

*The Emotional Well-Being of Looked
After Children and Adolescents*

NEEDS ASSESSMENT REPORT:

**Commissioned on behalf of
Haringey Social Services**

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Emotional Well-Being of Looked After Children and Adolescents

PROLOGUE:

Tasks of the Report:

- *To identify and consider what needs to be provided for Looked After Children and Adolescents (LACA) to ensure their emotional Well-Being.*
- *To provide a starting point for dialogue and exchange between all those involved in the care of children and adolescents who are Looked-After.*

Who is the Report For?

- *All those involved in the care of Looked After Children and Adolescents*
- *and who are concerned to ensure that emotional well-being is at the forefront when planning services, day-to-day care and interventions in relation to Looked After Children and Adolescents*

INTRODUCTION:

The purpose and design of this Report

The commissioning of this Needs Assessment Report came about following discussions between the Service Manager, Marion Wheeler, authorised by David Derbyshire, Deputy Director of Children's services, and some of the team from the Tavistock Clinic who had been involved in a very small project offering on-going psychotherapy to interested Looked After adolescents in Haringey. Not many Looked After young people are attracted to this option, as at this point in their lives there is often too much disruption, and they cannot see the point of it. We became aware, however, during the course of this project, of a huge unmet need in relation to mental health / emotional well-being in the looked-after population. We thought we could go some way towards meeting this need by providing a different type of service. However, we were approaching it from the perspective of a specialist mental health team. We were conscious that there were other perspectives, and planning a service would need to take into account viewpoints different to our own.

Meanwhile, Haringey commissioning plans included a similar wish to develop a different type of service, which would be responsive to the needs of those who were Looked After. We agreed to work together, and the Haringey – Tavistock LACA-CAMHS team was developed, initially commissioned for one year (2003-2004), and then re-commissioned for a further three years (2004-2007). The brief included provision of a service, but also undertaking a needs assessment exercise. This Report is the result of that exercise. Our brief was to undertake a needs assessment specifically in relation to emotional well-being in children and young people who are Looked After. There are many other aspects to a Looked After service; these are beyond the scope of the Report. We would like to acknowledge the creativity of the commissioners, particularly Marion Wheeler and David Derbyshire, in requesting and supporting a needs assessment exercise that would cover not only the facts and figures but also seek out the opinions of people involved in all the layers of the service, to be integrated into the final picture of what is needed.

Throughout, we have worked with and reported to a Steering Group, consisting of Marion Wheeler in role, together with the lead workers in relevant Social Services Departments, Alison Botham, Clive Preece, Rachel Oakley, and the Service manager for Haringey CAMHS at St Ann's, Shaun Collins.

We approached the project from a number of different perspectives, trying to incorporate views from across the service, including the service users, the young people themselves; the various teams involved in working with Looked After children and adolescents; our own perspective as a mental health service provider; the foster carers; and previous research into this area.

Terminology:

Before proceeding, we'd like to say a word about the terms used to describe the services: nationally and locally people refer to LAC, i.e. Looked After Children. However, as the statistics later will indicate, many of those who are Looked After are adolescents. It is our

experience in work in mental health that often the needs of adolescents, particularly the older adolescents, are given less priority than the needs of younger children. We think it is important to keep the distinctive needs of adolescents firmly in mind, and so we have adopted the acronym LACA, standing for Looked After Children and Adolescents. Where we refer to other reports and to services other than our own, we retain the usual term of LAC, as this is the term they have used.

The User Perspective:

Firstly we wanted to hear what the main “users” of the service thought about it, and what was needed. It is not however easy to just elicit views from young people, particularly those who have had such a history of disruption and who may be suspicious of our motives. We thought it would be easier for them to talk to people who were not involved with any part of the services, who could be seen as neutral. We also wanted to ensure that what they had to say was the cornerstone of the needs assessment, and wanted to enable them to make a powerful intervention into the system of which they were a part.

We made links with staff and students working on documentary making at London Metropolitan University (Sir John Cass Department of Art and Design and the Department of Applied Social Sciences). We obtained all the appropriate consents to go ahead and make a video about the experience of being in care with a Local Authority. During a series of social encounters which we arranged, students from the University got to know the volunteers who had agreed to participate in the project. The video was made with 7 young people from the Leaving Care Service. Many hours of footage were shot, and this was edited by the students into themes. The final product was twenty minutes long, and was a moving description of the experiences of these young people, who had each spent many years being looked after in residential and foster homes.¹

The video has been shown to a variety of people working in this field in different screenings, including a conference (see below). We believe it helps emphasise the importance of taking into consideration the emotional aspects of being in care, and those who have seen it have commented on how much they have learned from it. As we believe that the voice of the young people themselves should be heard clearly when planning services, we have transcribed their words, and include them in full as the first chapter of this Report: Care Stories: the Voice of the Young People.

Putting it all into Context:

No needs assessment can ignore the context in which a service survives or thrives. Chapter Two, Fact and Figures: the Voice of the Researcher, pulls together significant amounts of data, both about the service in Haringey and across Britain. We start with attempting to define what is meant by mental health, and then look at what might be the specific mental health needs of the populations of young people who are looked after, unaccompanied minors and refugees, based on research data. Taking the demographic profile of Haringey’s population into account, we try to estimate the resource requirements of a mental health service for Haringey and then compare this to the service we provided in the first year of the new Tavistock-Haringey LACA-CAMHS team.

¹ Video footage was also shot of foster carers’ experiences. This material was not edited in time for the Conference and was not included in the original video available; a later version does include this material. However it was not on hand when this Report was being prepared.

What do those who work with LACA in Haringey think about the service provided?

Chapter Three, Focus Groups: the Voice of the Local Stakeholders, relates a very important piece of work that was undertaken as part of this exercise. We wanted to hear from those intimately involved in the work at all levels of the service. What was their experience of working with this population, and within this service? We tried to arrange a Focus Group for each team involved, conducted by independent consultants who have nothing to do with the service. In all, nineteen focus groups² were held representing disparate teams within the service, from the Adoption team to the Youth Offending Team Managers. Once again it was important to us to include those who were Looked After themselves in this exercise, and the children in one of the residential homes had a Focus Group of their own. Similarly there was a Focus Group for Foster Carers so that the views of this group, hugely important to this work, could be represented. Participants were asked about their experiences, and asked in the context of needs assessment to identify key needs for children and adolescents in care. As a focal point, key stages of care were identified around which needs could be discussed. There was space for general and specific discussion with the neutral consultants who were both professionals without connections to either social services or health.

Summarising the information obtained in nineteen focus groups is no easy task, and the participants had plenty to say. The chapter tries to group the results under key needs which were identified. Direct quotes from participants are used where possible, and links are made to similar ideas quoted by the young people in the video, to underline the similarity of positions from givers and receivers of the service.

This chapter concludes with some personal views from the consultant (Gabriella Braun) who conducted eighteen of the nineteen Focus Groups. She was in a unique position to obtain an overview of the services, and she has given us her reactions to her findings in a candid and sincere account.

Interprofessional and Interagency communication and cooperation:

Very early on in our work we became aware of the numbers of professionals and agencies involved. We made links with relevant groups, both as part of the on-going work around particular clients referred to us, but also to engage in general discussions about the work we were all involved in. One of these interagency groups still continues, where the LACA-CAMHS team meets bi-monthly with LAC Health and LAC Education. Discussions about a shared assessment framework contributed to the formation of a new interagency group which also now meets regularly with development of shared assessment as one of its primary tasks.

However, we became aware that many of the groups do not necessarily meet up, and that there were many misconceptions about each others' contributions and focus. Accordingly, we organised a Conference, with the title: the Emotional Well-Being of Looked After Children and Adolescents. Participants from every part of the service were invited. We saw the Conference as an opportunity for people all across the Borough to meet up and hear about or tell about the contributions made by the different teams. It was also an opportunity to show the video of the young people to a large audience. The Report on the Conference is the focus of Chapter Four.

² Within the timeframe, unfortunately it was not possible to make the arrangements for a Focus Group for every team we had wanted to include, and a few were left out. However we are reasonably sure that we have covered a sufficiently wide range of services to gain a good overview of how the service is seen, and what people would like to see in a service focusing on the mental health needs of LACA in Haringey.

The dedicated mental health intervention

While providing a CAMHS service, we tried to keep in mind how this fitted into the service as a whole for LACA. We saw it as another way of undertaking a needs assessment, by examining and reviewing the impact of providing mental health resources, and noting the responses to this as we went along. We tried to provide a range of interventions, in a service that tried to be responsive to referrers' needs as well as the needs of carers and LACA. What we did is described in Chapter 5: Working with Emotional Well-Being in Mind: the Voice of the Tavistock / Haringey LACA-CAMHS team. Examples of our work in response to different types of referrals are given, to give the reader a flavour of our clinical interventions and our reaction to the work.

Recommendations:

Finally, in Chapter 6, we offer some recommendations, coming out of the variety of needs assessment activities reported in the preceding chapters. We, inevitably perhaps, found this the hardest chapter to write. Along the way, we have had all sorts of "weird and wonderful" ideas about how a service might incorporate emotional well-being of its clients into its structures and thinking. The reality of course is that if it were that easy, it would have been done long ago. We are aware of the particular difficulties for large organisations that have statutory responsibilities. We know that resources are limited, and there is great competition for what is available. And we know about "restructuring fatigue" that besets Public Sector organisations these days.

We have tried therefore to offer ideas that have a realistic expectation of achievement, that incorporate thinking from many sectors, and that we hope will seem sensitive to the ideas we have heard as we went along.

We hope our suggestions will be helpful, and that they might be incorporated into an organic development of the overall service that is already underway.

Our recommendations about a potential mental health service for LACA are more specific, as this is a newly developing service. In relation to other areas of the service we offer ideas about what we think might be helpfully included in strategy discussions and policy fora, where those intimately involved in the developments of the future have a voice. We will be happy to discuss any of these ideas and recommendations further in any appropriate contexts.

The Report concludes with two appendices: our acknowledgements of those who helped, and a Reference list.

Confidentiality

It was important to us to respect confidentiality throughout. However the young people in the video have given permission for their first names to be used and so we have attributed their own comments to them.

Where we have used examples from clinical work, we have given fictitious names and changed details, in order to protect identities.

In the reports from the focus groups and also from the conference, we have not named any individuals or attributed any quotes to particular people. Where it seemed necessary we attributed quotes to particular groups, but generally left them unattributed. We have tried to quote exact words, as clearly as they were remembered when writing up notes after the sessions, but inevitably there will be some inaccuracy in this. However we have tried to convey the spirit of what was said as clearly as possible.

CHAPTER 1: CARE STORIES:

The voice of the young people

At least sit down and listen them and try to work them out, they want it, you know, those kids in care do want to be heard. (Mehmet).

Listening to children

Please ... when you're working with a young adult or a young kid, please first of all sit down and listen them, please try to understand them, then even if they are in a way wrong or right, judge them with them, not just judge on their behalf and ... please try to like them, because if you don't like them and if you don't like what you're doing and you're only doing it for the pay check at the end of the month, please just don't do it. (Mehmet).

If Haringey just listened to people and actually made the people feel like they were going to do something about what these people are telling them, not just listen and go away and do nothing and think 'oh, this is just another problem child'. (Catherine).

What workers do affects that child, it's going to affect that child for ... the rest of his or her life. So they should take the time to think the decisions they make through. (Richard).

Entering care

I never really got to know my mum or dad. I don't even know my Mum's name. In a way, she's more like an un-existent person who just gave birth to me. (Suad)

I lived with my mum and we never got on and so I lived with my dad, we never got on, so the only option he had was to put me with foster people. (Linda).

I was in secondary school at the time, so I come back from my PSE lesson and ...they did all like the violence in the home and ... something clicked in my brain and said to me 'I shouldn't be going through what they do at home. I'm supposed to be reporting this'. So I went to a police station and I didn't want to go back home, so I didn't go back home. (Carol).

Basically, that was around the time my Mum died and it was me and my younger brother and it wasn't a very happy time. But we got put into care because, you know, there was a whole lot of problems with the person that we were staying with, so basically, yeah, we both got put into care. (Catherine).

My mum told me that the reason that she had to put me in care was because my dad was sort of hitting her and, 'cos I was so young, she was worried that he was going to start ... mistreating me as well. So then she put me in care. (Richard).

And at that time I was still 12, I was just near enough to my thirteenth birthday party and that's when I went into hospital and everything came out and ... Social Services really got involved and I met my foster mum on the 6th March 1998. (Edna).

How do I say it, I had to leave home. I had to break away from the people I love and the people I hate. Basically, it was quite tough in the first place moving to live with strangers. (Mehmet).

Living with strangers

I didn't know this woman, I felt very uncomfortable, I mean she was really nice and all that, but because ... I didn't know her and she wasn't my family, I didn't feel right, I didn't want to take off my jacket when I was in the house, I slept in my jacket, I woke up in my jacket, I wouldn't even want to use her bathroom or nothing like that, but after a while, I got used to her still, so. (Linda)

My first foster carer system was in Finsbury Park. I remember that one because that one I did not understand at all ... I was about 10 years old and I moved into her house and the lady was very nice, but she had an older daughter and at that time she was attending college or whatever it was and she was nice to me, but she was ... like a person who would say to you: 'Here's your bedroom, here's your knife, here's your fork, here's your spoon and here's your plate and here's your bowl and here's your cup'. She would name everything after you and she would tell you: 'Right and you're not allowed to touch this and you're not allowed to touch that and you're not allowed to touch this'. That's the kind of rules she gave me, instead of saying: 'Hullo, hi, how are you doing'. It wasn't that kind of conversation. It was more like a bed and breakfast. It was really strange to me, 'cos I'm only 10 years old and I'm meant to have someone who's acting more like a parent to me, more than acting like a hostess. (Suad).

Christmas time I believe is the hardest for children in care, because everyone wants their family. OK, you're with people and you're going to get presents, but at the back of every child's mind – they might be like, yeah, I'm happy, I'm happy – they're not happy, 'cos Christmas is supposed to be a time with their family and ... underneath the truth is somebody was trying to play like your parent or somebody is trying to go all out to try and make you happy rather than just ... being relaxed or just being themselves. But its just the fact that somebody is going around fussing over you because you see that they're trying to make you happy, but why are they trying to make you happy, it's because you're not really a part of them. (Edna).

Being fostered

I don't think looking after a child for money is the best thing either, so my ideal foster carer would be a person who doesn't care about money, who cares about you and puts you the first. Because that's what ... children in care are missing is somebody putting them first. (Suad).

You have to have the love, you can't be selfish if you want to become ... a foster carer ... you have to love and care for children. You have to know it's not about the money ... it's all about love and you're just trying to help the person. It's not just about the money, so that's all I can say'. (Linda)

It can't just be like plonk them in between, in the middle of a family and hope everything's going to be alright. I was moved round from different families and it was always the same. But then they moved me to this family who I still keep in contact with now, so they treated me like I wasn't a foster child. They treated me like I was actually part of their family and I think that's the way it's got to be. Because, then you stop thinking, 'I'm just a foster child and you don't really care about me' and you start to think, 'well you do care about me and, if you're saying stop being bad, its for reasons, 'cos you care about me, not because you're going to get in trouble with my social worker'. (Richard)

She was a good thing, because she took the time to sit down, reading me. When I was going to school, she was the first one to actually ask me about my homework, if I'd got anything and if I needed help ... she would sit on the table and actually help me with everything and then afterwards she would say 'right then, go to bed or something' ... She was the first one to put those kind of, and I followed it for like about a year and a half and then she said that she couldn't take care of me anymore because she wanted to take care of kids that are disabled or less able to be cared for, ... and she was having a whole career change and I had to deal with that and it was like I had to move from somewhere that was perfectly nice and nothing wrong with it at all to, back to the same children's home again. (Suad).

She did do a lot, I lived with her for about 2 years and once I got to her it was, 'Edna you're a child and you're going to learn to do things that children do'. I mean, she pushed me and she pushed me and she just changed a lot of things about me. She taught me how to speak more about my feelings. She taught me how to relax, even though she didn't quite accomplish everything that she wanted to do with me, and that's because she couldn't really break me out of what I was used to and the environment I was used to and I'd grown up in. I had my own room and I had everything and she always used to give me stuff and I loved her and I still do, because it was like she showed me so much different things, but at the back of my mind it was like 'why can't my mum do this'. (Edna)

Placement and culture

I lived with a white family in Surrey, no not Surrey, yeah Hertfordshire, so there wasn't that many black people around and so I got confused about what I was and I think that if I'd lived with a black family as well as a white one, it would have balanced the culturating out, I guess. (Richard).

I was always paired with the ... same background, with black people from Trinidad. I didn't like it, because I felt that, at the time I probably thought why they placed me with Trinidadians, just because I'm Trinidadian doesn't mean you need to place me back with a Trinidadian family, because any person who is suitable to look after a child, I'm quite happy with. (Carol)

Placement disruptions/ moves

You can't keep track of how many people you meet and you can't keep track of how many parents or trying to act like parents to you or how many people that social services has given to you. (Suad)

I think 13 foster carers and 2 children's homes. (Suad)

Walthamstow, my aunt's house, Hackney for a night, Crouch End, Muswell Hill again, about 5. Oh yeah, Mitcham and Bedford. (Carol)

Well, everything, all the children's houses and all I've been through, I must have been going around with loads, like I can say about 15 'till 20 of different places for different stretch of times. I've been, kind of, pushed around a bit. (Mehmet).

The hardest one was, I was living in a children's home for 3 years and they gave me a half an hour notice to go out of the house, to come and pack my clothes – 'you're moving in half an hour notice'. That was the hardest thing. (Suad).

Challenging behaviour

Until you get used to them, those nice people, you kinda make their life hell as well, whether you want to or not, because you can't trust them straight away, because your heart or ... your feelings been broken before and your trust has been lost and ... the first thing that ... you know when you're off from you family, ... that's the point when you break up, that's the point when you realise that you're all your self, that you won't get no one to love you, your family never loved you, that's why you're in care now, that's why, as I say, if you never received love from your family no one else will give it to you, you go with that brain. (Mehmet).

