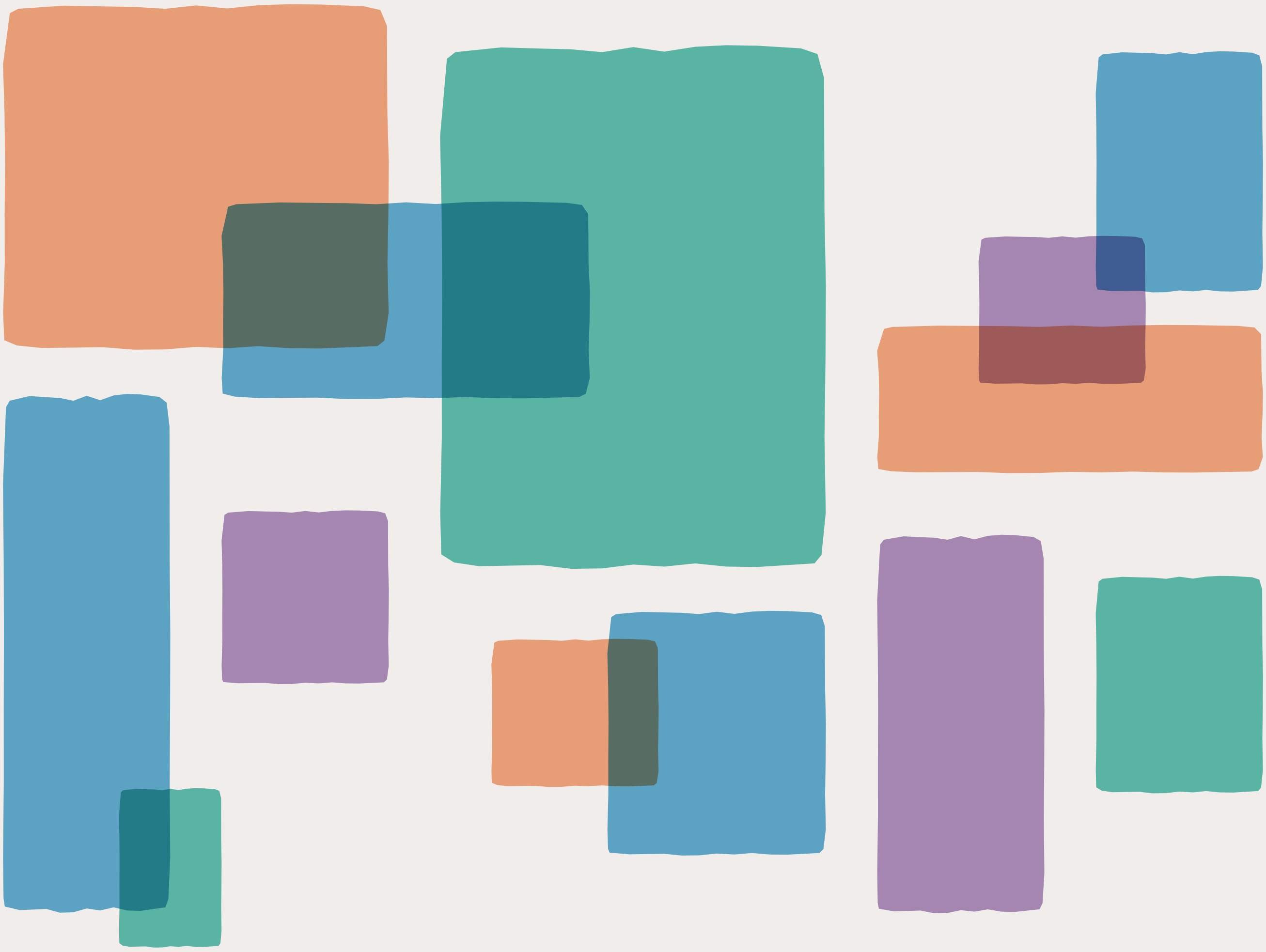


Increasing access to evidence-informed mental health service provision for children in care in England

National recommendations for change

UCL

coramBAAF
adoption • fostering • kinship

UK TRAUMA COUNCIL

Acknowledgements

This report has been prepared in partnership with CoramBAAF, with support from UK Trauma Council (a project of the Anna Freud) and National Children's Bureau. With particular thanks to: Ellen Broome (former Managing Director, CoramBAAF), James Bury (Head of Policy, Research and Development, CoramBAAF), and Ellie Johnson (Health Consultant, CoramBAAF); Adelaide O'Mahony (Senior Impact Manager, UK Trauma Council, Anna Freud); and Tessa Morgan (University of Cambridge).

Our sincere thanks to: Molly Clifford, Nicola Crawshaw, Francesca Crozier-Roche, Shaunna Lydia Devine, Taliah Drayak, Toya Dunscombe, Kim Emenike, David Graham, Terri-Anne Hamer, Will McMahon, Alexander Parker, Jasmine Sillitoe, Jack Smith, Kane Wilton, and other anonymous contributors, who provided invaluable input to shape and refine this work.

