The submission from **NSPCC** (submission 41) highlighted the organisation's view that there should be parity between mental and physical health in local authorities' work as corporate parents. It is also highlighted their view that mental health assessment should form part of the assessments conducted when a child or young person enters care.

A submission from **CoramBAAF** (submission 57) highlighted the permanent family placement as a model of care for children who are in need or at risk of significant harm. In particular, this submission emphasised the role that a stable and loving family environment can play in helping children to recover from early trauma. The submission also highlights longitudinal research suggesting that adoptive placements can support recovery from early adversity.

United Kingdom Council for Psychotherapy's submission (submission 15) identifies the use of psychotherapies and psychotherapeutic approaches 'outside the consulting room' as a key means of supporting the emotional wellbeing and mental health of young people. They report ongoing work to align these approaches to the trauma-specific needs of young people in care. They recommend a systemic approach in which practitioners receive training and supervision in psychodynamic thinking in order to provide support in an 'orchestrated psychodynamic environment'.

Submissions from parents and parent representatives

A submission on behalf of **Adoption UK, POTATO and adoptive families** consulted via social media (submission 81) made the following statement:

'We would like child and adolescent mental health services and any changes being considered to services to take full cognisance of the following core principles:

1. The role of parents and family relationships is valued, respected, supported and promoted in the healing of adopted children who have experienced trauma, early adversity and loss.
2. All mental health professionals who work with adoptive families must be trained in the impacts upon children and young people of early adversity, trauma and loss and in the ways these are manifested in real life situations within and outside the family home.'

A submission from a parent of a young person diagnosed with an Autism Spectrum Disorder (submission 77) describes in detail the circumstances in which their son was taken into care as a result of a mental health crisis (under section 20 of the Children's Act 1989) and the difficulties which they and their son faced in gaining support. They note that the complexities of their son's problems made provision of support especially difficult. They recommend that support for young people in care with complex needs should be holistic and strengths-based, and include input from a range of disciplines. They also note that partnership working with parents can be difficult for professionals (who may automatically assume that a young person's difficulties are a result of neglect or poor parenting), and they suggest that meaningful work with parents should be promoted wherever possible.

Research submissions

A submission from the Care Leavers Association (submission 34) highlighted a piece of research being undertaken exploring the health of care leavers. This highlights the health issues that care leavers experience, particularly in relation to mental health, and some of the challenges in accessing appropriate support.

The submission from **Grandparents Plus** (submission 73), a national charity championing the role of the wider family in children's lives, is based on recent research exploring the experiences of young adults who have grown up in kinship care, and

their carers. The findings show that people who have grown up in kinship care have similar experiences to looked after children, including impact on their mental health. They also suggests that while young people in kinship care tend to do better than those in foster care, they still do less well than the general population, for example, they are more likely to have dropped out of college or sixth form, and this is often due to emotional difficulties. Better support is required for children in kinship care and their carers, as well as a range of prevention strategies such as better awareness within schools, education and health services about kinship care and the experiences of children in kinship care.

A submission from **Halliwell** (submission 59) highlighted the importance of the physical environment in children's residential homes, particularly in the light of potential hypersensitivity to environmental stimuli. It reports the findings of a survey in three children's homes aimed at assessing the suitability of the physical environment from a sensory perspective. Initial responses suggested that the homes found this exercise useful.

A research organisation (submission 80) submitted fieldwork completed for a CCG examining the mental health needs of adopted children and young people for whom the CCG is responsible. The fieldwork included feedback from experts by experience (including parents and carers) and was submitted as an example of evidence gathering and information sharing.

Other submissions

Submission 78 from **Wirral Council's** Children's, Young People and Families team included a summary of their most recent Children in Care and Care Leavers' Conference, and provided links to Joint Strategic Needs Assessment documents. The Children in Care and Care Leavers' Conference included discussions regarding the support that a 'good' service should provide as well as an exploration of the impact that moving placement can have on wellbeing. The submission also linked to a survey on the mental health needs of young people in Wirral and the availability and responsiveness of local services.

A Nurse Consultant for Looked After Children and Care Leavers (submission 79) provided a number of documents summarising the stories of young people, their views on being in care, and their thoughts on the support they received. The submission also referenced ongoing research examining the experiences of young people who had received support from a looked after children's nurse.

Appendix 1. List of contributors

ADCS

Adoption UK

ATTACH (Oxfordshire County Council)

Bangor University

Barnardo's

Barnardo's and LGA National FGM Centre

Blackpool Teaching Hospitals

Bryn Melyn Care

Central Manchester University Hospitals NHS Foundation Trust

Carelink CAMHS, South London & Maudsley NHS Trust

Central Manchester University Hospitals NHS Foundation Trust

Centre for Youth and Criminal Justice

Chrysalis Associates

CoramBAAF

Core Assets Children's Services

Cove Care Residential

Dudley & Walsall Mental Health Partnership Trust

Eastern and South Cheshire CCG

Family Futures

Family Rights Group

Five Rivers Child Care

Focus Fostering

Fostering Network

Grandparents Plus

Hackney Council

Halliwell Social Enterprise

Hillingdon CAMHS

Islington CAMHS

Kim S Golding Ltd

Lancashire Care NHS Trust

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North Yorkshire County Council
Northamptonshire County Council
Northumberland County Council
Nottinghamshire County Council
Nottinghamshire NHS Trust
NSPCC
Oxford Health NHS Foundation Trust
Public Health England National Health and Justice Team
Roberts Centre
Rotherham Doncaster and South Humber NHS Trust (RDASH)
Sandcastle Care
Salford City Council/NHS

Shared Lives Plus

South London & Maudesley NHS Trust

St Christopher's

St Christopher's (in partnership with Department of Health and Social Care Isle of Man)

Sussex Partnership Foundation Trust

Tavistock & Portman NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

The Child Psychology Service

The Institute of Integrated Systemic Therapy - Childhood First

The SpringBoard Bursary Foundation

Therapeutic Social Work Team

United Kingdom Council for Psychotherapy

University of Manchester

West London Mental Health NHS Trust and Ealing Local Authority

Wirral Council

Appendix 2. List of abbreviations

CAMHS	Child & adolescent mental health services
CEQ	Carer Efficacy Questionnaire
CHI-ESQ	Commission for Health Improvement Experience of Service Questionnaire
CORS	Child Outcomes Rating Scale
CPRS	Child Parent Relationship Scale
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
CYP	Children and young people
DAWBA	Development and Well Being Assessment
DBT	Dialectical Behavioural Therapy
DDP	Dyadic Developmental Psychotherapy
ECBI	Eyberg Child Behaviour Inventory
ESQ	Experience of Service Questionnaire
FGM	Female genital mutilation
FPM	Family Partnership Model
GBO	Goal Based Outcomes
KPI	Key Performance Indicator
LAC	Looked after children
LGA	Local Government Association
MFM	Mockingbird Family Model
NPP	Neurophysiological psychiatry
ORS	Outcomes Rating Scale
PICCOLO	Parenting Interactions with Children: Checklist of Observations Linked to Outcomes
PRFQ	Parental Reflective Functioning Questionnaire
PSI	Parenting Stress Index
PSOC	Parenting Sense Of Competence
QUARQ	Quality of Attachment Relationship Questionnaire
SDQ	Strengths and Difficulties Questionnaire
SGO	Special Guardianship Order
TASAR	Teenage Attitudes to Sex and Relationships
TAYC	Thinking About Your Child Questionnaire
TSCC	Trauma Symptom Checklist for Children
WEMWBS	Warwick-Edinburgh Mental Well-being Scale