You've had so many houses that you've gone though and so many, I don't know, you lose the value of a place of your own, you lose that whole thing, ... and plus you lose your respect, your self respect in a way. When you keep moving from place to place you lose your self, and your self-respect as well goes along with it, and once you lose that, I think that's why most kids actually ended up in criminal stuff, because they lost themselves in that way. (Suad)

The fact that they hear that you're in care, to them kids in care are bad and some kids are in care because, I don't know how they've been brought up, but because they act bad, people see that every child in care is bad as well. (Linda).

Social workers

To tell you the truth, Social Services are my family. They are my family. I mean my social worker, Joy, before I actually became Leaving Care or independent life or independent, you might as well say, she was always like telling me 'I'm not going to be your social worker anymore, you're going to have to keep going to duty'. You could ask her now, I'm still pestering her and it's not the fact that I'm scared to go to somebody else, duty or whatever, but its just the fact that they're my family, I could call any one of them when I need help. I mean ... they're the ones that have taught me how to become a woman, how to live

independently and any complicated questions, questions that your parents are supposed to be answering, they answer it for me, so I don't know' (Edna).

I find the more you change the social worker, the harder it is for the young person, because the less they open up to them and the less the social worker's able to help them. Some social workers they're OK, but some, they'll tell you, ... 'we're going back to Australia or we're going back to Japan or Timbuktu. I mean, what's the point of telling someone if you know they're not going to stay there to help you through your problem'. (Carol).

Oh God, I've had about 6 social workers to tell you the truth. Yeah, I mean, my first social worker she's a social worker I can say, no matter what, ... she's there, I can always still get help from her, even though she's not my social worker. But apart from that, I've had various, 6 or so. (Edna)

And it's very hard for a new person to come in and then have to tell them all over again and then they don't do nothing, because they leave and then another one, so nothing ever got sorted out basically. So, it's very frustrating. (Catherine)

I don't feel there's any good social workers out there, they do their job with young people, their job is never completed, but they move on to a better paid and better job and their job with the young person is not completed and another person pick up their mess and it is never done properly. (Linda)

Other agencies/ staff

You can't keep track of how many people ... that social services has given to you or how many people that you see in your board meeting that you actually never even met in your whole entire life and you're there with 12 other people, all talking about the same subject and that's just you. (Suad)

When you leave the house and you're packing your clothes and you're packing your books and you're packing everything in your life, you're also packing an invisible package there as well, which is the piece of papers, that you can't see, because they're obviously floating around you and everybody else is reading about you and they know about you, they're doing courses about you ... You don't know what to say or what to do about it, 'cos if it was right in front of your face, then you ... could just say 'look here I don't think that's right', but they don't show it to you, they share that information amongst themselves. (Suad).

Leaving care

I do have ... loads of worries ... like even if I say I do feel strong enough to move on, I actually really don't. (Mehmet).

For myself, I do worry, because like I said to Haringey, I wasn't ready for this whole semi-independence thing, you need the support and I don't feel that I'm really getting that from Haringey, so I'd rather have been with the family ... because I was getting that when I was there and I'm still getting that with them anyway, so. (Catherine).

Therapy

I wanted to stop because the Tavistock was bringing out the wrong side of me. It was making me talk about everything that happened, but it just used to bring up too much and I just couldn't handle it because I would leave Tavistock crying, I would go home crying and it just used to bring up so much emotion, I just wanted to hide it. (Edna)

Doing the counselling, if you can do it with a proper person and ...you can work with your counsellor and you can get on with it, and you can build a friendship with it, I mean it does help you, it does get you forward. I would consider it to anyone to at least try counselling, at least try it once. At least you get the things out of your systems, at least you say what's in you, at least you can express it to someone. It does take a loads and loads of hard time to get used to that person though. (Mehmet).

Identity: loss of trust

Yeah, alright, you have to have this ... feeling where you say 'alright, I'm not going to have a relationship basis with you, I'm not going to let you in my life, so therefore you cannot do anything to me' ... That's how I've grown up, and still am, 'cos it's still with me, it's just, I can't trust someone, if I trust someone I feel as if 'this is going to happen and that's going to happen' and ... it just kind of ... messed up my whole basis of relationships with others, because I've moved so many times and had a relationship with so many people. (Suad).

The only person I consider is important to me now is only me, because my whole life I went through teaching that teach me the only person I can depend on is me. (Mehmet).

I don't know, its like, imagine living on planet earth ... and you've got different people that you have to live with, but you remember this is not your home, that's how I look at it, as if I live out in space or something and planet earth is not my home. I have to keep looking at it that way, because I think when I say its my home, my home will be somewhere where I put my footprint on it, where its actually my home, my home. (Suad).

The future

When I'm strong, I feel that I'm strong enough to go forward, I'm going to start running, I'm walking now, but basically I'm going to start running. (Mehmet).

I hope to do a PA course and with them 2 certificates, it's my ticket out of this country. It's just my way of leaving bad memories behind. (Edna).

I'd like to have completed my book and had it published and for it to be a success, so I can carry on writing and do another book. (Richard).

I hope to become either an MP or a social worker or a mentor. Only because I want to be a good social worker for these young people, because I don't feel there's any good social workers out there, they do their job with young people, their job is never completed, but they move on to a better paid and better job and their job with the young person is not completed and another person pick up their mess and it is never done properly, so I think that I'd be a good social worker and set a good example. Or become an MP, so I could speak up for black people. (Linda).

2.1 Definitions of Child and Adolescent Mental Health

'The identification of need in child and adolescent mental health services is hampered by different definitions of children's problems and the tendency to group children according to administrative or service categories rather than focusing on what the children, young people and their families need in order for stresses to be alleviated' (Tunnard 2000).

The definition of child and adolescent mental health difficulties is complex and contested – being subject to varying cultural perceptions and to the differing definitions of different social services and health professionals. Firstly, the concept of mental health or illness is influenced by psychological, social and cultural factors and has been differently defined at different times or within different cultures and communities (HAS 1995, James 2000). Secondly, different professionals use different definitions of mental health or emotional and behavioural difficulties. Where Health workers emphasise 'disorders' or problems, Education staff refer to 'educational and behavioural difficulties'. In contrast, social workers are often reluctant to apply the term 'mental health' to children and young people, as they perceive it as stigmatising (HAS 1995, James 2000).

'A shared understanding between different agencies may be reached by recognising the interplay of factors that influence children's mental health. These include social, family and individual child factors that determine a child's level of risk or resilience and the carer's ability to care for them appropriately' (James 2000 p6).

Emphasising the importance of shared definitions of need, the 1995 HAS review of child and adolescent mental health services, *Together We Stand*, outlines both positive and negative components of mental health (chapter 4). This report first identifies the following indicators of mental health in children and young people:

- A capacity to enter into and sustain mutually satisfying personal relationships
- Continuing progression of psychological development
- An ability to play and learn so that attainments are appropriate for age and intellectual level
- A developing moral sense of right and wrong
- The degree of psychological distress and maladaptive behaviour being within the normal limits for the child's age and context

Whilst acknowledged as 'something of an ideal state', these indicators provide the benchmark for identifying mental health difficulties. Mental health problems are thus defined as 'difficulties or disabilities in these areas which may arise from any number of congenital,

constitutional environmental, family or illness factors’ (p15). A continuum of mental health difficulties is identified. Firstly, the term ‘*mental health problems*’ is used to refer to ‘a very broad range of emotional or behavioural difficulties which may cause concern or distress’. These are perceived as ‘relatively common’ and as encompassing ‘*mental disorders*, which are more severe and/or persistent’ (p15). Finally, this report draws on Kurtz (1992) to identify the following diagnosable (ICD 10 or DSM4) mental health disorders in children and young people:

Table 1

A Classification of Mental Disorders	
• Emotional Disorders	eg. phobias, anxiety states and depression. These may be made manifest in physical symptoms such as chronic headache or abdominal pain.
• Conduct Disorders	eg. stealing, defiance, fire-setting, aggression and anti-social behaviour.
• Hyperkinetic Disorders	eg. disturbance of activity and attention, and hyperkinetic conduct disorder.
• Developmental Disorders	eg. delay in acquiring certain skills such as speech, social ability or bladder control. These may affect primarily one area of development or pervade a number of areas as in children with autism and those with pervasive developmental disorders.
• Eating Disorders	eg. pre-school eating problems, anorexia nervosa and bulimia nervosa.
• Habit Disorders	eg. tics, sleeping problems and soiling.
• Post Traumatic syndromes	eg. post traumatic stress disorder.
• Somatic Disorders	eg. chronic fatigue syndrome.
• Psychotic Disorders	eg. schizophrenia, manic depressive disorder or drug-induced psychoses.

2.2 The mental health needs of looked after children and young people

‘Adolescents in the care system showed particularly high levels of psychiatric disorder compared with adolescents living with their own families. Not only did they suffer from serious psychiatric disorders – notably, major depressive disorder; they also showed high levels of comorbidity ... One of the most worrying findings was that a significant number of adolescents were suffering from severe, potentially treatable, psychiatric disorders which had gone undetected’ (McCann et al 1996).

Since the 1990s, research reports have identified the high level of mental health problems³ amongst looked after children and young people, together with the relatively low level of provision to meet these needs.

Firstly, McCann et al (1996) uncovered high levels of mental health problems amongst young people (aged between 13 and 17 years) looked after by Oxfordshire local authority. They also identified the failure of recognition of, potentially severe, psychiatric disorders by staff and agencies involved.

³ Comorbidity refers to “the simultaneous appearance of two or more psychiatric or physical illnesses”.

*67% of adolescents in the care system had a psychiatric disorder – compared to 15% in a comparison group
28% had a conduct disorder; 26% were overanxious; 23% suffered from major depressive disorder (compared to 4% in the control group); 8% were diagnosed as having unspecified functional psychosis (including auditory hallucinations).*

96% in residential units had psychiatric disorders, compared to 57% of those in foster care.

The study by Dimigen et al (1999) revealed a similar pattern amongst 89 children (aged 5 to 12 years) at the point of entry into care. The most common disorders were conduct disorder and depression, with comorbidity being found in over a third of the children.

*13 (38%) boys and 12 (33%) girls had severe conduct disorder and a similar proportion suffered from severe depression.
21(30%) had severe attention difficulties; 18(26%) had autistic-like detachment; 15(21%) had elevated levels of acute problems and 11 (16%) had anxiety disorders.*

Elevated levels of depression were significantly more common among children in residential settings than those in foster care.

Like McCann, these authors identified a high level of unmet need amongst children in the care system:

‘The study shows that a considerable proportion of young children have a serious psychiatric disorder at the time they enter local authority care but are not being referred for psychological help’ (p675).

A study of social workers’ perceptions of the mental health needs of foster children confirmed these difficulties:

‘Eighty percent of children were considered by social workers to require treatment from a child mental health professional, but only 27% had received any input. The reasons given ... for not referring were placement instability, inadequate child mental health resources and insufficient local authority funding’ (Phillips 1997 p249).

Other small-scale studies have highlighted this convergence of high levels of mental health disorder, with inadequate diagnosis and treatment:

Of 32 looked after children referred to a Birmingham service, all but 3 had ICD-10 diagnoses – mostly mixed affective-conduct disorders – yet only 10 had had any previous psychological input (Butler & Vostanis 1998).

The authors conclude: ‘The current system had failed to provide stability and nurturing for these very needy children with emotional and behavioural difficulties’ (cited in Richardson & Lelliot 2003 p249).

The recently published ONS survey (Meltzer et al 2004) focused on the prevalence of mental health problems amongst looked after children and young people aged 5 to 17 years. Their sample of 2,500 looked after children provided a response rate of 1,039 – of whom 909 (88%) were white, 63 (6%) were black and 67 (6%) from other ethnic groups. Whilst there

appeared to be some differences in the prevalence of mental disorders by ethnicity, none of these proved statistically significant.

Overall, 45% were assessed as having a mental disorder:

- 37% had clinically significant conduct disorders
- 12% had emotional disorders (anxiety and depression)
- 7% were hyperactive
- 4% had pervasive developmental disorders, tics or eating disorders.

LAC were 4 to 5 times more likely to have a mental disorder than those living in private households.

42% of looked after 5 –10 year olds had a mental disorder compared to 8% in private households. 49% of looked after 11-15 year olds had a mental disorder compared to 11% in private households.

The incidence of mental disorder was greater amongst looked after boys than girls (49% compared with 39%).

Placement type proved significant:

- 68% of those in residential care had a mental disorder, compared with 51% of those living independently and 40% of those in foster care or with their own parents.
- 20% of children living with natural parents and 18% of those in residential care had emotional disorders – compared to 9% of those in foster care.
- 56% of children in residential care had conduct disorders compared to 33% of those in foster care and 28% of those living with natural parents.

Placement stability was also important:

- 49% of LACA in their current placement for less than a year had a mental disorder, compared to 31% of those in the same placement for at least 5 years.

This study again confirmed the high level of unmet need amongst LACA with clinically assessed disorders. Whilst most had accessed front-line services in the previous year (80% had been in contact with a social worker, 49% had seen a teacher and 20% had received advice or treatment from a GP), only 34% of those with clinically assessed disorders were in touch with a specialist in child mental health.

Finally, based on the HAS report, Wallace et al (1997) have estimated the percentage of the childcare population likely to require services at each tier of provision. Drawing on Meltzer's comparison between looked after children and those living in private households, the following table outlines the projected level of need for different services within the LACA population:

Table 2: Tiers of Service

Tiers/ Providers	Estimated levels of need:	
	Total childcare population	LACA population
Tier 1: Mild emotional and behavioural difficulties or the early stages of disorders. <i>Primary care services</i>	15%	67.5%
Tier 2: Common disorders with one or two risk factors. <i>Individual specialist/ uni-professional care</i>	7%	31.5%
Tier 3: Less common problems indicating a more severe, complex or persistent condition. <i>Multi-disciplinary teams in a community child mental health clinic or child psychiatry outpatient service</i>	1.85%	8.33%
Tier 4: Potentially severe disorders. Intensive and highly specialised care usually provided for older children and adolescents who are severely mentally ill or a suicidal risk. <i>Tertiary services such as day centres, highly specialised outpatient teams and in-patient units</i>	0.075%	0.34%

To conclude, whilst there is considerable variation between the epidemiological rates suggested by different studies, there is broad agreement both about the high levels of mental health needs amongst LACA and about the lack of adequate provision to meet these needs. Table 3 provides an overview of the key findings from the research literature, with the following summarising the key issues:

- Between 45% and 67% of looked after children and adolescents have mental health problems of clinical significance
- This increases for those in residential care (to between 68% and 96%)
- Stability of placement is significant: 49% of those in placement for less than 1 year have a mental disorder, as compared to 31% of those in the same placement for more than 5 years.

Table 3

Prevalence of specific mental health disorders amongst looked after children and adolescents			
	McCann et al 13-17 yrs	Dimigen et al 5-12 yrs	Meltzer et al 5-17 yrs
Anxiety	26%	11%	12%
Depression	23%	37%	
Conduct Disorders	28%	37%	37%
Hyperkinetic Disorders		30%	7%
Developmental Disorders			4%
Eating Disorders			
Habit Disorders			
Post Traumatic syndromes		26%	
Somatic Disorders			
Psychotic Disorders	8%		

2.3 The mental health needs of unaccompanied minors and refugee children

'The most distinctive health problems for refugees are psychological and may be linked to either trauma or isolation from friends, family and community whilst in the UK. There are broadly two types of problems – most common are problems of adjustment, whilst a smaller proportion ... may experience persistent post traumatic mental health problems' (Aldous et al 1999 p27).

Literature on the mental health needs of refugees and unaccompanied minors emphasises the relatively high levels of need – given, not only the history of trauma, loss and separation, followed by 'sometimes hazardous and prolonged journeys in pursuit of safety' but also the privation and hardship of life within resettlement countries (Hodes 2002 p367).

However, researching the health (and mental health) needs of refugees raises methodological difficulties: 'In considering the mental health needs of young refugees in the UK it is important to bear in mind that there is no population-based information available and only extremely limited data resulting from contact with mental health services' (Hodes 2002 p367). User involvement is also problematic and Murphy et al (2002) note the lack of 'evidence of consultation with refugees themselves about their mental health needs' (p223). These difficulties are further compounded by the relationship of the refugee to their host country:

'For refugees and asylum seekers, suspicion is a survival skill. Therefore, refugees may distrust a researcher or, for that matter, any official' (Aldous et al 1999 p28).

Despite such difficulties, several small-scale studies provide some indicator of need. Referring to refugees as a whole, Murphy et al note a wide variation in rates of disorders, according to the focus of study: 'The prevalence of PTSD is lowest in epidemiological samples (3-12%) and may rise to 90% in psychiatric clinic populations' (p222). Summarising several studies, Aldous et al report: 'There are high levels of mental health problems reported amongst groups of refugees and asylum seekers. Where PTSD criteria are used ... prevalence figures suggest that conditions exist in 25 to 50% of cases in the sample under study. However, it is not clear how these samples relate to the wider population of refugees and asylum seekers' (p44).

Focussing on refugee children, Hodes (2002 p368)) cites a Swedish study of 50 young Iranian children, most of whom had been 'exposed to bombardment from missiles or seen assaults on parents'. Twelve months after arrival in Sweden, only 26% had 'good psychological adjustment'. Thirty months later, 38% had 'good psychological adjustment', 18% had severe post-traumatic stress symptoms and a further 18% reached the criteria for PTSD. The prevalence of PTSD did not diminish over time.

*A Canadian study found that, even amongst refugee children not exposed to war, rates of mental disorder were significantly higher than amongst their peers:
In a group of 200 adolescents from 35 countries, the rate of psychiatric disorder among the refugee children was 21%, compared to 11% in a comparison group (cited in Hodes 2002 p368).*

To summarise, despite considerable variation, these studies underline the high level of unmet need amongst refugees and asylum seekers (including unaccompanied minors) – with

difficulties in accessing mental health resources being compounded by cultural variations in perceptions of mental illness and associated feelings of ‘shame and stigma’ (Murphy et al 2002 p223).