We also wish to acknowledge the many children's social care and mental health professionals who have contributed to the learnings presented in this paper. There are large numbers of dedicated professionals across the UK, working hard within resource-stretched conditions, to deliver innovative and high-quality mental health care to children and young people in care and care-leavers. These professionals, teams, and organisations have been instrumental in our learning of the significant challenges faced, but also what is possible at the local and regional level and could be scaled nationally. Our particular thanks to Carmen Chan (Oxfordshire CAMHS), Jodie Rawlings (Avon & Wiltshire Mental Health Partnership Trust and Anna Freud), Leah Trathen (Cornwall CAMHS); Sarah Holland and Lucy Wilson (Clinical Psychology & Therapy Team, Cornwall Council); Alison Foster and Louise Woolfe (Full Circle, Durham County Council), Emily Dale and Derek Hanlon (Darlington CAMHS), and the many other social care and mental health professionals who provided feedback on this paper.

Funding for this paper was provided by the National Institute of Health and Care Research (NIHR) Applied Research Collaboration, from a project led by Rachel Hiller, and funded via: ARC South West Peninsula (PenARC), ARC West, ARC North Thames, and ARC North East and North Cumbria. The views expressed are those of the authors and not necessarily those of the NIHR or Department of Health and Social Care.

This work is dedicated to the memory of
Aisha Hamzat.

Authors & Contributors

Rachel Hiller
Professor in Child & Adolescent Mental Health,
University College London;
Co-Director of the UK Trauma Council

Robbie Duschinsky
Professor in Social Science & Health,
University of Cambridge

Pasco Fearon
Professor of Family Research,
University of Cambridge

Lisa Holmes
Professor in Applied Social Sciences,
University of Sussex

Rick Hood
Professor of Social Work,
Kingston University

Rosie McGuire
Research Fellow,
University College London

David Trickey
Consultant Clinical Psychologist;
Co-Director of the UK Trauma Council

Dinithi Wijedasa
Associate Professor in Child and Family Welfare,
University of Bristol

Matt Woolgar
Consultant Clinical Psychologist, South London & Maudsley NHS Foundation Trust and King's College London

Please direct any queries to lead author Prof. Rachel Hiller at UCL: r.hiller@ucl.ac.uk

Supported by:

Executive summary

What is the problem?

In England, over 80,000 children are in care, a number that continues to grow. Many of them have experienced abuse and neglect, often linked to poverty, inequality, domestic violence, parental mental ill-health, and/or substance misuse.

Once in care, separation from siblings and family networks is all too common, and every year around a third of children in care experience a placement change. These moves disrupt their stability, relationships, and sense of belonging. Older teenagers in care may also face inadequate housing and limited support as they transition to adulthood.

There is strong evidence highlighting the mental health needs of children in care. Research shows they are at least four times more likely than their peers to have a diagnosable mental health condition, such as anxiety, depression, post-traumatic stress, or conduct problems.

Despite this, many children in care still face significant barriers to accessing effective mental health support. Young people, caregivers, and professionals continue to raise concerns about inequalities and inequity in care. Addressing these challenges is crucial to ensuring that children in care receive the support they need to be well and thrive.

What needs to happen?

Addressing the challenges in children's social care and mental health services requires urgent attention from policymakers and commissioners. Underfunding not only affects young people and caregivers but also impacts the professionals working within these systems, with wider societal and economic consequences.

In times of financial pressure and increasing complexity, it is more important than ever to prioritise evidence-based solutions. High-quality assessments, trust-building, effective interventions, and ongoing evaluation should be the foundation of mental health care for young people in care.

Skilled and dedicated professionals are already delivering good practice in parts of England, demonstrating that positive change is possible. With the right training, commissioning, and a shift away from unevidenced practice and misconceptions around mental health, more areas can improve their mental health provision. These national recommendations aim to spark meaningful discussions and drive change where it is most needed.

Key recommendations

- All local areas to develop a joint service-delivery plan and new KPIs, between CAMHS and children's social care, to increase knowledge and accountability.
- Introduction of an initial mental health and wellbeing assessment, 4-6 months after entry to care.
- All local areas to have a co-located mental health service between children's social care and CAMHS, which is commissioned to provide direct and indirect evidence-based support.
- The development of a new children's social care mental health practitioner (CSCMP) training programme, to upskill the children's social-care based mental health workforce on evidence-based therapies.
- Update to the NICE guidelines for Looked After Children.

Along with further actionable recommendations for children's social care and mental health services, including regarding referral practices; where placements are unstable or out-of-area; and training needs.

Our Focus & Terminology

A note on language

This paper presents both actionable and aspirational recommendations for addressing gaps in mental health service provision for children and young people in local authority care in England. Formally, this group are referred to as 'Looked After Children'. However, this phrasing is now considered outdated, and the paper therefore uses the terminology 'children in care' and 'young people in care' to mean children and adolescents (<18 years of age) who are under local authority care.

Focus of Paper

This paper is focused specifically on ways to increase access to evidence-based mental health service provision for children in care experiencing mental ill-health. In doing so, we are particularly focused on children's social care and mental health services. We consider how to improve practice from the initial identification of need, through to access to mental health services, and once there, increasing the opportunity to access evidence-based mental health care for their needs (see Table 1 for key terminology definitions).