2.4 Demographic profile of Haringey’s looked after population

This section details the demographic profile of Haringey’s looked after children – as the basis for subsequent projections of mental health need.⁴

Total numbers of looked after children:

- At 31.04.03, Haringey had 526 looked after children
- By 31.03.04, this number had slightly reduced to 510

Age profile: The majority of Haringey LAC are 11 years or older. However, as detailed in table 4, at 31.03.04 there were significantly more LAC aged 16 years and over than in the previous year.

Table 4

<i>Age profile of Haringey LAC</i>				
	At 31.04.03		At 31.03.04	
	Numbers	Percentage	Numbers	Percentage
0-5 years	95	18%	83	16%
6-10 years	92	17%	91	18%
11-15 years	288	56%	197	38%
16+ years	51	10%	139	27%
Totals	526		510	

Gender: At 31.03.03, there were approximately equal numbers of males and females in the looked after population, with the number of males being slightly higher for those aged between 6 and 16 years. By 31.03.04, the proportion of males had increased to 56.5% of the total LAC population.

Ethnicity: Haringey’s looked after children come from a range of ethnic backgrounds, with the 31.03.04 returns listing a total of 34 different ethnic groups. In Table 5, these groups are classified according to the Office of National Statistics (1999) categories:

⁴ The information in this section is drawn from the following sources:

- Haringey performance information for year ending 30.04.03
- Haringey performance information for year ending 31.03.04
- Performance data, Haringey Asylum Service, June 2003

Table 5

Ethnicity of LACA at 30 March 2004		
Ethnic Group	Number	Percentage
White – British	83	16%
White Irish	16	3%
Other White ⁵	71	14%
<i>Sub Total White</i>	170	33%
White & Black Caribbean	35	7%
White & Asian	7	1%
Other mixed	49	10%
<i>Sub Total Mixed</i>	91	18%
Indian	3	1%
Pakistani	3	1%
Asian or Asian British – Other	10	2%
<i>Sub Total Asian & Asian British</i>	16	3%
Caribbean	92	18%
African	118	23%
Black or Black British – Other	8	2%
<i>Sub Total Black or Black British</i>	218	43%
Chinese	7	1%
Other Ethnic Group	8	2%
<i>Sub Total Chinese or Other Ethnic Group</i>	15	3%
TOTAL	510	100

Unaccompanied minors: There were 272 unaccompanied minors (at 30 June 2003). Of these, 186 (68%) were under 16 years and 86 (32%) were 16 years or over. Seventy-six (28%) of these were LAC.

Type of placement: Between 2002 and 2004, the proportion of Haringey LACA in foster placements remained fairly stable, however the numbers in residential care had reduced, whilst those in semi-independent and independent placements had increased. This latter change reflects the increased number of looked after young people aged 16 years or over. Table 6 outlines these changes.

Table 6

Profile of LAC by type of placement				
	At 31.04.03		At 31.03.04	
Type of placement	Numbers	Percentages	Numbers	Percentages
Foster care	324	61.6%	325	64%
Residential care	113	21.5%	77	15%
Placed for adoption	15	2.8%	19	4%
Placed with parents	21	4%	25	5%
In semi-independent, independent care (or missing)	34	6.5%	64	13%
Not known/ missing data	19	3.6 %	0	0%
Total	526		510	

⁵ Includes Albanian, Croatian, Greek Cypriot, Kosovan, Kurdish, Serbian, Turkish, Turkish Cypriot & White Other

Stability of placement:

- The proportion of Haringey LAC experiencing 3 or more placement moves has increased over recent years. In 2000/01 17% of LAC had 3 or more placement moves. By 2002/3, this had increased to 20%. At year ending 31 March 2004, 100 LAC (19.6%) had experienced 3 or more placement moves during the preceding year.
- Adoptions for Haringey LAC increased from 2.4% in 2002/3 to 4.4% in 2003/4 (of all children looked after for more than 6 months, excluding unaccompanied minors).
- Long-term stability of Haringey LAC has reduced – from 79% in 1999/00 to 45% in 2002/3. At 31.03.04, 49% of children looked after for 4 years or more were in a placement where they had spent at least 2 years.

2.5 Projected levels of mental health need in Haringey’s looked after children population

Key factors: To re-cap, the mental health needs of looked after children and young people are significantly higher than in the general childcare population – with the research evidence identifying the following as exacerbating factors:

- Placement type: LACA in residential care had significantly higher levels of assessed mental health difficulties.
- Placement instability increased the risk of mental health problems.
- Whilst none of the cited studies demonstrated a statistical link between ethnicity and mental health disorders amongst LACA, the ethnically diverse character of Haringey LACA would seem likely to further exacerbate the risk of mental health difficulties.
- The research evidence suggests an increased level of mental health need amongst Haringey’s refugee and asylum seeking children and young people (including unaccompanied minors).

In the following, this evidence is used to project possible levels of mental health difficulties within Haringey’s LACA population⁶.

Projected mental health disorders: Table 7 outlines the projected level of mental health need for the total Haringey LAC population.

Table 7

Projected mental health need in Haringey LAC population		
<i>Type of disorder</i>	Estimated prevalence rates of mental health need	Projected need for Haringey LAC (numbers)
Overall level of need	45 - 67%	230 - 342
Anxiety	11 - 26%	56 - 133
Depression	12 - 37%	61 - 189
Conduct Disorders	28 - 37%	143 - 189
Hyperkinetic disorders	7 - 30%	36 - 153
Developmental disorders	4%	20
Eating disorders		
Habit disorders		
Post traumatic syndromes	26%	133
Psychotic disorders	8%	41

⁶ Projections based on numbers of looked after children in Haringey at 31.03.04

Placement type: As detailed above, there is a significant variation in the levels of mental health difficulties experienced by children and young people in different placement types, with Table 8 summarising the implications of the epidemiological evidence for Haringey LACA.

Table 8

<i>Projected mental health need in Haringey LAC population by placement type</i>			
	Estimated prevalence rates of mental health need	Numbers of Haringey LAC (March 2004)	Projected mental health need for Haringey LAC (numbers)
Total LAC population	45-67%	510	230 - 342
LAC in Residential care	68-96%	77	52 - 74
LAC in foster care	40-67%	325	130 - 218

Placement stability: Whilst the data for placement stability is less easily matched against the research evidence, the relative instability of Haringey’s LAC population would suggest an increased level of mental health need:

- Meltzer’s research identified higher rates of mental disorders amongst LAC in less stable placements: 49% of those in their current placement for less than 1 year were assessed as having a mental disorder, as compared to 31% of those in the same placement for at least 5 years.
- In Haringey, 100 children (19.6%) had experienced 3 or more placement moves during 2002/3. Forty-nine percent (of those in care for at least 4 years) had been in the same placement for at least 2 years.

Unaccompanied minors: Whilst the research evidence makes it difficult to identify prevalence rates for this group of the population, all the studies confirmed an increased level of mental health need amongst refugee populations. Thus, the relatively high number of unaccompanied minors known to Haringey Social Services would suggest a further increased level of mental health need amongst the LACA population.

Tiers of provision: Finally, based on Wallace and Meltzer, the following table estimates the numbers of Haringey LAC requiring different tiers of provision.

Table 9

Tiers/ Providers	Estimated rates of need within LAC population	Estimated numbers within Haringey's LAC population
Tier 1: Mild emotional and behavioural difficulties or the early stages of disorders. <i>Primary care services</i>	67.5%	344
Tier 2: Common disorders with one or two risk factors. <i>Individual specialist/ uni-professional care</i>	31.5%	161
Tier 3: Less common problems indicating a more severe, complex or persistent condition. <i>Multi-disciplinary teams in a community child mental health clinic or child psychiatry outpatient service</i>	8.33%	42
Tier 4: Potentially severe disorders. Intensive and highly specialised care usually provided for older children and adolescents who are severely mentally ill or a suicidal risk. <i>Tertiary services such as day centres, highly specialised outpatient teams and in-patient units</i>	0.34%	2

2.6 Referrals to the Tavistock/Haringey LACA team

The Haringey LACA CAMHS team was established in May 2003 with a staff team of 2 child psychotherapists, 2 adult psychotherapists, 1 systemic family therapist and a clinical social worker (all part-time). Psychiatric consultations (including assessments of children/young people) have been provided on a sessional basis from staff within the Tavistock Clinic.

At the outset, it was envisaged that the clinical activities of this team would provide a further source of information about the mental health needs of looked after children and young people and the kinds of difficulties faced by the carers and professional staff involved in their care.

- This section outlines the demographic characteristics of LACA referred to the team and provides a comparison with Haringey's total LAC population.
- Chapter 5 draws on qualitative data to illustrate the types of referrals to the team and the varying clinical, consultancy and training activities undertaken by members of the team.

Pattern of referrals: The rate of referral to the team steadily increased between May 2003 and August 2004.

Table 10

By August 2004, there had been a total of 88 referrals to the team:	
Before May 2003:	6 referrals
May-July 2003:	12 referrals
August-Oct 2003:	11 referrals
Nov 2003-Jan 2004:	18 referrals
Feb-April 2004:	24 referrals
May – August 2004:	17 referrals

Source of referrals: The vast majority of referrals (76) have been made by children’s social workers, residential staff or fostering link workers. In recent months, however, there have been a number of referrals from other sources – including 6 from paediatricians, 1 from a GP, 4 from health staff (including LAC nurse, health visitor and school nurse) and 2 from LAC education staff.

Age and gender: Table 11 details the age and gender characteristics of those referred to the team, with table 12 providing a comparison with Haringey’s total LAC population. Compared to Haringey’s total LAC population, referrals to the team have involved a higher proportion of children/ young people aged 6 to 16 years and a significantly lower proportion of those aged over 16 years.

Table 11

Referrals to LAC CAMHS team by age and gender					
	Age bands				Totals
	0-5	6-10	11-16	Over 16	
Male	7	11	22	2	42
Female	4	12	20	7	43
Totals	11	23	42	9	85

Table 12

Comparison with age profile of all Haringey LAC				
	All Haringey LAC (at 31.03.04)		LAC CAMHS referrals	
	Numbers	Percentages	Numbers	Percentages
0-5 years	83	16%	11	13%
6-10 years	91	18%	23	27%
11-16 years	197	38%	42	49%
Over 16 years	139	27%	9	11%
Totals	510		85	i.e. 17% of all Haringey LACA

Placement type: Table 13 details referrals to the LAC CAMHS team by placement type. Whilst placement types approximately matched those in the total LAC population, the lower percentage of young people in semi-independent or independent care reflected the relatively low rate of referrals for the over-16 age group.

Table 13

Referrals to LAC CAMHS team by placement type				
	All Haringey LAC (at 31.03.04)		LAC CAMHS referrals	
Type of placement	Numbers	Percentages	Numbers	Percentages
Foster care	325	63%	45	53%
Residential care	77	15%	11	13%
Placed for adoption	19	4%	2	2%
Placed with parents	25	5%	4	5%
In semi-independent, independent care (or missing)	64	13%	5	6%
Not known/ missing data			18	21%
Total	510		85	

Placement stability: Table 14 compares the stability of placements for children and young people referred to the LAC CAMHS team with those in Haringey’s total LAC population. Compared to Haringey’s total LAC, referrals to the team included a particular concentration of those with 4 or more placement moves.

Table 14

Referrals to LAC CAMHS team by placement stability				
	All Haringey LAC (at 31.03.04)		LAC CAMHS referrals	
	Numbers	Percentages	Numbers	Percentages
One placement	237	46%	12	14%
Two placements	171	34%	23	27%
Three placements	51	10%	9	11%
Four or more placements	49	10%	15	18%
Unknown/ missing data	2	0.4%	26	31%
Total with 3 or more placements	100	20%	24	28%
Totals	510		85	

Requests for training and consultation: In addition to offering professional consultations to staff involved with the children and adolescents referred to the team, members of the Tavistock/Haringey LACA CAMHS team have been involved in offering consultations and training to social work staff in various agency settings. These are described in greater detail in Chapter 5, but include the following:

- Consultation and training to staff in Haringey’s residential homes
- Training for social workers on ‘Child Development and Emotional Deprivation’
- Training for foster carers on the emotional needs of looked after children and the particular needs of refugee children
- Training for staff in the Asylum teams
- There have also been various requests for training from other agencies and staff which we have been unable to meet, due to staffing constraints.

2.7 Summary and conclusions

National research evidence highlights the gap between need and provision for the mental health needs of looked after children and adolescents. Whilst research studies consistently reveal a high level of mental health problems amongst LACA, they also confirm a continuing lack of adequate provision to meet these needs. Within Haringey, these difficulties have been compounded by various factors:

- Demographic features – including, for example, the diversity of the population and relatively high numbers of refugee and asylum seeking children
- Placement characteristics – including the high level of placement disruptions
- The historically low level of CAMHS provision for LACA

The establishment of the Tavistock/Haringey LACA CAMHS team and the commissioning of this needs assessment report was informed by a commitment to resolve this area of unmet need. However, despite these increased resources, the above research suggests a continuing gap between the projected mental health needs of Haringey’s looked after children and adolescents and rates of referral to the Tavistock/Haringey LACA CAMHS team:

Table 15

	Projected levels of mental health need amongst Haringey’s LAC population⁷	Referrals to Tavistock/Haringey LACA CAMHS⁸
Overall numbers/ projected need	230-342 i.e. 45% - 67%	88 i.e 17%
Level of need amongst LAC in residential care ⁹	52-74	11
Level of need amongst LAC in foster care ⁶	130-218	45
Level of need amongst LAC with 3 or more placement moves ⁶	50	24

As summarised in table 16, the projected need for tier 2-4 services similarly suggests a significant gap between need and provision for the mental health need of Haringey’s looked after children and adolescents:

⁷ Based on returns for 31.03.04

⁸ Between May 2003 and August 2004

⁹ Missing data on placement type and stability means that these figures represent minimum numbers for each category

Table 16

Tiers/ Providers	Estimated levels of need within LAC population	Estimated numbers of Haringey's LACA
Tier 1 Primary care services Mild emotional and behavioural difficulties or the early stages of disorders.	67.5%	344
Tier 2 Individual specialist/ uni-professional care Common disorders with one or two risk factors.	31.5%	161
Tier 3 Multi-disciplinary teams in a community child mental health clinic or child psychiatry outpatient service Less common problems indicating a more severe, complex or persistent condition.	8.33%	42
Tier 4 Tertiary services such as day centres, highly specialised outpatient teams and in-patient units Potentially severe disorders. Intensive and highly specialised care usually provided for older children and adolescents who are severely mentally ill or a suicidal risk.	0.34%	2

A number of factors need to be taken into account when interpreting these figures. Firstly, a number of Haringey's LACA are placed at a significant distance from Haringey and some of these will be children and adolescents requiring (and receiving) more intensive therapeutic/residential in-pat. Secondly, therapeutic interventions for looked after children can be delayed by ongoing court assessments and proceedings. Thirdly, several other providers are involved in offering counselling and therapeutic services to Haringey's looked after children and adolescents:

- i) Within the St Ann's CAMHS team, a clinical psychologist offers consultation and short-term interventions in relation to social work referrals to the team (including looked after children).
- ii) The Adolescent Outreach team offers clinical services to adolescents (including looked after adolescents) presenting with severe and enduring mental health problems – though children and adolescents within this category are also referred to the LACA CAMHS team.
- iii) The two proposed LAC Senior Practitioner posts will offer consultation and support to front-line social workers and provide an important mediating role between LAC Social Workers and staff within the LACA CAMHS team.
- iv) Open Door offers psychotherapy and counselling to adolescents in Haringey, including some looked after adolescents.
- v) Other community services (including, for example, drug or pregnancy counselling or counselling for specific ethnic groups) may also offer therapeutic or counselling support to looked after children within Haringey.

Despite these provisos, the gap between referrals to the team and the numbers of Haringey's looked after children would suggest a significant shortfall in the provision of tier 2 and 3 services. Whilst the projected levels of need identify just over 200 of Haringey's LACA as having a degree of mental disorder requiring tier 2 and 3 services, rates of referral to the Tavistock/Haringey LACA CAMHS team suggest an annual referral rate of 66¹⁰. This figure is likely to be an under-estimate (given the newly established nature of the team), however the size of the team would place severe constraints on any significant increase in referrals. Further, the large numbers (344) of Haringey LACA requiring tier 1 provision would also suggest an additional increased need for consultation and training and one which is unlikely to be wholly accounted for by the new senior practitioner posts.

¹⁰ Based on the 88 referrals to the team between May 2003 and August 2004

CHAPTER 3: FOCUS GROUPS:

The voice of the local stakeholders

3.1 INTRODUCTION

The Focus Groups were run as a specific piece of work, using independent, external consultants¹¹ and assistants in order to ensure neutrality. Those involved were not clinicians, had no connection with the Tavistock Clinic's work in Haringey and were not social workers.

The willingness and openness in which Haringey staff, foster carers and other agencies engaged in this process was noticeable and led to the amount of material that it was possible to obtain. As well as meeting the intended aim of gathering information, it seemed that the Focus Groups also provided a welcome opportunity for thinking and expressing views and concerns.

The needs identified in section 3 of this chapter, and issues arising are a synthesis of the findings from the Focus Groups. Quotations from the video made with young people (see chapter 2) have been included, so that their voice is integrated as part of the findings from key stakeholders. The Observations (Section 4) are my views as the consultant running the Focus Groups.

3.2 METHOD

Nineteen Focus Groups were run with the following teams:

Adoption; AOT; CAMHS; Disabilities; Education (LEA); Foster Carers (Under 11s); Fostering Service; Haringey Park children; Haringey Park staff; Health; Hornsey Long term child care team; Hornsey Management; Hornsey Referral and Assessment team; Leaving Care Service managers; Muswell House staff; Placements and reviewing team; Tavistock team¹²; Unaccompanied minors and refugees; Youth Offending team (managers).

The groups were asked to identify key needs for children and adolescents in care and issues arising from the work. Needs were identified against key stages of care. Some overall needs and issues throughout care were also identified. Reports were completed for each Focus Group and checked with the teams.

3.3 NEEDS AND ISSUES IDENTIFIED

1. Some needs were identified as critical throughout care:

These overall needs for children and young people identified by the Focus Groups were:

- Boundaries
- Consistency (of relationships)

¹¹ Due to the timing of the work, the second consultant could only do one Focus Group.

¹² The feedback from that Focus Group is included in the main body of the Tavistock Report.

- Containment
- Education (including its importance in providing stability).
- Faster and more comprehensive response by services (including CAMHS)
- Good placements/foster carers
- Health
- Information (for young people, workers and carers)
- Safety
- Stability (and so less disruption)
- To maintain contact with family

Better care planning was identified as critical in meeting these needs:

“Kids need to be clear about where they are going to be and clear about their plan. If social workers aren’t clear, the child can’t possibly be.”

“... my ideal foster carer would be a person who doesn’t care about money, who cares about you and puts you the first. Because that’s what ... children in care are missing is somebody putting them first.” (Suad).

2. Other needs identified throughout care

Dealing with attachment, separation and loss was identified by eight Focus Groups (42%):

“The kids are searching for love, in the face of such extreme rejection by parents.”

“Forming an attachment is the key need for the child throughout. This is difficult for older children. Placement moves and delays hinder this process.”

“Sometimes delays in court or changes in placement are not made for good reasons. During the legal process the children are in limbo – how do we expect them to carry that? ”

One Focus Group identified the need for children not to feel judged

“...and for us to try to get across to them that what has happened is not their fault.”

A particular concern for the Children’s Homes is safety – children abscond and staff are left feeling very anxious and helpless.

“These kids are so young and vulnerable, on the streets for several days and nights. We talk to them, but what else can we do? No-one does anything. Until there is a tragic death –which is waiting to happen – no-one will.”

Young people in the Home complained about uncertainty and delays - delays in getting into education, and not knowing what was happening to them.

3. Mental health services

There is great frustration about difficulties in accessing mental health services: problems were identified of CAMHS intervening too late, of services not taking LACA until permanency has been established, or because they are too difficult, or too young (one team identified a struggle to get CAMHS for children under 12, who often need it so badly).

“The refusal of therapeutic services to see children until permanency has been established is hugely frustrating. They need some sort of help and emotional support NOW.”

“No-one will take some of our children. For example, a ten year old boy, who has had 12 placements and was excluded the first day of school. Now his foster parents are being seen, but what about the boy himself?”

“We can’t get help with an eight year old suicidal girl.”

“I wanted to stop because the Tavistock was bringing out the wrong side of me. It was making me talk about everything that happened, but it just used to bring up too much and I just couldn’t handle it because I would leave Tavistock crying, I would go home crying and it just used to bring up so much emotion, I just wanted to hide it.” (Edna)

One Focus Group identified the difficulty for both social workers and foster carers in dealing with issues of mental illness, as they lack the knowledge to do this. One team raised the question of identifying mental health issues:

“Who is responsible for identifying a mental health problem? And when it is suspected, what do we then do? There is a real gap in the system at the moment.”

Difficulties in getting LACA to use mental health services was raised. One Focus Group thought that having a range of therapies available would be helpful (e.g. play therapy), since many children refuse psychotherapy. Another Group also raised the issue of some youngsters not being able to make use of psychotherapy even if they do attend, in which case, it was suggested, simple supportive interventions would be more helpful.

The stigma attached to psychotherapy can sometimes be cultural, which effects unaccompanied minors; the needs of this group are recognised but workers find it very difficult to get them to accept any form of therapeutic intervention. In some cases this is probably also about the fear of losing their ability to maintain a false story about their lives – a story which they have learnt/been taught in order to protect themselves and, they believe, increase their chances of asylum.

Two Focus Groups were concerned about the lack of feedback from CAMHS to workers, teachers, carers etc.. While the issue of confidentiality was understood, it was felt that some feedback would allow other professionals or carers to better support the youngster in therapy. Two Focus Groups (one of whom was not part of CAMHS) wanted CAMHS to be involved throughout the Care process, i.e. in matching, placements etc..

One team identified the very good therapeutic work which can be done in secure placements, but said that little support is then given when the young person leaves. It would helpful they suggested, if interventions started in secure placements, could in some way be continued.

4. Communication

All the Focus Groups identified –either directly or indirectly – problems with communication:

- Communication being hindered through the array of different services.
- Lack of information provided to workers and carers (or provided at the right time).

- Problems in liaison, e.g. between mental health and social services.
- Problems in communication stemming from a duty system: “*Liaising with a duty system means there is little consistency.*”
- Foster carers pointed to the lack of information to children (for instance about their siblings, who may be taken into care and they don’t know).
- Young people reporting to workers that they are not heard enough.

“Please ... when you’re working with a young adult or a young kid, please first of all sit down and listen them, please try to understand them, then even if they are in a way wrong or right, judge them with them, not just judge on their behalf and ... please try to like them, because if you don’t like them and if you don’t like what you’re doing and you’re only doing it for the pay check at the end of the month, please just don’t do it.” (Voice of the Young People: Mehmet).

5. Overall needs and issues identified for workers and carers

The following key overall needs for workers and carers were identified:

- Stability of staff (see below).
- Sufficient, timely information.
- Support, education and training for carers (e.g. re mental health issues and attachment; to help with the challenges of maintaining relationships with LACA; what to expect when a child is newly placed; support through respite care etc.).
- Support, education and training for workers (e.g. consultation about cases; training in mental health issues; education in attachment (identified by two teams).
- Education and consultation for other professionals: LAC Education suggested education in attachment would be very helpful for teachers, as would a forum for teachers to get practical advice re handling difficult behaviours etc..
- General information about mental health services – what is available, how to access it, criteria etc. (identified by one Focus Group).

Stability of staff

Turnover of social workers clearly has an immeasurable impact within the system. Comments were made about the speed with which social workers change, which also hinders information and communication. One team commented about how much more disruptive it is when a child, let alone other staff, is not even told that a worker is going. There is also concern about the resulting lack of knowledge in the system, where so many workers do not know either the system or the children they are responsible for. Those who have little direct contact with children and young people, such as reviewing officers, who only see the child every 6 months, find that they now know the children best. Turnover of staff also means that reviews are often postponed because a worker has left or the plans are so inadequate.

“I find the more you change the social worker, the harder it is for the young person, because the less they open up to them and the less the social worker’s able to help them. Some social workers they’re OK, but some, they’ll tell you,... ‘we’re going back to Australia or we’re going to Japan or Timbuktu.’ I mean, what’s the point of telling someone if you know they’re not going to stay there to help you through your problem.” (Carol).

Pressure and performance

The pressure of work loads and performance targets is seen as detrimental to the work. One team thought that this can contribute to assessments and reviews overlooking emotional well-being. Another team was concerned that when a child begins to disclose, there is not time to deal with this, and that children do not get the chance to talk about the trauma of being taken into care. Other workers and carers recognise the immense pressure that there is on district social workers now; one team commented that the work now seems to be reduced to meeting statutory requirements.

Some teams commented on the style of management, which is felt to be heavy handed and controlling. Two teams commented on the considerably increased numbers being taken into care as a result of anxiety after Climbie (though another team thought that there is no longer an increase in numbers).

“Work now is reactive rather than preventative.”

“Workers are undermined by management and then do not own decisions.... So much now is about crisis. We then try to reconstruct something suitable out of a mess. Some of this is our own doing.”

The issue of so much being resource-led was raised repeatedly. Staff feel extremely frustrated by this. Problems with placements – using inappropriate foster carers, moving children back into Borough, poor matching - are seen as related to this. Two teams commented on the cost of private carers/agencies – which is bitterly resented among some teams. There is an implicit question about how well Haringey uses its financial resources.

One Focus Group thought that the Service is too often about the anxieties and needs of carers rather than the children (e.g. carers needs to *“save the young person.”*). One team identified the enormity of pressure on them as social workers in dealing with conflicting demands and trying (and failing) to keep everyone happy.

The question of whether more harm than good is done was raised by three Focus Groups, who also acknowledged the poor chances kids from care have (statistics in prisons; homeless, etc.).

Effective working and emotional well-being of workers

The need identified for support and consultation for workers was not only to help them, but also to protect the LACA service. One team mentioned the danger of workers colluding with children and adolescents. They suggested that the culture of social work, in which you are seen as a failure if you let something affect you, does not help. The effects on workers arising from what the children and adolescents bring, was raised by another team. One group identified the danger of workers not being able to think because of the pressure of work and the need for consultation to help them stand back and remain reflective.

“Workers get overwhelmed by the feelings of failure and hopelessness that the young person brings with them. If workers were supported with this it would help them to support the young people better.”

“You can get caught up in a merry-go-round of finding, trying to maintain, finding placements the whole time and not have the chance to step back and think.”

“You may be plugging away at something that is not the key issue – it is good to see it from a different perspective.”

3.4 NEEDS IDENTIFIED AGAINST KEY STAGES OF CARE

The following is a description of the needs and issues arising identified by the Focus Groups at each stage of care.

1. PRE-ENTRY INTO CARE (referral; initial assessment; planning)

Available information

Eight Focus Groups (42%) identified the need for proper information, clear care plans, initial checks and risk assessment. Information is needed in order to make a suitable match, identify needs, make decisions and plans. In the children’s homes this information is vital so that routines and boundaries can be quickly set up. One Focus Group was concerned about the lack of care and planning while court proceedings are ongoing.

The lack of adequate or timely information was highlighted as a major frustration and difficulty. Linked to this is the issue of inadequate planning.¹³ There are problems with information to workers (in social services and other agencies), carers and LACA (who, one team said, are often left uninformed about what is happening to them). Three Focus Groups said that information to pre-warn those concerned about what to expect would be very helpful. For example, letting foster carers or children’s homes know that a child wets the bed; letting teachers know what to expect if a child goes into therapy. Essential gaps in information were identified. For instance, contact arrangements; not knowing a child is Looked After; children disappearing into other boroughs for months with no information given to a team. The problematic nature of confidentiality was raised by one Focus Group, who thought that it was not always in the interest of the child. The question they said, is whether different professional groups trust each other or:

Is confidentiality being used as a blanket to withhold information?

Supporting families

The importance of supporting families in order to maintain the child at home was identified as the key need at this stage by two Focus Groups (11%).

One group identified the need for support for the family of origin around contact with the child, and how difficult this is. The emphasis they said, is quite rightly on the child, but all family members need support around contact. Two other groups identified the need for more involvement of parents at this stage.

“Intensive rehabilitation for parents is needed so that the bond with the child is not destroyed. Many kids are in and out of care, yet there is no work done to rehabilitate their parents and make returning to the family easier and less traumatic.”

For the adoption and fostering link teams there is an additional need to recruit adoptive families and carers. Assessment of adoptive families or foster carers is “very intense and

¹³ This is also connected to the turnover of social workers.

intrusive”, probing into the backgrounds of potential adoptive families or carers. It is a demanding and emotional experience for people, needing sensitivity and support from workers. One team identified the lack of follow up for potential carers/adoptive parents, for whom very difficult issues may have been raised, such as their own infertility or experience of past abuse.

Support to the family and child at this stage is also important for the Disabilities team, since it often takes a long time to find the right placement, which can be very difficult for families to deal with. On the positive side, this provides a period of adjustment by the child and their parents.

Protection

Two Focus Groups identified the issue of protection, safety and building trust. For the Referral and Assessment team the short timescale for completing the initial assessment (7 days) – a difficulty in its own right - compounds the difficulty of trying to establish trust with the child, particularly in child protection cases.

Protection is also a significant, complex and ongoing issue in work with unaccompanied minors (e.g. in the case of traffickers). For these young people basic needs - money, food, clothing, accommodation, physical health, education – have to be met at the initial assessment stage.

Mental Health involvement

Three Focus Groups (not CAMHS) identified the need for CAMHS involvement at this stage. One of these said there needed to be a CAMHS input from the beginning of the care process as these children are more likely to have mental health issues that can cause further damage. Another group said there should be CAMHS involvement where emotional difficulties are apparent, requiring prompt intervention to identify and address the problems. The third group was concerned with the need for CAMHS to be involved where abuse is suspected; they are extremely frustrated by the lack of this:

“There is a need for CAMHS input to help the child to verbalise abuse. There is a real lack of interagency work in this, which means that the abuse continues longer than it need.”

Another Focus Group identified the importance of speed in getting support and counselling for the child.

Seeing the child/young person

“When you leave the house and you’re packing your clothes and you’re packing your books and you’re packing everything in your life, you’re also packing an invisible package there as well, which is the piece of papers, that you can’t see, because they’re obviously floating around you and everybody else is reading about you and they know about you, they’re doing courses about you ... You don’t know what to say or what to do about it, ‘cos if it was right in front of your face, then you ... could just say ‘look here I don’t think that’s right’, but they don’t show it to you, they share that information amongst themselves.” (Suad).

An issue for the Disabilities team is that youngsters can often become invisible, with their needs being identified by parents, carers, teachers. Similarly, in child protection cases, the wishes of the child need to be kept in mind and represented in court.

Inappropriate referrals

This can be an issue for the children's homes who sometimes get youngster referred to them that they are not equipped to deal with. At other times, the referral may be appropriate, but the child would be too disruptive/unsafe within the particular community at that point in time.

2. ENTRY INTO CARE

Seven Focus Groups (37%) identified needs relating to placements – better matching; the importance of getting the right placement to avoid future problems and placement breakdown; the need for continuity in placements. One Focus Group commented on how continuity gets stopped at this stage:

“Continuity is needed but at the moment there is a change of social worker as the child goes from the assessment stage to long term care. Further loss is generated by placing children out of borough. The children routinely lose contact with their community of origin.”

One Focus Group commented that on the lack of understanding of the emotional issues relating to placement moves, such as attachment issues that get provoked with every placement. They thought that carers could be given much more preparation about what to expect when a young person takes up a new placement, for example the “acting out” that may happen at the beginning, or once a youngster feels safe enough to challenge carers.

Another team suggested that placement breakdown is a key stage for foster carers as well as for LACA. Carers often feel guilty and blamed. Workers need to be very sensitive about how they handle this. One team mentioned the use of the disruption meeting - there were different views as to whether this was in order to try to repair a placement, or whether it was called after a placement has already broken down.

One Focus Group suggested that matching needed be related to LACA's attachment patterns. Two groups (one non-CAMHS) thought that CAMHS should be involved in the matching process.

“Sensible placements are very difficult to make, but the wrong placement leads to a much more disturbed child further down the line (so making it more expensive in the long term). Lack of care about placements and disrupting young people causes serious damage and can jeopardise their futures.”

The crudeness of matching was raised by a number of teams. It was recognised that given the shortage of carers, and turnover and pressure on social workers, this is often all that can be done, but that it leads to much greater problems.

“If a black child is placed with a black family it is seen as a good placement, but it could be a Muslim child with a Christian family, with different food etc.. It's all about resources though.”

For unaccompanied minors out of Borough placements may mean that they are the only young person of their ethnic origin in their local area. Racism, including racial violence, can be part of what they have to deal with.

For younger children in homes, there is a real issue about the speed of finding foster care:

“It is very important for placements to happen fast as there is a brief window of opportunity when the child is still hopeful about their future. This often does not happen. There is a lot of drift; it is very frustrating watching a child deteriorate because plans for their care simply do not materialise. The reality is they have to deteriorate in order to get placed. And they know it.”

Permanency

The impact on placements of the uncertainty while court proceedings are ongoing was raised by one team. Another focus group identified the problematic issue of when a decision about permanency is made:

“The decision about permanency is a key stage, but at what point do you do that? Apart from anything else, long term planning often gets delayed by the courts (and Guardians).”

Supporting children

One group identified the need for support/therapy during the initial period of uncertainty while the court case is pending.

Two teams identified the need to deal with the trauma of going into care. For Foster Carers, this means it is important to deal with emotions about not being at home:

“Some kids need counselling to cope with loss and separation. Most are traumatised – we need to recognise that.”

“I didn’t know this woman, I felt very uncomfortable, I mean she was really nice and all that, but because ... I didn’t know her and she wasn’t my family, I didn’t feel right, I didn’t want to take off my jacket when I was in the house, I slept in my jacket, I woke up in my jacket, I wouldn’t even want to use her bathroom or nothing like that, but after a while, I got used to her still, so.” (Linda)

Young people in the children’s home said they wanted more to do and things you could do together (e.g. monopoly), when they first went into the home. They also implied how frightening the children’s home is initially, suggesting how important that entry stage is for them:

“I just said yes to everyone when I first came here.”

Staff in homes identified the need to establish a routine and boundaries for youngsters as soon as possible when children come into the home; getting thorough and speedy information is vital to this. Establishing a routine, and minimising the disruption of existing routines, especially for younger children, is also very important at entry into foster care; one focus group identified the importance of the placement agreement meeting in this, so that vital information can be passed on and an agreement made between the child, foster carers, parents and social worker about practical issues and contact arrangements.

Supporting families

For the Disabilities team this is a time of on-going support for parents – dealing with their loss and extreme feelings. As at pre-entry, there is a need to try to communicate directly with children.

When a child is first adopted, support to the adoptive family is key. It is linked to the particular needs of that child (e.g. attachment, experience of early parenting, neglect). Also in adoption a key point is the last contact meeting with parents:

“This goodbye visit is a key stage for the child. Sometimes parents don’t come – it is just too final. For everyone –workers too – it is hard to keep the goodbye visits in mind – maybe because it is so painful.”

Long term work

Ensuring adequate care plans, including contact and links with the birth family, is vital for long-term teams at this stage. Another key need for them is to balance all perspectives, which is very difficult with so many conflicting demands and needs.

“The social workers are always criticised at this point because they cannot please everybody.”

Two Focus Groups identified the importance of life-story work for children and young people going into long-term fostering. One issue around this is who does it; one team noted that foster carers should help with this, but often do not want to get involved. It was recognised however, that it can be a very difficult, painful piece of work, so a lot to expect from carers. Another team noted how important it was for social workers to do this work, but that they are so overrun at present it gets lost¹⁴:

“It then re-emerges when the trail has gone cold; this is a constant thorn in our side.”