Our focus in this paper is on children and young people currently under local authority care, rather than the broader care-experienced community or children with a social worker. However, we anticipate that recommendations will be applicable more widely to all young people with experience of the care system. We are also primarily focused on school-aged children, rather than pre-schoolers. Although, again, we anticipate some recommendations will be applicable across all ages.

Whilst this paper is concerned with improving access to evidence-based mental health service provision for children and teens in care, we recognise that mental health, and indeed professional mental health services, does not exist in isolation. Strengthening professional mental health care for this group of children is crucial, but should also be accompanied by consideration of other important practice-based issues that are likely to impede mental health. For example, we know that having a consistent trusted adult is essential for the mental health and wellbeing of children in care. Yet, placement changes remain common, as do changes in social workers. It may not be possible for a child to have one trusted social worker for their care journey or to remain in one placement, although this should always be the goal, particularly regarding placements. Where change does occur, services bear responsibility for planning and managing transitions in an age-appropriate manner, which includes explaining to children why their social worker or placement is changing, and facilitating established relationships across time and space, in consultation with the child. Services also bear responsibility to ensure a whole-service approach in upskilling all professionals, including foster and kinship carers, and residential care home staff, in trauma-informed care, that embeds evidence-informed practice to support emotional literacy and open discussions around mental health and wellbeing. Many aspects of the care system raise concerns about the quality of care being provided to children – including the overuse of deprivation of liberty orders, unsuitable, unregulated or even unsafe housing for older teens, and the lack of transition support for key periods, such as moving to secondary school or 'aging out' of care. All sectors – education, social care, mental health, and health and primary care – have a responsibility for monitoring and reflecting on whether and how their processes could harm children's wellbeing and mental health, and in turn how harm can be removed or minimised.

> *"I just want one person who is going to be there for quite a long time and not going to leave all of a sudden..."* [11]

Recommendations Summary

Top Five Recommendations

1. All local authority areas to develop a joint service-delivery plan, between CAMHS and children's social care, along with new KPIs, to increase knowledge and accountability. **page 19**

2. Introduction of an initial mental health and wellbeing assessment, 4-6 months after entry to care. This is to support decision-making on support pathways, not simply for data gathering. **page 20**

3. All local authority areas to have a co-located mental health service, between children's social care and CAMHS, commissioned to provide direct and indirect evidence-based support. **page 21**

4. The development of a new children's social care mental health practitioner (SCMP) training programme, to upskill the children's social-care based mental health workforce. support. **page 22**

5. Update to the NICE guidelines for Looked-After Children. **page 23**

Actionable Change for Commissioners

6. Nationally set training for commissioners to ensure understanding of trauma, mental health, and neurodiversity; evidence-based practice and service-evaluation. **page 24**

7. ICS, local authority commissioners, and Corporate Parenting Boards should carry out due diligence to ensure services and interventions are evidence-based. **page 24**

Actionable Change for Social Care

8. Social workers and personal advisors must receive high-quality training around mental health, which is driven by evidence, to support mental health literacy. **page 25**

9. Social care staff and foster carers should receive mandatory CAMHS-led training on discussing and supporting mental health.and therapy. **page 25**

10. All children in care receiving mental health support—especially 16-17-year-olds—should have an independent advocate. **page 26**

11. Social care and CAMHS should co-design referral forms, with training for social care staff on how to complete them. **page 26**

Actionable Change for Mental Health Teams

12. Mental health services (whether social care, third-sector or NHS) must conduct comprehensive mental health assessments with referred children in care, using standardised screening tools. .... **page 27**

13. Mental health services should not reject a referral on the grounds of it being a 'social care issue', unless a comprehensive mental health assessment has been completed showing no mental health concern. .... **page 27**

14. Mental health services should not be able to automatically reject or close a case due to placement instability. .... **page 27**

15. CAMHS must provide robust feedback when a referral is rejected, to facilitate learning on what mental health services are looking for and what is outside of their scope. Feedback must be discussed with social care professionals, to ensure there is a plan for how this will be communicated to the young person. .... **page 28**

16. CAMHS should have a priority access route for children in care placed 'out-of-area' where the young person is able to access the CAMHS within the area they live. There should be national funding available to support this, with dispersal to those areas who 'host' higher numbers of children placed 'out-of-area'. .... **page 28**

17. Mental health teams should have clear and actionable service guidelines for the transition into adult mental health services, which complements the social care transition plan and is ideally co-developed by multi-agency stakeholders (with input from care-leavers). Services should not be able to cease treatment mid treatment plan because a young person turns 18 years old. .... **page 28**

18. Doctorate of Clinical Psychology (DClinPsy) training programmes should renew their efforts and emphasis on evidence-based treatments, in a way which challenges misconceptions about evidence and treatment guidelines that may develop amongst trainees or within services. .... **page 29**