Meeting basic needs

One Focus Group identified the need to provide for basic physical needs and safety. For LAC Education, the need at this stage is to get LACA into school within 20 days of them becoming Looked After: for certain ages – particularly year 11 - this can be extremely difficult because of the shortage of school places.

Another need at this stage identified by two groups is for children to build trust – with social workers and carers.

¹⁴ In addition to the very real pressures of workloads, it seems to me that the pain of this work for social workers – as for carers - may be unconsciously contribute to it getting overlooked.

3. ADOLESCENCE

Identity

Three Focus Groups identified needs to do with identity formation: identity issues are clearly accentuated for Looked After Children and Adolescents. For unaccompanied minors identity is very complex, made harder at times through the necessary web of deceit that they have concocted about their lives. Around this age young people become much more aware of their race and ethnic origin but they do not have role models to learn from and identify with. Issues of difference also compounds the sensitivity of adolescence. Rejection – for instance in attempting to get a girlfriend - can therefore be particularly difficult.

One Focus Group thought that foster carers are not always equipped to cope with the race and cultural issues which all come to the fore at this stage. Addressing issues of sexuality is also an issue – one team were unsure if social workers talk to young people about these issues and organise support for them if necessary.

One Focus Group commented that cultural differences, as well as generational differences between LACA and their carers, may arise at this time. The amount of freedom allowed to adolescents for instance, is partly cultural.¹⁵

One Focus Group commented on the importance of social workers helping children to:

“... formulate a story to explain their situation and help them form an identity. Yet this can only be achieved successfully after a long time of developing a relationship with the social worker – with social workers changing so regularly, this is very difficult.”

“You’ve had so many houses that you’ve gone through and so many, I don’t know, you lose the value of a place of your own, you lose that whole thing, ... and plus you lose your respect, your self respect in a way. When you keep moving from place to place you lose your self, and your self-respect as well goes along with it, and once you lose that, I think that’s why most kids actually ended up in criminal stuff, because they lost themselves in that way.” (Suad)

Being adolescent

One Focus Group said that an issue at this stage for workers and carers is to distinguish between ‘normal’ adolescent behaviour and mental disturbance.

“At this age it may be difficult to identify if problems are related to issues of mental health or of care and control.”

As with other adolescents, vulnerability to mental illness can come to the fore at this stage for disabled youngsters, but for the Disabilities team there is the additional issue of distinguishing between the normal physiological changes of adolescence and changes caused by the disability (for instance as a result of medication). For this team there is the continuing need to listen to young people and give them a chance to voice their opinions for their care, rather than workers just hearing the voice of parents. Young people at this stage need:

“...to express their hopes and wants for the future. But this is in the painful context of the reality for the majority of these adolescents who will remain in a residential placement throughout their adult lives.”

¹⁵ I imagine this is a particular issue where a child and foster carer come from very different cultures.

In the children's home, staff noted the need to:

"...address the usual issues with young people, including puberty and sexuality. It is also important that staff provide positive role models for the adolescents."

One Focus Group commented on the difficulties faced by Looked After youngsters in relationships and felt that generally relationship issues are seriously neglected throughout the Service.

One team thought that social workers do not work well with adolescence:

"...they try, as is the nature of their job, to control the children, but adolescents won't let you do that. Social workers need to work in a way that works with adolescence, not against it."

Practical issues

A particular pressure at this stage for unaccompanied minors is to earn money and so there is the temptation for young men around 16 years old, to leave services and work illegally (e.g. on building sites). In these cases workers need to encourage them to remain in the service.

For disabled adolescents practical difficulties, such as it becoming harder for carers to physically move those who are unable to move themselves (which also has health and safety implications), mitigates against respecting the adolescent's autonomy and dignity. There is also the practical issue of resources to provide meaningful packages of care. For instance, an increase in Day Centres would mean it was possible to offer the young people more specialised packages, particularly in the transition to adult life.

One Focus Group said that more suitable youth facilities in Haringey with a range of activities and services are needed:

"A central venue with a range of activities would be very helpful. This could also house some mental health services; more children would go if mental health services were in a neutral environment such as 'shop front' where there is no stigma attached. Other health services could be here too. Looked After Children do not have one person to turn to for health advice like a parent, so they need at least one place for this."

Information and education about health, drugs etc. was identified as a need at this stage by three Focus Groups.

Transition

One Focus Group identified the need for support with transition points associated with adolescence (school, exams, etc.). For LAC Education, transition points are very significant and often times when difficulties occur. As well as the critical transition between primary and secondary school, year 9 and the pressure of choosing GCSE options is a key time. Those with early birthdays who move into Leaving Care and therefore into independent living while studying for GCSEs face a particularly difficult transition.

4. LEAVING CARE

Preparation for independent living

Five Focus Groups identified the need to prepare LACA for independent living. One team said that it was important that preparation is emotional as well as practical. The Leaving Care service has to try to meet a wide range of needs, from straightforward financial support to:

“...very complex and often high dependency needs...A key need is to fast track young people for independent living, so that they can cope with daily tasks such as cooking.”

Going into Leaving Care

“For myself, I do worry, because like I said to Haringey, I wasn’t ready for this whole semi-independence thing, you need the support and I don’t feel that I’m really getting that from Haringey, so I’d rather have been with the family ... because I was getting that when I was there and I’m still getting that with them anyway, so.” (Catherine).

Social workers and RSWs are very aware of the added uncertainty and change moving to Leaving Care creates for an adolescent, who is already dealing with so much¹⁶. Some teams raised the issue of how hard it can be to explain to youngsters that they are going into Leaving Care – some don’t understand, some refuse to talk about it. This makes preparation very difficult. On the other hand, some young people in the children’s home can’t wait to get to Leaving Care and be independent.

One issue for workers is the lack of flexibility in moving young people to Leaving Care:

“It might be a particularly difficult time in the kid’s life, when other factors are already making it hard for them to function successfully at school and at home. In these cases postponing leaving care for a few months would be far better.”

The financial imperative to move kids back into Borough at this stage was raised by several teams and is seen as a major disruption:

“One thing that does not help is bringing kids from out of Borough (and there is a 90% chance of a child being placed in Kent at the moment, with private fostering agencies), into Borough when they go into Leaving Care, which is done to save money.”

“This can be very detrimental to a child who has settled well into their placement. Sometimes an issue can occur, such as a fight, that is seen as related to geography, so the child is moved, but it may have nothing to do with this. Where a young person has never lived in Haringey, this change is even harder.”

One team commented on the loss of continuity, not only in the change of social worker but the change in care plan which can happen when youngsters go into Leaving Care (again this might relate to bringing them back into Borough). The impact of this is felt to waste a good deal of the work previously done. Another Focus Group identified the particular need for continuity at this stage – of the care plan; of social worker; of placement.

¹⁶ It is clear that workers also feel the pain of the transition.

An issue for the Leaving Care service is how hard it often is to engage with youngsters at this stage, due to their previous experience of the care system:

“...these young people have been let down continually, usually experiencing little stability while in care.”

Sometimes, it was noted, they engage better with housing workers simply because they are not social workers (particularly given the high numbers of social workers youngsters will have had by this point).

Assessment and risk

The needs assessment should be done by someone who knows the child well prior to them coming to Leaving Care, but the Leaving Care service has difficulties in getting progress reports, or any real evidence that work is occurring with the child.

Anxiety around risk is a need which the Leaving Care service has to manage:

“Some of the young people are very disturbed creating high levels of anxiety, particularly where they are suspected to have committed or be liable to commit sex offences. The anxiety is generally from outside the Service; dealing with that and constantly balancing risk - including assessing how current the issue is - is part of the job.”

Relationships

One Focus Group identified the problematic nature of relationships for LACA, as particularly worrying when they are leaving care:

“These youngsters do not have models of healthy relationships. Foster carers are faced with their dysfunctional understanding of intimacy; they sometimes perceive abuse as love, refusing to allow either the foster carer or social worker to support them in leaving abusive relationships, and so putting themselves at risk of abuse and domestic violence.”

One team commented on the high numbers of pregnancies amongst LACA, suggesting that more sexual health education is needed. The increasing number of pregnancies amongst unaccompanied minors, many of whom get pregnant very soon after coming to this country, may be linked to the belief that it will help to secure asylum status.

Education

Encouraging good education achievement (and meeting performance targets) is difficult. Motivation is one issue; getting up in the morning for instance, when there is no-one to make you. For unaccompanied minors - who can be highly motivated - there are barriers of language and the pressure of the ambiguity of their asylum status.

Leaving

The Leaving Care service identified the importance for young people to re-establish contact with family members at this stage:

“The corporate parent doesn’t go to weddings years after the child has left care, it cannot replace family.”

This also relates to the need to ensure that young people have support networks set up, and the anxiety felt when young people do not have this in place before they leave care.

For foster carers dealing with the emotional impact of a child or adolescent leaving a placement is important and painful, both for the child and the carer. In the children's home each leaving evokes feelings of loss and separation for all the other LACA, so there is a need to address the feelings brought up with those who are not leaving.

The importance of liaison with other services was identified by one Focus Group:

"The last few months before leaving care are crucial as often things blow-up for an adolescent at this point. This is also just at the transition point between child and adult services, so liaison with other services – for example adult psychiatry – is important."

As they go into Leaving Care, unaccompanied minors have the added pressure of dealing with ambiguity around their asylum status:

"This impacts on the social worker, who has the dual role of preparing the young person for possible independent living after care, while reinforcing the possibility that they may have to leave the country and enforcing Home Office decisions."

Premature leaving was seen as a major issue:

"It can be very painful when a young person is 16 and being made to leave care when they are clearly not ready to be responsible for themselves. It's not easy taking on your own life at 16 years old."

"Young people are often extremely reluctant to move from stable foster care into semi-independent living. The majority of them aren't emotionally ready for this – they are forced into premature independence - but the Service pretends that they are ready because they have to be. Many young people simply do not believe the support will end (they transfer their dependence on foster carers to Social Services)."

The ending of care means that the Leaving Care service is "the end of the line". There is therefore some frustration at the lack of preparation for independence before young people come into Leaving Care, where there is such a pressure to get everything "done and dusted" before a youngster hits 18:

"Yet the reality is that these young people are often very immature and cannot be expected to have done everything by the age of 18. The normal age for leaving home is around 23, whereas for Looked After Children it is 17."

The Leaving Care service also pointed to the lack of provision when young people are 19, a year after care has officially ended, but an age when many mental health issues can emerge.

3.5 CONSULTANT'S OBSERVATIONS

These observations are my personal views, based on my experience of running the Focus Groups. That experience is limited, and I may have some misconceptions, but I hope my observations can add to the thinking about the needs and emotional well-being of Looked After Children and Adolescents in Haringey.

I was repeatedly struck by just how enormously difficult and painful this work is, and how much commitment and involvement workers retain. I wondered about the inevitable stress and strain and how much support is given to workers in dealing with the emotional effect of the work. Clearly this is done through supervision and peer support, but I wondered for instance, when I heard about a team that had lost all its staff, how much work is done with teams to support them in thinking about the impact of the work and what is happening to and for the team.

1. Understanding the system

As an outsider coming into Haringey and into social services, I was initially confused: how did this system work, who did what, what did some terms, such as 'link officer' mean. Sometimes I found that just when I thought I had understood something, I discovered that I had not understood at all. What made it more confusing was that this often happened after clarifying with one team what another team did, only to find this was not the case when I met the other team. My guess is not that teams do not know what each other do (though of course that might also be true), but that it was often a case of language: we used terms differently without realising it, titles of teams are shortened which change the apparent meaning, or terms are used to convey what the intended practice is, rather than the reality. So, for instance, I thought long term meant just that, when in fact it can mean very short term. I discovered that the placements team are in fact the reviewing and placement team and do not place children; the referral team is actually the assessment and referral team and basically receive rather than make referrals.

I also had to rapidly make sense of the different systems and cultures within the system as a whole, so trying to understand what something meant when it was said by Health as opposed to Social Services etc..

What must it be like for children and young people, for parents, foster carers, different agencies and professionals coming into and trying to make sense of the Service?

2. The environment

While some of the backdrop against which Haringey is working was clearly expressed – financial constraints, low morale in social work generally and high turnover of social workers – what was spoken about less often, but nonetheless seemed to me to be very present as an emotional tone, was the ongoing impact of Victoria Climbié, with all the consequent guilt, blame, demoralisation, fears of using or allowing others to use, professional judgement. Part of this was the feeling, which some spoke about, of Haringey not being trusted by the courts and the difficulties that come from that.

In addition to the mirroring of dysfunctional warring families which is bound to get into the work, the effect of Victoria Climbié (and the degree of scrutiny and inspection which followed), must contribute to what felt to me a rather war-like environment. Accusations of people doing this just for money (children accusing carers and workers, workers accusing carers); people feeling the need to insist on and spell out their rights (children to carers and

workers, carers to workers); courts distrusting Haringey; Guardians using tactical delays; battles and poor communication between Health and Social Services and between different parts of the CAMHS service etc..

The 1999 Joint Review said that Haringey was in transition moving towards an empowering culture (1999, Joint Review, p. 19). I imagine that a further effect of Victoria Climbié is the shift back towards a more inhibiting culture with centralised control. This in turn makes it more difficult for workers to use their professional judgement and to own risk. It is of course a vicious circle, which increases risk, and so anxiety, leading to greater fear of owning risk, and so on. It seems likely that within this environment there is some collusion between management and workers for management to take even more control, which then only continues the vicious circle. The turnover of social workers and the consequent lack of experience in the system must compound this, as must the climate of central control by government on all public bodies.

3. Fact and fantasy

It seems that there is not always clarity around what is fact and what is fantasy. Certainly different teams have different perceptions about the facts, such as whether or not Haringey is currently taking considerably more children into care as a result of Victoria Climbié. The lack of clear facts seems to enhance the confusion and chaos which must be in the system, due to the nature of the work and the disturbance that LACA bring with them. While difficulties with information, communication and liaison, may in part arise from the chaos and confusion, they must certainly contribute to it.

4. Splitting between teams

It seems to me that different teams or parts of the system represent the different feelings and difficulties about the work within the system as a whole. There is a striking split between the Leaving Care service and the rest of the Service. Other teams often perceive Leaving Care as tough and uncaring; Leaving Care feels that sometimes other teams/carers are too soft on young people, doing them a disservice by not preparing them for the basics of independent living¹⁷. Another split appears to be between social workers and foster carers – it seems that neither group care or do enough in the other's eyes. Within social services, the Fostering Link team stand up for carers, but feel that they themselves are unheard. And indeed, they were not mentioned by other teams, which given their role, was noticeable. I wonder if this reflects the lack of linking within the system, in which many teams remain fairly invisible to each other. The Disabilities team also feel overlooked within the overall system. In relation to link workers however, it may also be that they are seen as too close to carers, and are therefore distanced by other workers. One area of unification amongst all the splits, seems to be in the common enemy of the courts and Guardians.

Some of these splits must arise directly from the work, mirroring the splitting, side taking and wars within the families the children and young people come from. It may also be that the resentments, blame and misunderstandings among teams, are exacerbated by the way the care system is carved up. The structure¹⁸ imports and repeats the original experience of the

¹⁷ Splitting around Leaving Care is likely to be influenced by the increase in anxiety which, feedback from the Focus Groups suggests, understandably increases for both young people and those around them, as youngsters move into this final stage of care.

¹⁸ I appreciate this is not just Haringey but is very common.

child taken into care. Going into care means being taken away from care – as damaging as that care may have been. It is about supreme loss. And loss is then built into the care system: once in care, as soon as the assessment and referral stage is completed and the care order secured, the child is removed again – on to another team, another social worker. Once they enter the final stage of care, they are removed again – on to the leaving care service – another team, another social worker, semi-independent living. This is structural, regardless of any changes in social workers. I am not suggesting that this can be avoided: the perfect structure does not exist and no structure can avoid the possibility of splitting between different parts of a service. But my impression is that this system lacks ways or opportunities of thinking about what is behind the splits and managing the structure so that splitting is reduced.

It may be that an unconscious aim of the splitting is to protect against some of the intolerable feelings caused by the work. In the case of leaving care, it could be against the brutal reality of care ending, and the limits of what it has been possible to do for young people. Worse still, the reality of the damage that the care system itself has caused. By making Leaving Care the ones who push young people out, others can be spared some of that pain. Likewise, Leaving Care can protect themselves from some of the intolerable feelings by blaming the previous lack of work. In the case of foster carers and social workers, it may be that each blames the other as an unconscious way of protecting themselves against unbearable pain: the pain from the children's unbearable pain and rage, which carers and social workers face the most and so absorb the most; and their own unbearable pain of not being able to repair the irrevocable damage done to these children, and the feelings of self blame, anger, impotence and incompetence that then ensues.

It may be that workers feel terrible failure and disappointment about LACA who do not emerge well from care. Writing about the need of staff for patients to get better, and the effect on them when this does not happen, Tom Main said:

“These failures did more than disappoint – they left all concerned with mixed feelings of uneasiness, personal blame and defensive blaming of others. They got under the skin and hurt.” (Main, 1957, p.27).

“Whenever something goes wrong with certain distressed patients after lengthy and devoted care, it is not difficult to notice the ... staff ailment...the blaming and contempt of others for their limitations of theory, ability, humanity or realism.” (Main, 1957, p. 29).

If there is some idealising about what can be done, the feelings of disappointment and blame will be heightened. So if, for instance, there is a belief that if only the right placement were found, all the damage would be fixed and the child would be alright, there will be greater disappointment and blame when it does not turn out like that. In reality of course there is no ideal placement, no ideal foster carer, no ideal social worker, no miracle therapeutic intervention and the damage cannot be fixed.

5. Fragmentation

Related to the issue of splitting is the fragmentation of the service: the vast array of professionals and agencies involved in providing care causes fragmentation of that care and must add to the potential for splitting. In this sense, it is likely to replicate and compound both the unhealthy external world LACA come from, and the disturbed internal world of these children and young people. My feeling is that the lack of containment within the system for LACA, workers and carers contributes to fragmentation; the more disturbed a child is, or the more desperate a worker or carer is, more people/agencies are called in to help.

6. Mental health issues

My impression is that potentially CAMHS could get completely overwhelmed by the needs in the system from LACA, workers and carers. Needs arising from high levels of disturbance and by the impact of that disturbance throughout the system, which must create desperation, for someone to make things right.

Along with potentially overwhelming need, I also suspect that CAMHS could be set up to fail (as perhaps social workers and carers are) by the system being overly optimistic about what mental health interventions can do. Perhaps this is linked to some denial within the system about just how damaged these children and adolescents are.

One of the anxieties seems to be about spotting mental illness, let alone dealing with it, without knowledge or training. The feeling that you will be blamed for not spotting something must only make it worse.

I am not sure if all those involved in providing care to LACA see emotional well-being as part of their brief, or whether to some extent this is left with mental health professionals. Given the pressures of the work, the extent of mental health issues and damage, this is very understandable, but the reality for the child or adolescent is that everyone throughout the system, whether they want to or not, has an impact on their emotional well-being.

While some teams differentiated between the local CAMHS and the Tavistock Clinic, others spoke generally about mental health services. It may be that there is confusion about the different services involved and/or that some parts of the system are not aware of changes in CAMHS provision in Haringey, and could be basing decisions for instance about referral, on outdated information.

7. Resources

Lack of resources is a very real problem. I had the feeling however, that feelings about resources, particularly about money, might also symbolise the impossibility of the work and the insatiable needs (perhaps what is felt as greed at times), which resources cannot meet. In this sense, money becomes a concrete thing on which to locate the frustration and despair about what cannot be done.¹⁹

Money also seems to represent the conflict between doing this work as a vocation or a job. LACA in effect accuse carers and workers of only working for money; workers are infuriated by the vast amount of money which goes to private agencies and carers. In this case money highlights inequity, but it also seems to represent what may be (unconsciously) seen as something rather dirty about this being just a job, rather than a vocation - done more for money, than love²⁰.

In the accusations about money, maybe what people are being accused of is also being needy. Perhaps it is okay for children to have needs, but not for workers or carers. Perhaps when

¹⁹ It is interesting to note in this context the difficulty in retaining social workers, despite Haringey's high pay rates.

²⁰ Given that the work must evoke a good deal of hate, I wonder if what also gets tangled up in this is the guilt associated with that.

workers complain about lack of resources, they are complaining in part, about the lack of care they receive in their work.

Resource problems clearly hinder or stop work, but perhaps at times they also provide a reason for backing away from unbearable pain. One example given of resources stopping work was not being able to take the time to talk to a child who begins to disclose or talk to them about the trauma of being taken into care. This is acutely painful and at times resource constraints protect workers from taking on such unbearable pain, particularly when they are under such pressure and do not have sufficient support in dealing with it.

8. Disadvantaged groups

Every group of LACA is by definition disadvantaged, but within the enormity of disadvantage and deprivation, it would seem that a covert hierarchy exists, with some groups at a greater disadvantage within the system, than others. The findings of the Focus Groups suggests that this stems either from implicit values about who deserves care, or is to do with complexity of needs. The experience of the Youth Offending service is that offenders are seen as “less worthy”, resulting in a reluctance to help them. It may also be that the existing pressure on services leads to passing around those LACA with other identifiers. So, for example, a child with mental health needs who is an offender is passed to the YOT, partly because CAMHS does not have the resources to cope with the demand.

The difficulty in accessing services for those with additional needs such as learning disabilities or organic problems, suggests that these LACA end up in effect get pushed down the hierarchy, perhaps because of the overwhelming amount of need and the additional time it would take workers already stretched too far, to set up other provision.

**CHAPTER 4: REPORT ON THE CONFERENCE:
Bringing colleagues together**

4.1 Introduction

The Conference was held on 30th April 2004, at the TUC Conference Centre, Crouch End. The Conference was seen as an essential element in the Needs Assessment. There is a wealth of knowledge about LACA within the various parts of the overall system that provides care; we became increasingly aware that the majority involved in the work had difficulties in perceiving and understanding the system as a whole. Accordingly, we wanted to provide an opportunity to bring people together who work in different parts of the system, and to hear and report their thinking about the work and their place within it.

4.2 Aims:

The aims were two-fold:

1. To provide a forum for dialogue and exchange between all those involved in the care of children and adolescents who are Looked-After.
2. To identify and consider what needs to be provided for Looked After Children and Adolescents to ensure their emotional well-being.

4.3 Who Attended?

All those involved in the care of LACA in Haringey were invited. On the day, representatives from many of the professions attended, although there were some professional groups who were not able to come.

Professionals who attended:

foster carers, link workers, social workers, teachers, school nurses, connexions workers, commissioners, managers; various health professionals including doctors, health visitors and nurses; and various CAMHS professionals including psychiatrists, clinical psychologists, child and adolescent psychotherapists, social workers, family therapists and administrators.

They represented a number of different services across the Borough:

Services Represented:

The fostering service, asylum team, LAC-CAMHS, residential service, the referral and assessment services in Tottenham and Hornsey, the long-term teams in Tottenham and Hornsey, disabled children's team, LAC-Education, Teenage Intervention Service, LAC-Health, AOT, Sexual Health Service, the Tavistock Clinic, Leaving Care Team, Youth Offending Service, Teenager Pregnancy Unit, NCH Haringey Children's Rights Service, NSPCC, Social Services, Family Placements, etc..

96 people were registered for the conference. On the day 86 attended.

User Representatives – Looked After young people:

They were represented through their video, described below, although we did not invite them to attend this particular conference in person. The young people had a very powerful impact on the proceedings of the day.

The number of services and of professional groupings represented brings home the complicated nature of the service as a whole and the difficulty of thinking about it as a single functioning system. The professionals themselves referred to its confusing nature. Questions arise about what it must be like for the child or parent trying to understand the system, and what it must be like to have responsibilities for managing it.

User Representatives/Professionals – The Foster-Carers:

Foster carers were invited and a number attended and contributed on the day. During the day, foster-carers were seen as part of the wider team of professionals looking after needy young people. Sometimes they seem to be seen as part of the client system, and sometimes part of the professional system.

4.4 Conference Content

The Conference was designed to encourage the participation of the participants themselves. Therefore only two presentations were given, and the rest of the day included discussions in small and large groups. To enable everyone to get the most out of the discussions, the groups were allocated experienced group facilitators.

We also wanted the voice of the young people themselves to be heard. We decided the most effective way of doing this was to show a video made with young people who were leaving care, talking about their experiences: “What is it like to be in Care?” was the theme of the video and the first Large Group discussion. It was followed by discussions in small groups on the theme: “What is it like to Care?”

In the afternoon there was a presentation by Jenny Sprince, Consultant Child and Adolescent Psychotherapist, “Towards an Integrated Network” describing an experience of bringing aspects of a service for LACA together. The Large Group Discussion: “What should our Looked-After service include?” was followed by Small Group Discussions: “What can we do now?”.

4.5 Was the Conference a success? Results of feedback survey

All participants were given an anonymous feedback form to complete. 25 forms were returned to us. The full analysis of the feedback is available on request. In summary: participants were asked to rate each element of the conference on a simple scale from 1 (poor) to 5 (excellent). They were asked to add additional comments if they wished, and many of them did, very helpfully. We have used some of these comments in constructing this report. Additionally, participants were asked to tell us what other topics they would have liked addressed, give ideas for future conferences, and any additional thoughts about the emotional needs of looked after children and the kinds of services required to meet these needs. Again, some of the responses to these questions have been incorporated into the report. Managers in Haringey, via the LACA Strategy Group were also given a full copy of the Conference Feedback Report, which included full details of the responses of participants.

The ratings, which indicate that the majority of participants found the Conference relevant and helpful, are given below:

<p>1. How would you rate the relevance of the video presentation? Range of responses: 4-5 Average rating = 4.84</p> <p>2. How would you rate the content of the lecture and discussion? Range of responses: 2-5 Average rating = 4.00</p> <p>3. How would you rate the workshop sessions? Morning Workshop: what is it like to care? Range of responses: 2-5 Average rating = 3.68 Afternoon Workshop: What can we do now? Range of responses: 2-5 Average rating = 4.04</p> <p>4. How would you rate the Conference overall? Range of responses: 3-5 Average rating = 4.20</p>	<p>[Key: 1= poor; 5 = excellent.]</p>
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4.6 Themes that emerged

The conference was remarkable for the amount of involvement of the participants and the degree of thoughtfulness about the content. It is hard to do justice to this in a summary, and difficult to pull together themes that sufficiently convey the quality of the contributions. Some particular themes emerged in most groups; others themes were elaborated by one or two. However there seemed to be an overall consistency about the fears and hopes, expressed through a richness of ideas.

1. Blame

Everyone seemed to feel blamed! Social Workers felt blamed by Foster Carers, who felt blamed by social workers; everyone felt blamed by managers who felt blamed by everyone; health workers did not do enough to satisfy social service workers or education, and social services felt that CAMHS did not pull their full weight; carers felt blamed by the Looked After children and adolescents, who felt blamed for their problems and behaviour, etc. etc..

Everyone present seemed to also be aware of the enormous difficulty of the work for everyone, no matter where they were in the system. So, although there was an understanding that things could and did go wrong, nevertheless there was a sense that it was somebody's fault, and the feeling that everyone blamed *you* for what went wrong. It was as if everyone was imbued with guilt that these children had suffered abuse or neglect.

The only ones who did not get apportioned blame in this conference were the perpetrators of the abuse or neglect. It was as if it was too dangerous to touch that topic. We wondered if it was easier to work with families if the sense of blame could be projected into professional colleagues. Then the worker might feel freer to offer professional understanding and compassion to the perpetrators.

We were aware of how difficult it is to maintain professional creativity and pride in an atmosphere of blame and shame.

2. Blame, shame and difficulty post-Climbie

What was mentioned rarely, but seemed to be omnipresent in the background was the awareness of the trauma of the Victoria Climbie case and its aftermath in Haringey. Workers complained of a culture of working in crisis and with crisis:

<p><i>"Haringey doesn't plan anymore"; "Nothing has changed"</i></p>
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Participants conveyed a sense that they were criticised for doing too much or for not doing enough. There was a general feeling of not being able to get it right.

3. Lack of communication between groups

This was a recurrent theme. But someone else was seen as having responsibility for communication. Other groups were blamed for not communicating, and it was hard to look at one's own contribution to the difficulty. Tales of frustration about foiled attempts to get information were told. Again, every part of the system seemed to be involved in this. But the expectation was that someone else should put the situation right, probably the managers.

We found ourselves wondering if the system of care, with so many teams working independently on their own contribution, aided or hindered easy communication between groups. This is not helped by the two dominant organisations, Health and Social Services, having such different cultures and organisational systems.

4. Desire for communication between groups

By contrast to this, all groups conveyed pleasure in actually being involved in something together, and requested more events like the conference where they could get together to talk about their work, and hear the different perspectives of different working groups of professionals. The conference ended with a positive atmosphere, a sense that it is possible for professionals to connect with each other and with the children.

Within the conference, workers pondered on the difficulty of working together to translate the concept of corporate parenting into something that is meaningful for a child in the care of a local authority.

5. Helplessness, powerlessness and impotence

This theme is linked to, but is separate from the theme of blame. Many workers conveyed this sense of helplessness in the face of a system that they disliked but could not change.

Many did not seem to fully understand the working of the complicated system of care with all the interconnecting groups and teams who might be involved in the care of any one child. There was a feeling that their contribution was diminished.

In one group, no doubt expressing a feeling common to all the other groups, there was a sense that every person in the group felt overwhelmed by the degree of need that they faced, and their sense of powerlessness to make a real difference to the children's lives.

"All the different workers want to help, but despite this we fail, because no one person has ultimate responsibility."

One theme was the helplessness evoked by the system; another was the sense of frustration and powerlessness experienced in the face of the "destructiveness" of some of the young people. But there was a general sense nevertheless of the importance of consistency and continuity.

"It's very important to stick with them through the good and the bad."

We were aware of how difficult this can be in a context of violent and destructive acting out; the repeated stories of staff turnover attest to this difficulty.

6. Acknowledgement of contributions

This should be mentioned, although the sense of blame was more powerful on the day than appreciation. Nevertheless there were examples where people and services were praised.

“The work of the foster carers is the essential underpinning to the success of the work of the other professionals and the child’s future.”

“The Adolescent Outreach Team is a good example of multidisciplinary work even when there are huge amounts of anxiety.”

7. Feeling unappreciated/unheard

Workers and carers feelings about this echoed the views expressed by the young people themselves. A foster carer spoke of his requests for support and how he did not received a response. There was awareness of the knock-on effects of this:

“Workers are not valued, this affects the children.”

Lack of recognition from managers was cited as a factor in demoralisation and resignation. There was a dominant theme – “Whatever people do it is never quite enough.”

Some conference members commented on the video, that the young people did not describe needing/wanting anything that cost financially. We wondered whether this too expressed something on behalf the staff: the atmosphere was of a group who could recognise the difficulties of lack of resources, but who wanted something less concrete, that recognised their emotional needs as workers and people.

8. Pain

Throughout the day, the difficulty of the work came across. Dealing with these young people had its price for the workers, who often seemed to feel alone with the painfulness of their experience. Most feel overwhelmed by the multitude of emotional needs that the young people present as a consequence of being in care. The plea of the young people in the video was, “Care for us”. It seemed clear to us that the workers, in their various roles, did care. There was a wish to look after the children better, but a feeling of being unable to do so. There was a general sense of disappointment that their care, at times anyway, did not make anything better for the looked-after child.

“I feel I’m part of the abuse as well, because what we do is so unfair on the child.”

The majority of the participants were moved by the video, but it was agreed that it was very painful to put oneself in the place of the child, as their grief, loss and sadness is enormous. People spoke of different strategies they used to help them survive: cutting off emotionally, using professional procedures to maintain emotional distance, and in some case workers resorting to leaving their post.

Many young people were described as feeling they are unworthy of love; they come into a placement fearing that this unworthiness will be discovered and they will be rejected by the carers, so they sabotage the placement first.

We were aware of the difficulty of working without opportunities for a sense of satisfaction, achievement and a job well done. But it is very difficult in this work – protecting a child may mean bringing him into care, which is painful for all involved, and mitigates the satisfaction related to the protection.

We thought that an additional aspect of the pain was the disappointment with themselves that staff carried because they came into the work with brave aspirations they felt that they had failed to achieve.

9. Anger

There was much less expression of this than might be expected in circumstances where the conference members were expressing some of the themes we are describing here. One example discussed was the anger evoked when a Guardian “ordered” a foster carer to braid a child’s hair every week, irrespective of cost or the child’s wishes. Perhaps this example expressed something about the sense of confusion about who is in charge of the care of the child, and what responsibilities, about what level of care, reside where in the complicated system.

10. Retention of staff

There was general recognition of the complaint made by the adolescents in the video that there was a big turn-over of social work staff. This led a School Nurse to ask, “Why *do* social workers leave?” The Social Worker replied, “Because the pain is too much.”

We wondered about the kind of support systems that might be necessary to contain staff, at all levels of the organisation including management, doing this form of work.

11. Fragmentation and disruption

Social workers spoke sadly of their relationships with the children breaking down – the other side of the coin from the young people’s complaints about not being able to retain their social workers. There seemed to be a theme of “broken experiences”, whether with the children or between professionals.

There was a recognition that many of these young people are already quite damaged by the time that they end up in care, but that the way the services are organised, especially the discontinuities in care caused by the frequent changes in social workers and placement changes, can cause further damage. Many thought there was nothing which could be done to avoid this, no doubt influenced by their sense of helplessness described elsewhere.

“It seems as soon as the young person begins to settle into a placement and a shift in their behaviour occurs, they have to move on.”

12. Tensions between different irreconcilable needs/views

A number of irreconcilable demands were noted, e.g. on the one hand the openness in the system and the rights of children to be at their care meetings, and on the other hand, the unfairness of this on the young people, their lack of privacy, and the disturbing nature of the meetings for them.

We thought that this irreconcilable tension would get inside the workers, making the whole process of thinking about the child more uncomfortable and ultimately unrewarding for them, contributing, possibly, to staff turn-over.

Other types of differing viewpoints were raised as problematic: e.g. the view of the child who feels she was never told of a proposed move and the view of the social worker who felt it had been on the table for months. How might it be possible to hear the truth in both of these versions, so each teller feels heard, and neither is told, “You got it wrong”? Again, we

thought that this might be very problematic for staff, who so often feel blamed and feel a need to defend themselves.

13. Some ideas for the future

One group thought that the reorganisation of Children's Services in 2005 offered an ideal opportunity to pilot some of the multidisciplinary approaches.

"The next step is to find a way for professionals from different services to work together that could be recognised institutionally."

The model of working on a case together was suggested, or finding mechanisms for people to meet with other appropriate objectives.

"Whatever model is agreed it must have at its centre the child, his or her social worker, and the foster carer or residential social worker. It would also protect the child from having to interact with large numbers of adults in a relatively tangential way."

5.1 The emotional context for the work²¹

The Tavistock/Haringey LACA CAMHS team offers therapy to Haringey looked after children and adolescents and a therapeutic consultation service to carers, schools, residential homes and staff from other agencies. Much of the work of this team involves offering advice and support on how to manage the trauma and distress experienced by looked after children.

Looked after children and adolescents are very different from other children as the loss of not being cared for by a birth parent remains with them long after the original move into care. It needs to be borne in mind, that whilst children may present with behavioural problems, they are often experiencing severe trauma due to the loss they experience coming into care or becoming a refugee.

Dealing with the emotional impact of the loss of birth parents remains a need throughout the life of a looked after child. Some of the effects emerge much later and often continue into adulthood.

Moving the child into care is not a solution. Before coming into care, they will have experienced dysfunctional parenting and possibly abuse. Entering care reinforces feelings of rejection and anger and exacerbates pre-existing attachment disorders. Such feelings are further compounded by placement disruptions.

Residential social workers have expressed despair at seeing children and adolescents moved from place to place and talked about the feelings of failure evoked in them as carers. They have also talked about feeling driven by challenging behaviour to 'manage' situations, rather than address the emotional needs of the child.