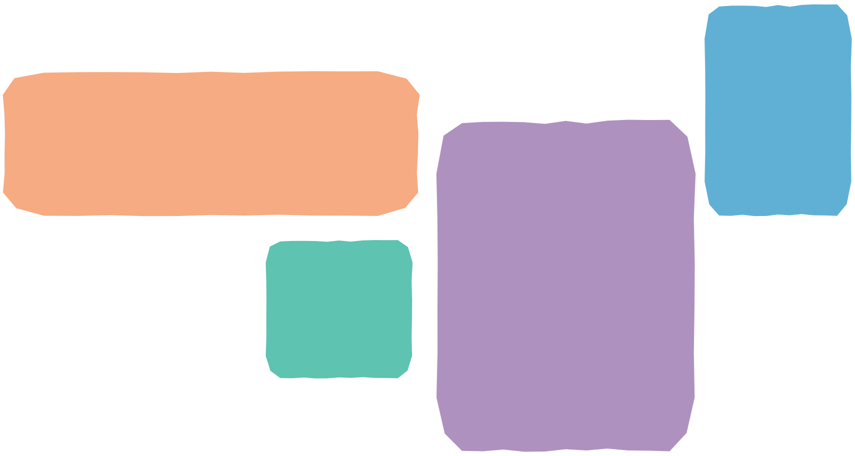
19. Mental health services should prioritise high quality training in evidence-based assessments and formulations and in NICE-recommended psychotherapies; as well as access to regular supervision (including with experts in trauma-focused therapies). ....**page 29**

20. All mental health services, regardless of sector, should be required to openly report on the effectiveness of their service, via agreed KPIs, including success at meeting goal-based outcomes and success at reducing mental health symptomology. Adult IAPT have a clear model of this which could be replicated in cross-sector child mental health services..................... **page 29**

Key Terminology

Mental health or Mental ill-health	The World Health Organisation defines mental health as a state of mental well-being that enables people to cope with the stresses of life, learn and work well, and contribute to their community. Mental ill-health is when a person struggles to cope and/or experiences distress at a level that impacts their general wellbeing and functioning. This includes diagnosable mental health conditions, such as depression, anxiety, post-traumatic stress, and conduct disorders.
Trauma or Traumatic events	As defined by the UK Trauma Council, here we use trauma to refer to a potentially traumatic event or events. These are events that are extremely distressing or frightening; where there may have been actual, threatened or perceived serious injury or death; or where the person was extremely worried for the safety of a loved-one. 'Trauma' spans a range of events from acute traumas (e.g., road traffic accidents; one-off assault) to multiple traumas (e.g., abuse; domestic violence exposure or experience; war and conflict). Most children in care have experienced trauma, either before coming into care or once in care (or both).
Complex or developmental trauma	Complex or developmental trauma are newer terms often used in practice. They do not necessarily have agreed definitions, but complex trauma usually refers to multiple traumatic events and experiences that may occur alongside other complexities or adversity. Developmental trauma is generally defined in a similar way, but is usually particularly referring to extended trauma (particularly maltreatment) that occurs within attachment relationships, and/or over critical developmental periods. Of note, traumas, of all forms, are events or experiences, and need to be distinguished from the emotional, behavioural, and mental health consequences of those experiences. This is important, because there is such diversity in how children respond to traumatic experiences. While knowing what a child has been through is important, it is not the same thing as assessing their behaviour, emotions, and coping strategies, which may or may not relate to the trauma(s).

NICE guidelines	NICE are the National Institute of Health and Care Excellence, and provides mental health, health, and social care professionals with access to summaries of best-evidenced treatments for a range of mental health outcomes. Guidelines also often provide insights into implementation and issues of complexity, as well as gaps in the literature.
Evidence-based	Here, 'evidence-based' predominantly refers to psychological treatments as recommended in the NICE guidelines for mental health, but could also include 'evidence-informed' treatments, that use core components of evidence-based treatments, or treatment approaches highlighted as effective in meta-analytic systematic reviews or practice reviews by reputable organisations (for example, reviews of randomised controlled trials).
Mental health services	Here, we are referring to teams or services who are commissioned to provide mental health care to children and young people. Unless otherwise specified this could be NHS (e.g. CAMHS or targeted CAMHS), third-sector, social care based, joint commissioned, or in the private sector. We define mental health professionals broadly, to be any professional trained to provide mental health interventions. Examples include clinical psychologists, psychiatrists, social work practitioners, mental health nurses, and psychotherapists.
Direct mental health work	We use 'direct work' to refer to psychotherapy with the young person, delivered by a trained professional, which could be individual (i.e. 1:1) or in a group.
Indirect mental health work	We use 'indirect work' to refer to work that aims to target the child's mental health indirectly, via (for example) consultation with a social worker or support for foster carer(s).



Introduction

There are over 80,000 children in care in England[1]. This number continues to grow each year. Reasons for entering care are varied and complex, but most young people in care have experienced abuse and/or neglect, and all have experienced adversity to varying degrees[1]. Family poverty and inequality are key drivers of harm to children[2]. Exposure to parental drug and alcohol abuse, parental mental ill-health, domestic violence, and/or extra-familial harm can all be common experiences of children entering care[1,3]. These types of experiences are well-established risk factors for poor mental health and wellbeing outcomes across the lifespan[4], and can be further compounded by experiences within the care system. For many children and young people, being separated from family and moved into care is an extremely frightening experience. Separation from siblings is also still common and around one-third of children in care will change placements each year[1,5]. Those with poor mental health are likely to change placements more frequently[5]. Changes of placement are almost always highly destabilising and a cause of considerable distress, given they represent a change in their home, bedroom, caregiver, and neighbourhood. For older children in care in particular, there can be issues with inadequate housing and a lack of agency and support[6]. Risk of exploitation and further trauma exposure is also elevated.

There is significant empirical evidence of the mental health needs of this group of children, including from large scale epidemiological research within the UK and abroad[7,8]. Estimates suggest at least half of children in care meet criteria for a diagnosable mental health condition, with rates four times higher than in the general population of youth. Children in care are known to have substantially higher rates of all common and trauma-related mental health conditions, as defined by diagnostic manuals (such as the DSM-5 or the ICD-11). This includes anxiety, depression, post-traumatic stress, and conduct problems[9]. Like for all young people, the mental health needs of children in care are also intrinsically linked to their wellbeing, with recent research showing moderate to strong associations between mental health and wellbeing.For older teens in care, almost all who are struggling with mental ill-health report low wellbeing[10].

Despite undisputed need, there is growing evidence that children in care have poor access to evidence-based mental health support. Young people themselves, their caregivers, and the broader care-experienced community have long voiced frustration and concern at their inability to access timely and effective support for their mental health[5,11,12]. Research also supports this and has shown unique challenges and inequity faced by care-experienced young people when trying to access high quality mental health care. The consequences of this can be lifelong.

What are some key problems in accessing evidence-based mental health care?

To identify solutions, it is crucial to first understand what the problems are – particularly problems that are solvable within the current organisational systems and funding climate. Whilst the challenges facing children's social care and mental health services can seem insurmountable, growing empirical, clinical, and lived-experience evidence shows areas where change is and has been possible. Below we highlight broad areas of concern that impact on the ability to access best-evidenced mental health care, which are discussed further under later recommendations.

The postcode lottery: Waitlists, lack of provision, and fragmentation:

Professional mental health care for children in care can be provided in community NHS teams (child and adolescent mental health services; CAMHS), targeted NHS teams (children in care CAMHS or similar), third sector services, social care based, or joint-commissioned teams. How this is set up differs substantially between local authorities and regions, with even neighbouring areas often having very different set-ups. This includes differences in accessibility for children in care.

> *"I feel complicit in a system that is not really helping these children it's just housing them, and that feels tragic"* **— foster carer** [12]

In many local authority areas in England, a young person in care would be unlikely to be able to directly access evidence-based mental health interventions, particularly psychological therapies recommended by the National Institute of Health and Care Excellence (NICE). Often, this is because of the lack of service provision or inadequate commissioning of existing services[14]. Young people in care commonly access mental health support through targeted children in care mental health teams (either local authority commissioned, NHS, or joint-commissioned). Yet, often, these services are only commissioned for indirect work, such as foster carer support or consultation with social workers. Whilst this is important work, this model leaves young people in care with no access to direct mental health support for their own needs. All too often CAMHS is also not an option[13]. In many areas or regions, the local CAMHS do not accept referrals for children in care, or would only do this for very specific needs. Of course, CAMHS teams have their own capacity and resource issues. But it is also the case that CAMHS exercise a high degree of caution when it comes to referrals of children in care; for example, referrals may be rejected because the problem is identified as being a 'social care issue', despite clear presence of mental health need. In particular, CAMHS may operate an unofficial threshold for this group of children to do with the stability of their placement, being unlikely to accept a referral where the placement is perceived as unstable. Yet, those with unstable placements are likely to be those with the highest mental health need. Altogether, whilst there are examples of excellent practice in England, it is perhaps more common to hear reports of fragmentation and frustration between children's social care and CAMHS[16], with service leaders rarely meeting, and a lack of shared understanding of need from the commissioning level to the front-line. Such systems have major consequences for children in care to be able to access evidence-based mental health support. The bottom line is that, however it is delivered, all children in care in all regions of the country should have equitable access to evidence-based healthcare, including for their mental health.

De-prioritisation of evidence-based practice

Further adding to inequity faced by young people in care, there is a growing trend within social care and mental health sectors to move away from evidence-based mental health practice and towards pseudoscience (particularly a misuse of the neuroscience of trauma, as it relates to 'trauma informed care' packages) and unevidenced 'silver bullet' interventions, which use-up financial resources and reduce access to evidence-based care. Research has shown that front-line mental health professionals are less likely to identify common mental health needs if a child is in care, and more likely to over-emphasise attachment problems[18]. There is also a growing focus in social care and mental health teams (particularly those working with children in care) to rely on non-specific trauma labels, such as using 'developmental trauma' to describe mental health needs[14,15], in place of established trauma-related mental health conditions (e.g., posttraumatic stress disorder). These issues are largely driven by the pervasive myth that children in care do not meet criteria for existing mental health difficulties[7-9]. This is often coupled with a reluctance or refusal to use standardised mental health screening tools. Such practice and beliefs prevent children in care from accessing accurate and helpful information about their mental health needs, and are also a barrier to accessing evidence-based support[19].