Entering care is, in itself, also traumatic. Not enough recognition is given to the fact that it is very bizarre for a child to have to learn to live with strangers. As professionals we can become desensitised to how traumatic this must be for the child. For unaccompanied minors, these problems are compounded by language and cultural barriers – there is a real issue of 'aculturalisation'.

The level of distress and disturbance is extreme and the pain for professionals can be unbearable. This can lead to denial about the extent of damage and disruption. It may be too painful for carers to accept that the child is not like other children of the same age and they may try to relate to the child as though they were less damaged than they are.

Training and supervision for carers is essential. They need psycho-educational work to develop understanding of the emotional needs of looked after children – including space to reflect on their own childhoods and experiences of parenting and the way in which the child's disturbance may provoke their own vulnerabilities.

²¹ This section is based on the focus group undertaken with the Tavistock/Haringey LACA CAMHS team.

Professional staff may hide defensively behind the ‘cloak’ of their profession to avoid becoming too involved in other aspects of the child’s care. They can dis-empower each other as professionals. Denying their own expertise and knowledge, they can also believe that they need to refer the child to another agency.

More professionals can also be brought into the system as a way of deflecting unbearable pain – with the extent of fragmentation reflecting the level of disturbance. The more trauma a child is experiencing, the more chaotic and prone to risk they become. Additional people are introduced in an attempt to provide containment and “share the burden.” This leads to further fragmentation. In some cases, so many people are involved that communication between the professionals is lost.

Containment remains a major issue throughout the life of a looked after child. Corporate parenting is a paradoxical and irresolvable difficulty – an institution cannot be a parent. There is a need for a small group of professionals to meet consistently and thus become the ‘face of the corporate parent’.

Staff find it hard to admit how damaged these children can be, as this highlights the fact that some are too damaged to “fix”. Such feelings can also lead to unrealistic expectations about the CAMHS service, with the notion that psychotherapy can somehow produce miracles and ‘fix’ these children.

5.2 Working with networks

Work with networks is thus essential to any intervention with looked after children. Following referral, we generally convene a meeting with significant people in the network – carers, social workers, link workers and possibly others, such as educational staff and GALs. These meetings help clarify differences of view within the network and identify key areas that need to be addressed, including whether, when, where and in what context any therapeutic work might take place. Whilst therapeutic work is often offered to a child or young person individually, on occasion the intervention focuses primarily on professional consultations to social work staff.

“Heimi” was a highly disturbed young person, with a troubled placement history, an enmeshed and worrying relationship with his mother and an ambivalent relationship with his previously violent father. Following several consultations, it was agreed that there needed to be a thorough assessment of the young person and his parents, including addressing his welfare in relation to contact and needs for permanence and placement stability. It emerged that “Heimi” had been seen for some years by another specialist hospital and, following liaison, this team agreed to undertake the assessment. Whilst having no direct contact with the young person, members of the team played an active role in ‘unsticking’ an uncertain and conflictual situation and contributing to the development of a coherent plan to determine the young person’s needs. By re-engaging a team previously involved with “Heimi” the additional disturbance of his getting to know yet another series of professionals was avoided.

Work with these wider networks is also important for containing the inevitable anxieties aroused by this work. Conflicts and tensions within a case or family are often mirrored in the relationships amongst professionals. Professional staff may become split and get caught up in apportioning blame, such that it is difficult to work or think together. Creating a neutral space to explore these dynamics and to think together can be particularly helpful in these complex and, often fraught, situations.

5.3 Working with foster and residential carers

Work with foster and residential carers is also an essential component of work with looked after children and adolescents, with work in this area highlighting the following issues:

- Developing understanding and strategies for managing challenging and disturbed behaviour with children and young people.
- Coping with the impact of caring on the carer themselves and on their family.
- Helping carers to understand and talk with children about their thoughts, feelings and past experiences and about contacts with birth families.
- Processing feelings and experiences about children moving on and dealing with the aftermath of placement breakdowns.

In our experience many carers have a real desire to understand more about the emotional needs of the children in their care and are keen to develop their own skills and abilities. Some carers feel that behavioural management is the primary issue and this is an area where we can offer structured cognitive/behavioural strategies. However, another important aspect of the work is identifying the day-to-day things carers can do in terms of developing a language for feeling with the children they care for and thinking about and containing their anxieties. Thinking about underlying emotions and interactions between carers and children/young people is often harder to explore and an area that can naturally arouse anxiety and defensiveness amongst carers.

Work with kinship carers – including grandparents, older siblings and family friends who are caring for children – can raise particularly distressing and painful issues, as highlighted by the following example:

Work with an older sister “Mary” caring for her (much younger) half-sister “Susan” involved looking at behaviour management strategies, whilst also working to understand the meaning of “Susan’s” disturbing behaviour. We talked about the history with the birth mother and father, supporting “Mary” in helping the child to ask questions and begin to develop a story about why her parents had been unable to care for her. We explored with “Mary” patterns of caring in the birth family and her hopes and worries about trying to parent little “Susan”. We met with the social worker and link worker and supported “Mary’s” request for a respite carer. When “Mary”, herself still a very young woman, (19 or 20) ultimately felt she could not offer “Susan” a permanent home, we joined her in talking to the child. We continue to work with both the child and her older sister whilst a permanent placement is sought.

A small number of referrals have focused on processing the painful experiences associated with children moving on or the aftermath of breakdowns. This has proved particularly helpful – facilitating the carers’ understanding of such experiences, developing their resilience and thus also supporting their retention as foster carers.

One carer, “Ayesha” wanted to talk about her feelings of loss and anxiety about a baby, “Maya”, who had been with her since birth and was now moving on to permanency. “Ayesha” was churned up about how she and her family would experience the change and manage their feelings of loss and grief. We talked with “Ayesha” and her birth child, thinking together about the importance of the job they had done with the baby and about how helpful it was that “Maya” was so cared for by the family. Thinking about “Maya’s” future placement allayed their anxieties and provided some reassurance.

When seeing a child or young person for therapy, it is always important to work with the carers, as they have the opportunity to support the child and help them manage the feelings that may be churned up by therapeutic work. Such meetings provide space to think about and understand the, often powerful and disturbing, feelings that these children may evoke in their carers, thus also reducing the risk of enactment. Joint sessions for children and carers can be particularly helpful for exploring the relationship and communication between the child and carer and working together on behaviour and feelings. They also enable clinicians working with the child individually to gather information and a holistic sense of the child within their day-to-day context.

“Sonny”, a 7 year old boy, presented with sexualised and disruptive behaviour that had resulted in recurrent placement breakdowns. He was described as constantly restless and uncontrollable, with a possible diagnosis of ADHD. In a joint session with the foster carer and 2 therapists, “Sonny” started by drawing a picture of the world, as something very far away from him. He asked what kept the world together. The therapist wondered whether he was asking what held people and things together – what were the rules of the world? He looked thoughtful but said he didn’t like rules.

Later, “Sonny” said the world (pointing to his use of colour in his drawing) was white. The therapists commented on the fact that he and his carer were both black, whilst they were white. He next coloured the white part brown – and all present acknowledged, it was an important colour.

In contrast to his usual behaviour “Sonny” was very focused and alert for all of this session. At the end, he seemed exhausted and, hugging his foster carer, said he felt tired.

Inevitably, carers vary in their willingness and capacity to engage in this work. It is important to emphasise that this is not therapy, but rather an opportunity to support and think therapeutically about their work, the children they look after, and what this feels like (both for them and other family members). Occasionally carers are wary of such meetings. Others are less anxious and more comfortable about engaging in this work. Availability and time constraints can also limit the carer’s engagement in this process.

Residential staff have an important role to play in supporting therapeutic interventions. Key workers may bring the young person to therapy. On occasion they have joined the therapy session with us, when the child/young person has felt very anxious or preferred this. Such joint work can be immensely important in bridging the gap between therapy and the child’s day-to-day life. Liaison between therapists and residential staff is also crucial – providing staff with some awareness of the general progress of the therapy and therapists with information about the young person’s day-to-day issues. As well as supporting the young person’s engagement in and use of therapy, such liaison encourages and acknowledges the residential workers’ understanding of the young people and their development of therapeutic skills.

5.4 Clinical work with children and young people

The therapeutic and clinical needs of looked after children and young people is at the core of the work undertaken by members of the team. Thus, whilst our work encompasses a range of direct and indirect interventions with staff from the various agencies concerned with Haringey’s LAC population, our primary focus throughout is on interventions to improve the emotional well being of looked after children. The following is an example where the foster carer was helped to understand problematic behaviour in her foster child:

“Louis”, an 11 year old boy, had been born prematurely with a heart problem and spent much of his early months in hospital. He had been in the same long term foster placement since he was 2 / 3 years and the plan was for him to remain there. However, he presented with various problems. He had learning difficulties, linked to an inability to concentrate. He was very fearful – frightened of injections, of getting his hair cut and so on. Whilst the foster mother felt she knew “Louis” well, she also felt he was, in part, a stranger to her. In one session, it emerged that “Louis” had been unable to ‘get’ the letter ‘a’. He had learnt all the other letters (‘b’ to ‘z’), but not ‘a’ and, of course, this made it impossible to read. The therapist talked about whether the missing ‘a’ somehow represented his missing early months and the months the foster carer also did not know. They also talked about whether his many fears might relate to his early months in an intensive care unit.

Refugee children: A number of refugee children have been referred to the project. These have ranged in age from 6 to 16 years. Half these referrals have focused on the assessment and suitability of kinship carers. The others have all involved separated children (unaccompanied minors), with emphasis being directed to the psychological distress caused by losses and traumatic experiences. In some cases, young people have reported symptoms associated with exposure to traumatic experiences, such as nightmares, flashbacks and depression. In other cases, such experiences have contributed to other difficulties, such as repeated placement disruptions or an inability to settle into school or college.

“Carl”, a 13-year old Kosovan Albanian, was an unaccompanied minor who had recently arrived in this country. Little was known about his background. He seemed unable to provide much information to enable professionals to formulate a confident assessment of his needs. Some of this related to his highly confused, fragile and disturbed psychological state; but he was also wary about who he could trust in a foreign country, where he barely spoke the language and had no understanding of professional roles and the system he was now within.

“Carl’s” disturbed behaviour had already led to 2 foster-placement disruptions and, during the 9 months he attended therapy, there were 2 further disruptions. There were no foster-carers in Kosova and he did not know how to relate to foster-carers. He found the enormous pain of coping with so many losses in his life and the uncertainty of not knowing whether any family members were still alive in Kosova very difficult to bear and also very difficult to face and talk about. Whilst he remained unsettled, during the course of therapy, he became less fragile and anxious, more able to cope with his external situation and to talk about plans for his future.

Work with refugee children – particularly separated refugee children – has highlighted their enormous emotional and social vulnerability. There needs to be much greater awareness amongst professionals, including foster-carers, of the considerable traumas/losses these children have experienced and the effects on their psychological well-being. The loss of their culture, which gives them a sense of ‘who they are’, should not be underestimated. Where there is uncertainty about whether family members are alive or not, efforts need to be made to trace them, through the appropriate agencies.

The social worker has a vital role, in being willing to listen to the young person. Often this can be a very difficult task and, in the face of these children’s narratives of cruelty and violence, it may feel easier to pass this task to another professional. The social worker also has an important function in providing the young person with support and advice, and

ensuring that they have proper access to health care, for their physical, mental health and educational needs; and where necessary, appropriate legal advice.

In the case of separated refugee children there is no one who holds parental responsibility and, because of their experiences, lack of language, or knowledge about the system, they are a group who need help to communicate their wishes and feelings clearly, perhaps by the appointment of independent advocates. The need for these children to be provided with a sense of 'belonging', even when their legal status in this country remains undetermined, is very important.

5.5 Work with Haringey's residential homes

Given the distressing and demanding nature of the work with looked after children and adolescents, it is often helpful for staff teams to have the opportunity for external sources of support and consultation. As part of the contract with Haringey Social Services, it was thus agreed to offer a programme of organisational consultancy to the two in-house children's residential homes – Haringey Park and Muswell House – to focus on the following issues:

- To ensure the units accommodated young people to their fullest capacity
- To facilitate a reduction in placement breakdowns
- To develop skills in managing change and understanding the change process

Muswell House: In the work with Muswell House, the focus has been on the management of change, given the impending shift from a younger age group (8 to 12 years) to an adolescent intake (12 to 16 years). The work involved role consultancy with the unit manager, meetings with the management team and team building with the whole staff team.

Haringey Park: Within Haringey Park, the main objectives were improving and enhancing the functioning of the staff group, paying particular attention to team dynamics. The initial focus for work was on developing and strengthening the management team, before working with the staff group.

Future needs: Staff in both units have responded well to the consultation work and spoken of its benefits. The success of this work has also suggested its potential benefits for other staff groups.

5.6 Training

Requests for training have also highlighted a range of needs amongst professional staff. Thus, over the past year, members of the LACA CAMHS team have provided a range of support groups and training sessions to staff from different agencies within Haringey. In some cases, these sessions have been undertaken within the LACA CAMHS existing budget. In other cases, they have been funded extra-contractually. Whilst throughout focusing on the emotional needs of looked after children, the specification for each course has been determined by the particular needs of each section or agency.

Social Workers: Staff from the Asylum team, Fostering and Adoption team, Youth Offending Service, Children & Families teams and the Leaving Care team requested a three day training programme on 'Child Development and Emotional Deprivation'. Attendance

was good and the feedback very positive – however, it was acknowledged that there was a lot to cover in the available time and a request for the opportunity for more discussion.

Residential Staff: Over the last 6 months, members of the LACA CAMHS team have delivered ongoing training to staff at Muswell House Children’s Home. The initial training was intended to prepare them for the impending change to an adolescent intake. It aimed to: ‘Give them knowledge, confidence and a measure of security in dealing with adolescents and to help bridge the gap between this new intake and the younger age of their previous residents’. The course included the impact of early childhood on adolescence, neuro-biological influences and attachment research. The feedback was positive and the staff requested further half-day workshops. They have also consistently requested ongoing clinical discussion.

Foster Carers: Training activities with foster carers have focused on the emotional needs of looked after children and adolescents and the particular needs of refugee children. We have also offered foster carers training on promoting the emotional well-being of children and young people.

Asylum teams: The Asylum teams were offered a 5-session training programme by a multi-disciplinary team of professionals from the Tavistock Clinic. This programme aimed to raise awareness of the vulnerability of this group of children and young people, given the context in which most of them come to this country, and to improve understanding of their mental health needs, taking into account the significance of race and culture.

Summary and conclusion: Unmet needs

In this chapter, we have described the types of clinical and consultative work undertaken by members of the Tavistock/Haringey LACA CAMHS team – with emphasis placed on work with carers and professionals as much as with looked after children and young people. Our hope is that this chapter will contribute to a greater understanding of the range of work undertaken by members of the team.

In concluding, it is important to acknowledge the restrictions placed on the team’s activities by its limited size and resources. Whilst every effort has been (and will continue to be) made to offer a responsive and flexible service, there have been occasions when requests have severely stretched – or even exceeded – our capacity. The following provides some examples:

1. The referral of a family of 4 children (in 3 placements) – all presenting with serious mental health needs – at one stage involved almost every member of our team. The clinical interventions offered to this family were inevitably informed by our capacity to respond (rather than solely by the level of clinical need). The more recent referral of a family of 5 children has presented similar challenges – with emphasis placed on offering consultations to the social workers and other key staff (rather than direct work with the children).
2. There have been several referrals of looked after children and young people placed outside London – often where local mental health resources are limited or involve a lengthy waiting period. Whilst we have offered assessment appointments for some of these children and young people (generally at the Tavistock Clinic), any longer term work is obviously unrealistic.

3. Looked after children and young people in court proceedings have raised particular difficulties. We are not in a position to undertake assessments for the court, but have been prepared to offer therapeutic support to children and young people in proceedings. Whilst, in a few situations, this has presented no difficulties, more commonly, there has been a potential for some confusion and difficulty, with requests for information being dictated by court directives.
4. The limited size of the team inevitably restricts the range of therapeutic provision. Work with LACA and their carers ideally requires therapeutic diversity – including, for example, psycho-educational and cognitive/behavioural – as well as psychotherapeutic modalities. As discussed in the final chapter, we would like to be in a position to extend the range of therapeutic services offered by the team.
5. Finally, this report would confirm the need for increased consultation and training for primary care workers and, whilst we have undertaken some limited work to support tier 1 staff, these have generally been funded extra-contractually. We have also had to refuse some requests. Ideally, we would like to be able to offer this work as part of our primary activity.

CHAPTER 6: RECOMMENDATIONS:

Looking to the Future

At least sit down and listen them and try to work them out, they want it, you know, those kids in care do want to be heard. (Mehmet).

6.1 Summarising the needs assessment process

This report describes an unusual and innovative approach to assessing the emotional needs of looked after children and their carers – with the objective, fact gathering, voice of policy makers and researchers being set alongside the subjective voice of young people, foster carers, social workers and other professionals. The process has been complex – combining different methodologies, drawing on the skills and experiences of staff from specialist agencies and throughout being intended as an interventional, as much as a solely fact gathering, project. Thus, whilst the statistics, definitions and policy framework (chapter 2) establish the objective boundary and framework for this assessment, the video, focus groups and conference materials (chapters 1, 3 and 4) vividly relate the subjective perceptions and experiences of all involved – with the conference providing an opportunity for bridging institutional boundaries and beginning a process of dialogue contextualised by the powerful experiences of looked after young people.

However, whilst representing the end-point of this particular intervention, the conference report highlights the extent to which this is only the beginning of a necessarily ongoing process of communication and integration and one which needs to prioritise – not only the emotional well-being of looked after children and young people – but also those of the carers and workers involved in this work. Where the facts and figures provide an apparently rational and ordered framework for identifying need – the video, focus groups and conference reports reveal the intensely turbulent and distressing feelings of all involved, with the repeated trauma and pain of the children and young people seemingly reverberating through the system and impacting on the policies and structures, as much as the practices, of different professionals and staff groups. Thus, underlying the varying comments and complaints of different staff groups what we ultimately witnessed was – not only the distress – but also the commitment of staff to looked after children and young people and to the process of engaging in change.