Lack of or unclear accountability for evidence-based practice

In general, the fragmentation of service provision and move away from evidence-based care is further entrenched by a lack of accountability in decision-making. At the service leadership and commissioner level, there can be pressures and key performance indicators (KPIs), which move teams away from best-evidenced practice. For example, a focus on waitlists and numbers of children into services, is arguably only useful if it is accompanied by evidence on the quality of care being received once in a service (i.e., via service self-evaluation). Yet this focus, in already highly pressured and stretched services, can mean services are inadvertently pushed towards an over-focus on low-intensity offers, 'quick fixes' (e.g., small numbers of sessions), unevidenced 'silver bullets', or a sole focus on indirect work over high-quality evidence-based direct psychotherapies. This focus is often coupled with a general lack of understanding of evidence-based mental health practice at the commissioning and corporate parenting board level, where there is an increasing focus on pseudoscience (i.e., non-evidenced practice; particularly as it relates to misuse of the neuroscience of trauma to underpin 'trauma-informed care'). Some children's social care services are developing large-scale (costly) service provision, aimed at targeting mental health, drawing on models of practice with little or no underpinning research or evidence but significant leverage in popular culture; leading to an ever-growing mismatch between what is considered evidence-based by research and what is being chosen by services and commissioners. These unevidenced models can move services away from, not towards, evidence-based practice. Perhaps even more concerning is that such models are mostly coupled with a reluctance or refusal to fully and transparently evaluate potential benefits and harms, meaning there can be both a lack of accountability and lack of incentive to review practice.

Inadequate funding

It would be remiss not to highlight the lack of adequate funding of services for children and young people in care[20]. Many young people in care experiencing mental health difficulties will also have comorbidities and complexities. Trying to address this by limiting services to only offer a small numbers of sessions or only low-intensity support with no stepped-care, is akin to putting a Band-Aid on a broken leg, and likely only further adds to inefficiencies in systems and young people oscillating in and out of mental health care with little resolution. Yet, currently, most services are simply not commissioned and staffed to provide best-evidenced practice. For services to be able to provide best-evidenced care, staff must also have access to high-quality training and high-quality supervision, and have the resources and structures they need to provide said care. Yet, even in mental health teams or other services that provide evidence-based mental health interventions to children in care, there is rarely the staffing or general resource capacity to adequately address the scale of need. This will not change without more funding, but it is also essential that the funding provided is used to facilitate best-evidenced care.

Guiding Principles of Good Practice in Mental Health Care

Rights-based approach
Children in care have a right to high quality assessment, support and treatment for their mental health needs. They also have a right to be seen as an individual. Being care-experienced is one part of the identity of children in care, but not the only part. It is crucial that services see children and teens in care (and care-leavers) as young people first, and be aware of unconscious (or conscious) biases and myths that can negatively impact on access to information and care for these young people.

Listening to young people
Children in care also have a right to have their voice heard and valued in decision-making about their mental health care. The voice of young people should be central to decision-making about their needs and support. Young people should always be given the opportunity to be directly involved in assessments of their own needs and in decision-making about support options. Children and young people should also be given reliable and accessible information about their mental health and the support and treatments recommended for, and available to them.

Use of evidence-based mental health care: Services should commit to using evidence-based mental health care. Perhaps the most tangible definition of evidence-based mental health care is the National Institute of Health and Care Excellence (NICE) guidelines for mental health, which provides comprehensive evidence-based guidelines for addressing a wide range of mental health needs, including mental health conditions that are elevated in children in care. These guidelines provide professionals with an up-to-date guidebook for their practice. There are many myths around these guidelines, such as the research being focused on non-complex and non-diverse groups (yet, for example, the majority of studies included in the NICE treatment guidelines for PTSD are with children who have experienced multiple complex traumas, including child abuse).

Commitment to multi-agency communication
Child and adolescent mental health service (CAMHS) leadership and children's social care leadership must commit to regular meetings to ensure all parties are aware of mental health provision in the local area, and how this might work for children in care. Often, these conversations might helpfully involve other agencies or sectors, such as key staff from education and health, leadership from therapeutic care homes, and service leads from commissioned voluntary sector mental health teams.

Never too early, never too late

Children and young people who are already struggling with their mental health when they enter care, are most likely to still be struggling years later[21,22]. There is no evidence that waiting for long periods is helpful. It is never too early to provide mental health care to young people in care, but it is also never too late.

Recognising need

Young people in care do not all have the same mental health needs. The first step to providing high quality care is to understand the needs of the individual child. This should be done via a high-quality comprehensive evidence-based mental health assessment. Standardised screening tools should be used as part of this assessment, to understand the symptom profile and needs of the child. Services should not develop their own screening tools, given so many well-validated and free tools are available. In Appendix 1 of this document we provide examples of screening tools that could aid assessments.

Flexibility in delivery and 'readiness'

It is likely that some young people in care will require a more flexible delivery of evidence-based practice. For example, young people in care might be understandably distrustful of professionals and more sessions may be needed to build this trust, before moving on with evidence-based practice. Or, in the case of trauma-related distress, avoidance is a core symptom. Services may misinterpret these issues as meaning a child is not 'ready' for treatment. Such statements about 'readiness' should only be made very carefully, given the challenges in accessing mental health services. Part of good clinical practice should include rapport building and sessions to support a child to move to high-quality therapy. Similarly, if a young person disengages in the treatment this should not be justification for closing their case. Young people must be able to re-engage when able, without having to go through further complicated pathways and re-assessment.

Recognising biases

It is crucial that services talk openly and frankly about how potential biases or blind-spots in their own practice might affect young people. An important example is the adultification of young people in care (i.e., professionals viewing children as more grown-up or adult than they are)[23]. Another example might be diagnostic overshadowing, where young people in care receive broad-brush statements about their mental health, such as attachment problem or developmental trauma[15,17]. Both of these examples can result in young people not receiving appropriate information or treatment or receiving no treatment at all.

Identifying young people in care to support monitoring of service provision

It is crucial that mental health services record in their electronic systems if a child is in care. Most NHS electronic record systems include this option, or it can be easily added – yet currently, it is not systematically recorded. This means many CAMHS cannot easily identify how many children in care are on their records, or what service they are receiving. Without this simple piece of information, services have no way to easily reflect on whether they are meeting needs or potential blind-spots in their provision or accessibility, using a data-driven approach.

Evaluation of services

All mental health teams, whether NHS, third-sector or social care, must commit to robust and open evaluation of their service provision, based on change in scores on routine outcome measures and goal-based outcome measures, alongside general feedback from children and caregivers. Services should not be developing their own measures of mental health, when many validated, standardised, and free tools are available. KPIs cannot only focus on numbers of children and wait times, but also whether needs are being met. The adult IAPT system provides a model of this, which could be replicated.

The Top 5 Overall

National Recommendations for Local Action

Recommendation 1

All local authority areas to develop a joint service-delivery plan, between CAMHS and children's social care, along with new KPIs, to increase knowledge and accountability.

Children in care have a right to access best-evidenced care for their mental health needs and local authorities have a statutory responsibility to ensure this. NHS and social care leaders must jointly commit to ensuring children in care have access to high-quality evidence-based mental health care, including assessment and support. This includes the co-development of an agreed joint service delivery plan, led by social care and mental health service leadership, but with inclusion of other key multi-agency professionals (e.g., key education staff; therapeutic residential care home leadership; commissioned voluntary sector mental health service leaders). There should be no ambiguity about which organisation is responsible for providing mental health assessment and treatment and the agreed delivery plan should specify what assessment and treatment options are to be provided.

To ensure accountability, key performance indicators (KPI) should be set which move to a focus of whether needs are being met by services. Currently, a common KPI is the completion of yearly Health Assessment Reviews. These meetings provide an important mechanism for monitoring the health of young people in care. This includes a section specifically related to mental health and wellbeing. Here, we recommend three additional KPIs, measured 6-months following the completion of the yearly health review, for those where a mental health need was identified:

1. **Has the young person had access to a mental health service, if a mental health need was indicated at their past review or between reviews?**

and 2. **If so, does the young person perceive that their mental health need is being adequately supported by the mental health service?**

and 3. **Does the young person perceive that their mental health need is being adequately supported by social care?**

Needs-focused KPIs would provide services with concrete information to advocate within and between sectors for important discussions on mental health provision for this group of youth, and a way to meaningfully track whether needs are being met, not just whether paperwork is being completed.

Recommendation 2

Introduction of an initial mental health and wellbeing assessment (HAWA), as part of a commitment to high-quality evidence-based mental health screening for children in care.

Without a full picture of the young person's needs, services risk failing to act on, and meet, these needs. This has far-reaching consequences beyond mental health, including for schooling and placements (and therefore an economic cost as well). Not having a provision to meet need is not a reason to avoid assessing need. Understanding need is key to understanding provision and gaps in provision.

Whilst aspirational, given it would require funding and capacity, we propose as an ideal model that all children in care receive a comprehensive mental health and wellbeing assessment as part of a new statutory Health and Wellbeing Assessment (HAWA). Currently, all children in care receive an initial health assessment (IHA), within 28 days of entering care. This is already a lengthy assessment of need, covering important physical health considerations, and a more limited focus on mental health and wellbeing. Given this is done so soon after a child has entered care, it would likely not be the most appropriate time to conduct a comprehensive mental health assessment (both because of time burden for the child and professional and because high distress may be typical at this point). Instead we propose:

1. Continuation of the Initial Health Assessment (IHA) within 28 days of entering care.

2. A new second assessment (Health and Wellbeing Assessment; HAWA) 4-6 months after entering care, allowing professionals an opportunity to reflect on any key aspects of the health assessment and conduct comprehensive mental health screening.

3. The usual 12-month health assessment review to occur 12-months following the HAWA (instead of IHA), to allow ongoing monitoring and response to health, wellbeing, and mental health needs.

This model not only provides an opportunity for a comprehensive mental health and wellbeing assessment, but also meets long reported need to have an earlier review of the IHA. The newly proposed HAWA would be conducted by the children in care nursing team, with support of a local authority based or seconded mental health professional. The HAWA would use caregiver and child-report standardised mental health screening tools, covering common (e.g., anxiety, depression, conduct) and trauma-specific (e.g., posttraumatic stress) symptoms. The purpose of this is not to provide full diagnostic assessments, but to understand symptom profiles to aid evidence-driven decisions around options for support. It is also not simply a data gathering exercise. Example screening tools can be found in Appendix 1. This assessment should also include elements exploring the child's strengths, skills, and likes. Ideally, initial screening for neurodevelopmental conditions and learning needs may also occur at this point, to trigger earlier referrals for full assessment for these aspects.