This final chapter brings together and summarises the key findings of this report, as the basis for a series of recommendations.

6.2 Key findings

The video of Haringey's looked after young people powerfully highlighted not only the distress and trauma of looked after children and young people, but also their desire to be listened to and heard. To be fully appreciated this video needs to be seen and discussed.

Entering care:

Is generally predicated on prior experiences of abuse
Necessarily involves feelings of rejection and abandonment
And involves moving to live with strangers

Being fostered:

Needs to be predicated on love, not money
Interest and commitment make a significant difference

Repeated losses and placement disruptions:

Create a loss of trust and of self-respect
That can result in challenging, including criminal, behaviours

Social workers:

Play an extremely important role in the life of looked after children
Frequent changes of social workers cause disruption and undermine trust
The involvement of too many professionals compounds these difficulties

Therapy:

Can be distressing and painful
Takes a long time to get used to, but can be very helpful

Quantitative findings: The facts and figures

The gap between provision and need for the mental health needs of looked after children and adolescents is a national (rather than solely local) problem, however difficulties in Haringey have been compounded by:

- Demographic features – including, the diversity of the population and relatively high numbers of refugee and asylum seeking children
- Placement characteristics – including the high level of placement disruptions
- The historically low level of CAMHS provision for LACA

The needs assessment exercise identified a significant shortfall in the provision of CAHMS services to support primary care workers in offering tier 1 provision or to enable a sufficient (and sufficiently diverse) response to the 203 LACA requiring tier 2 or 3 services.

Level of need:

- 344 LACA with mild emotional or behavioural difficulties requiring Tier 1 provision
- 161 LACA with common disorders requiring Tier 2 provision
- 44 LACA with more severe, complex or persistent conditions requiring Tier 3/4 provision

Referrals to Tavistock/ Haringey LACA CAMHS team:

- 88 referrals between May 2003 and August 2004
- Giving an annual average of 66 referrals
- Various requests for consultation and training, not all of which could be met

Qualitative findings: feedback from the focus groups and conference

Resources

Whilst this harsh short-fall in resources is real and provides the context for many of the difficulties and complaints raised by both young people and stakeholders, we argue that feelings about resources, particularly money, also symbolise the impossibility of the work and the insatiable needs which resources alone cannot meet (see chapters 3 & 4).

The ongoing impact of Victoria Climbié

Although often unspoken, the other harsh reality that we felt pervaded both the focus groups and conference was the ongoing impact of the death of Victoria Climbié. Part of the impact of this is that everyone feels blamed; a sense of being criticised for doing too much or for not doing enough - a general feeling among workers of not being able to get it right.

Splitting between teams

We argue that this culture of blame and criticism mirrors the side taking and wars within the families of origin of looked after children and young people. However, it also creates a splitting between different teams that was particularly evident from working across so many teams in the focus groups.

Fragmentation

The vast array of professionals and agencies also fragments care and adds to the potential for splitting. Many staff did not fully understand the working of the complicated system of care with all the interconnecting groups and teams. Facts and fantasy seem to get mixed up. Communication is a problem throughout the system. Lack of containment within the system also contributes to fragmentation. Ultimately, we wondered whether the system of care, with so many teams working independently, aided or hindered easy communication between groups.

Helplessness, powerlessness and impotence

Many of these difficulties were acknowledged and cited, not only by the young people but also by staff at all levels in the system. Powerlessness to influence the system was mirrored by helplessness in relation to the multitude of emotional needs that the young people present.

Pain

Dealing with these young people has its price for workers. The plea of the young people in the video was, "Care for us". It seemed clear that the workers did care. There was a wish to look after the children better, but a feeling of being unable to do so and a sense of disappointment that their care, at times, did not make anything better. We wondered what kind of support systems might be necessary to contain staff, at all levels of the organisation including management, doing this form of work?

Mental health issues

Thus, both the focus groups and conference confirmed not only the high level of need, but also the lack of adequate resources to meet the mental health needs of looked after children and young people and support the carers and staff involved.

Ideas for the future

Finally, there was some – if muted – optimism about future possibilities. At the conference, all groups conveyed pleasure in being involved in something together, and the conference

ended with a positive atmosphere, a sense that it is possible for professionals to connect with each other and with the children.

6.3 Recommendations

In reporting our findings, we hope we have done justice to the thoughtful and wide-ranging discussions that took place in both focus groups and the conference. Translating these findings into recommendations has proved testing – particularly given the broader context of structural changes consequent on the Children’s Bill. However, this context could also provide an opportunity for incorporating within the new structures some of the key themes raised by the various stakeholders. We have organised these themes around 3 key principles which we argue should underpin the looked after system. We also argue that this project has highlighted the need for stakeholder involvement in the planning – as much as in the implementation – of any process of change.

In the following, the 3 key principles are outlined – as the basis for a series of recommendations that span not only the LACA CAMHS team, but also broader aspects of the looked after system. We also address the need for follow-up work and for a comprehensive dissemination both of this report and of the video of Haringey’s looked after young people.

Key principles

1. Supporting Looked After Children and Young People’s emotional well-being

And, in order to do this:

- 2. Supporting workers and carers in providing care**
- 3. Strengthening the system: integration and containment through process and structure**

Whilst informed by all the components of this research, these 3 key principles ultimately derive from careful analysis of the voice of the stakeholders – the video of young people and the focus groups and conference discussions. What we heard throughout was a high level of concern about the pain and distress of all those involved in the looked after system – not only the children and young people, but also the carers and the staff from the many specialist agencies. Reverberating around the system, these feelings contributed to intense anxieties about blame and to the fragmentation and splitting between different parts of the system that was particularly evidenced within the focus groups. Some of these feelings would seem inevitable, given the nature of this work. However, we feel that the convergence of publication of this report with the imminent re-structuring of children’s services permits a unique opportunity to frame services in a way that might reduce fragmentation and provide increased containment to staff at all levels within the system.

In the following these principles are applied:

- firstly, to proposals for the development of the LACA CAMHS team,
- secondly, to proposals for developing other parts of the looked after system since the findings suggest that it is important to consider further interventions,
- and thirdly, to proposals for follow-up and dissemination of this report and the video.

Developing the LACA CAMHS team

This needs assessment report has identified a significant shortfall in provision for the mental health needs of looked after children and for the support/ consultation needs of carers and staff – with the evidence from the statistical research being repeatedly confirmed within the focus groups and conference discussions. We therefore recommend the following:

Structural Recommendations:

1. Supporting Haringey's Looked After Children and Young People's emotional well-being will continue to require a specialist LACA CAMHS service. The complexity of need and of external circumstance amongst LACA and their difficulties in accessing universal CAMHS services has been well evidenced both locally and nationally.
2. To provide a robust and responsive service that can combine offering support to primary care workers (tier 1) with direct services for LACA with mental health disorders (tier 2/3), the LACA CAMHS service needs to be increased and diversified – to include child and adolescent psychiatry, child psychotherapy, family therapy, CPN, psychology, social worker with mental health training. We recommend that all workers should have a specialist training and/or interest in working with looked after children and adolescents, and in offering consultation to carers and staff.
3. We recommend that the current service should be increased by 150% (at the least). Our current LACA CAMHS team offers a service to 17% of the LACA population. The recommended increase would bring the service to 42%. With the additional service provided by the St Ann's team, particularly the AOT this would bring service provision closer to the 67% prevalence rate of mental health need. (See Chapter 2.)
4. Integration with other services is critical. It is recommended that the new Senior Practitioners (Mental Health) be partially located within the LACA CAMHS team and that, reciprocally, (within the limits of our resources) each LACA CAMHS worker be attached to a particular children's team for at least 1 session. This would facilitate mutual training across services and permit joint assessments and joint working. It would also help reduce splitting and projection across teams.
5. It is also recommended that close links be maintained with other Haringey CAMHS teams particularly the AOT – including involvement in relevant management and referral meetings. The current practice of employing some joint staff between the St Ann's and LACA CAMHS team has provided a useful mechanism for linking and integrating services and, if possible, should be encouraged and extended to other Haringey CAMHS services.
6. Clarity regarding lines of accountability and managerial responsibility is also essential. Funding for the Tavistock/Haringey LACA CAMHS team needs to be clearly allocated to the team – as do managerial responsibilities. Ideally, any additional discipline/clinical supervisory arrangements should be located within the service that is holding the managerial Lead. At the moment this is the Tavistock Clinic.

Service Recommendations:

1. Increased diversity within the staff group would enable the LACA CAMHS team to extend the range of services provided both to LACA and to workers and carers, to include, for example:
 - i) Parenting programmes, such as the Webster-Stratton groups or those for parents/carers of troubled adolescents.
 - ii) Incorporating aspects of the Treatment Foster Care programme to support carers in taking more problematic young people.

- iii) Extending the range of therapies and types of intervention for LACA – for example, short term supportive and behavioural interventions and play therapy, alongside psychotherapy.
 - iv) Providing earlier interventions to avoid placement breakdowns and developing an early screening programme. (See also below.)
2. A larger team would increase accessibility of and to the team:
 - v) It would be possible to provide more outreach facilities – for example, to the Leaving Care team and other disadvantaged groups
 - vi) It would also be possible to provide CAMHS consultation to placement panels, adoption and fostering panels and other meetings where difficult decisions are being made about children.
 3. Further thought needs to be given to ways of meeting the mental health needs of various disadvantaged LACA, including:
 - a. Those in court proceedings – given the potential for confusion between the role of the expert witness and the mental health specialist.
 - b. Those in impermanent or out-of-borough placements – particularly where there is some difficulty in accessing local services.
 - c. Those with additional needs – such as, learning difficulties or organic problems and those known to the YOT.

Reducing placement breakdowns:

Service recommendations:

1. Closer involvement of CAMHS workers throughout the selection, assessment and engagement of foster carers.
2. Involving CAMHS staff in assessment and training to improve subsequent take-up of CAMHS support in the event of difficulties.
3. Developing more complex matching criteria. The proposed research into foster parent attachment patterns is intended to facilitate both matching and post-placement support services.
4. Involving CAMHS workers in the matching processes – for example, through membership of relevant adoption and fostering and/or placement panels and through their availability to advise social workers on specific issues.
5. Involving CAMHS in post-placement support for foster carers – with a CAMHS assessment being made an integral component of every new placement.
6. Providing accessible support to foster carers on, for example, ways of handling particular behaviours. This could be available through a range of methods such as a telephone help-line and regular CAMHS in-put to carers meetings.
7. Intervening sooner to avoid placement breakdowns by referral to the CAMHS service for work with LACA and/or carers or foster family.
8. Developing the treatment foster care initiative to establish foster carers who could provide respite care for other foster carers or residential homes.

Developmental/ consultancy recommendations:

There is evidence from the focus groups, LACA CAMHS team and conference of a culture of disruption across both foster and residential care settings. In addition to the service recommendations outlined above, we therefore think there is a need for a specific consultancy/ training initiative. To some extent this has been piloted in the residential sector,

where the consultant has used some sessions to work with both homes to map placement moves with specific young people and to consider what steps might have been taken to reduce these disruptions. This model could be extended to include residential and foster carers together with their supervising social workers – with, for example, half day workshops permitting a combination of training and work discussions specifically focused on placement moves and disruptions.

Developing other parts of the looked after children system:

Supporting Looked After Children and Young People’s emotional well-being:

We suggest consideration be given to the following:

1. Establishing a smaller network of professionals and carers working directly with the child, thus providing a more integrated service with a limited number of people involved, so that LACA can relate to them and they can effectively work together. This would mean fewer workers providing more of the care; mirroring effective parenting and making the care environment more like a family.
2. Given the very high turnover of social workers and the high rate of placement breakdowns, measures are put in place to try to provide LACA with a consistent adult figure throughout their care. One suggestion was for children to have an outside visitor who moved with them through their time in care.
3. Greater attention is paid to the information that LACA get, so that they automatically get sufficient, timely and accessible information about themselves, plans for their care, their options and where to get further and specific support.
4. All those involved with LACA need to pay attention to emotional well-being – such that, identifying emotional well-being is a prioritised part of assessments, reviews and other progress reports undertaken by professionals (including, social workers, carers, health professionals, teachers, youth offending team, etc.).

Supporting workers and carers in providing care

We suggest consideration be given to the following measures – all of which might also help reduce staff turnover and sickness rates:

1. Education and training:
 - i) For all professionals and carers in child and adolescent development and mental health to address ways in which their role can contribute to children and adolescents’ emotional well-being.
 - ii) Creating some common information about the system, the different agencies and roles within it and some common training and development programmes delivered across agencies and disciplines, would also promote integration.
 - iii) For social workers, retention might be aided by the integration of post-qualifying training into contracts. Such training could be specifically devised to focus on the needs of LACA and their carers.
2. Clinical supervision and staff support:
 - a. For social workers and other staff in other agencies. This would also provide opportunities for encouraging workers – particularly those at the front line – to acknowledge feelings and difficulties and learn from mistakes.

- b. Having regular meetings for teams focusing on process issues (unconscious as well as conscious), providing opportunities to consider what is happening in and for the team, to disentangle fact from fantasy, explore the impact of the work, and issues such as role and the use of authority.
3. Policy and procedures:
 - i) Reviewing the allocation of work (and work loads), so that district social workers have the chance to include the more rewarding aspects of the work, such as life story work, which also enhances children's emotional well-being.
 - ii) Developing a more empowering culture where professional judgement can be used and risk owned. This means supporting managers to relinquish some control when the demands on them from government lean in the opposite direction (i.e. greater control, blame when anything goes wrong etc.) and allowing for mistakes, so that people do not feel they have to cover up.

Strengthening the system

We suggest consideration is given to integration and containment through both structure and process:

In thinking about structure, we suggest that it would be helpful to consider ways of promoting integration of disparate groups and mitigate against the inevitable tendency to mirror dysfunctional, fragmented warring families and disturbance:

- i) One way of doing this might be to create central groups, such as groups of practitioners from different agencies, with different roles, meeting to develop specific practice. In particular these groups could focus on questions of corporate parenting and on developing a model for practice that reduces the numbers of staff involved.
- ii) Creating greater links between different parts of the system, and considering ways of enhancing transition between parts. For example, could policies from long-term teams and Leaving Care be harmonised?
- iii) Strengthening procedures within the structure for communicating facts and looking at ways of helping the system to distinguish between fact and fantasy (including about different services/agencies within the system).
- iv) Working with the effects of structure: having regular meetings across services providing opportunities to disentangle fact from fantasy, to increase communication and understanding and so reduce blame and splitting. These multi-agency/ disciplinary meetings would have the task of keeping the whole system in mind seeing the parts of the system in relation to the whole – what each part formally contributes, what they represent and hold (consciously and unconsciously) for the system – and to think about ways of improving the effectiveness of the system in its task of providing for LACA.

Disseminating the video and this report

Given the richness of the video, focus groups and conference materials, we think it important to carefully address questions of dissemination:

1. Thus far, the video has only been seen by limited groups of staff – those who attended the conference and a few interagency groups. We think it important that it receives far greater exposure – including being borne in mind by those responsible for the restructuring (obviously with appropriate care in relation to confidentiality).
2. In order to build on the work of this Needs Assessment and interest it has generated, the findings of this report more generally need a wide dissemination – not only to those who participated in the focus groups and/or conference – but also to staff at all levels within the looked after children network. One way of doing this would be to have a dissemination conference. This in itself would be an additional intervention to take the work forward.

A final word: A Needs Assessment is, by definition, the beginning of a process. We are hopeful that Haringey will continue to develop this course of action.

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APPENDIX 2: REFERENCES:

- Aldous et al (1999): *Refugee Health in London: Key Issues for Public Health*, Health of Londoners Project.
- Butler, J & Vostanis, P. (1998): 'Characteristics of referrals to a mental health service for young people in care', *Psychiatric Bulletin*, 22: 85-87.
- Dimigen, G., Del Priore, C., Butler, S., Evans, S., Ferguson, L. & Swan, M. (1999): 'Psychiatric disorder among children at time of entering local authority care: questionnaire survey', *British Medical Journal*, 319: 675-675.
- Health Advisory Service (1995): *Child and Adolescent Mental Health Services: Together We Stand*. London: HMSO
- Hodes, M. (2002): 'Implications for psychiatric services of chronic civilian strife: young refugees in the UK', *Advances in Psychiatric Treatment*, Vol. 8, pp. 366-376.
- James, C. (2000): *Report on Child Mental Health in the Looked After Population of the London Borough of Lewisham*.
- Kurtz, Z. (1992): *With Health in Mind*. Action for Sick Children/ South West Regional Health Authority
- McCann, J.B., James, A., Wilson, S. & Dunn, G. (1996): 'Prevalence of psychiatric disorder in young people in the care system', *British Medical Journal*, 313: 1529-1530.
- Main, T. (1957): 'The Ailment' *Address to Medical Section, British Psychological Society*. Published in: Main, T., (1989) *The Ailment and Other Psychoanalytic Essays* Edited by Johns, J., Free Association Books
- Meltzer, H., Corbin, T., Gatward, R., Goodman, R. & Ford, T. (2004): *The Mental Health of Young People Looked After by Local Authorities in England: Summary Report*. Office of National Statistics.
- Murphy, D. et al (2002): 'Mental health of refugees in inner-London', *Psychiatric Bulletin*, Vol. 26, pp. 222-224).
- Phillips, J. (1997): 'Meeting the psychiatric needs of children in foster care: social workers' views', *Psychiatric Bulletin*, 21: 609-611.
- Richardson, J. & Lelliott, P. (2003): 'Mental health of looked after children', *British Journal of Psychiatry*, 9: 249-256.
- Tunnard, J. (2000): *Report for the Department of Health on Child and Adolescent Mental Health Services: Quality Protects – Year 2 Management Action Plans*. London: Young Minds.
- Wallace et al (1997): *Epidemiologically based needs assessment: Child and Adolescent Mental Health*. Department of Health.