Of course, young people have a right to decline an assessment. However, this is not a reason not to offer it. If they do decline, they should be offered it again at a later point.

Both social care and mental health services should avoid generic assessments on attachment or trauma, which are often costly and not actually using evidence-based assessment methods or providing nuanced details on mental health needs.

Whilst establishing this new structure, later recommendations (see Recommendation 12) outline what must be implemented now around mental health screening.

Recommendation 3

All local authority areas to have a co-located mental health service between children's social care and CAMHS, which is commissioned to provide direct and indirect evidence-based support.

Co-location means bringing together CAMHS and children's social care professionals into a single mental health team, to fully meet the needs of children in care via an offer that includes direct and indirect work. That could be a social care based team, with CAMHS staff seconded in. But it could also be key social care professionals seconded into a CAMHS children in care team. Co-located teams are as much about access for children, as they are about building connections, relationships, and strong cultures between staff, which then only further benefits children. What is key is that the co-location creates a culture of shared understanding and shared learning, built around evidence-based mental health practice. This model allows for the forging of crucial relationships, supporting the early identification and efficient problem-solving of system-challenges, and supports the identification and delivery of training and support to the broader social care workforce. A national commitment to co-located evidence-based mental health teams attached to all local authorities (and their local CAMHS) would go a large way in reducing the current postcode lottery. Of note, this co-located team would also still be accountable to working alongside the community CAMHS or other relevant mental health teams (see Recommendation

1). This is crucial, as some young people would still need onward referrals (e.g., for psychiatry input, or particular specialist care). Ensuring this is planned and agreed on remains crucial in the co-located model.

Whilst this may seem aspirational, there are already models of this within England, showing it is possible to provide high-quality co-located service provision within the current funding climate. Currently, many local authority areas do have a targeted mental health team for their young people in care, and sometimes these are joint-commissioned. However, currently, these teams are often only commissioned for indirect work, and commonly will not ever meet the young person either for assessment or treatment. Others may provide some direct work, but only in a limited capacity (e.g., a small number of sessions). They are rarely providing access to NICE-recommended mental health interventions, although there are exceptions.

Ideally, these teams would also be commissioned to provide services for up to 25 years old, to provide crucial continuity of care for care-leavers. At the very least, services should be allowed flexible delivery to complete treatment plans for young people who were under 18 when treatment started and turned 18 during their treatment (also see Recommendation 17). The same flexibility would be needed in a model that went up to 25 years.

For areas where a co-located service is not immediately or obviously possible, and the social care-based mental health team can only provide indirect or limited direct support, then the CAMHS and social care leadership must come together to design a service specification that allows for efficient identification of need and onward referrals to CAMHS (see Recommendation 1). This model can work but is less ideal as to work, it requires strong across-service collaboration, leadership, and buy-in to evidence-based practice, and can therefore be vulnerable to staff changes. To succeed, this would include a shared referral form, agreed language around mental health, agreement around key information for a referral, and agreed access pathways. The referral form should explicitly encourage the focus on observable concerns and discourage assumptions and overgeneralisations, such as the problem being all attachment or all trauma or developmental trauma. An example referral template is provided in Appendix 2.

Recommendation 4

The development of a new children's social care mental health practitioner (SCMP) training programme, to upskill the children's social-care based mental health workforce on low-intensity evidence-based therapies.

To ensure the success of a co-located mental health team, it is crucial that mental health staff receive high quality training in evidence-based mental health interventions and understand the specific contexts and needs of children and young people in care.

Whilst children in care might comprise a small number of children within the population of UK young people, their needs are significant and costly, and continue to be poorly addressed. Addressing the mental health needs of children in care is not only the right thing to do, but also makes economic sense. A children's social care mental health practitioner (SCMP) training programme could follow the model of the successful education mental health practitioner (EMHP) training, which upskills the mental health workforce who sit in education settings, whilst providing the essential supervision and support of NHS mental health services. This model means providers are located where children need them (in the EMHP model, in schools; in the new programme, within co-located mental health teams), but ensures continued high-quality delivery of interventions and access to high quality supervision and clinical governance. This model also provides important career development opportunities for the social care workforce, with likely wider benefits beyond only children in care.

This programme could be commissioned by the NHS via the same mechanism that other psychological practitioner programmes currently are.

Recommendation 5

Update to the NICE guidelines for Looked After Children

Throughout this document we have referred to 'NICE guidelines', meaning the NICE guidelines for mental health (see Table 1). However, there are also NICE guidelines specifically for children in care (NICE guidelines for Looked-After Children). Here, we recommend that these specific guidelines should be updated. First, they should include a stronger up-front statement on the need for mental health teams to follow the NICE-guidelines for mental health. Second, they should highlight upfront the strong evidence-base showing children in care have high rates of common and trauma-related mental health difficulties, and recommend these be assessed using existing standardised measures. Whilst there remains an urgent need for clinical trials research that is focused on children in care, children in care are children first, and the evidence base for child development and mental health care should still be applied. In their current form, the NICE Guidelines for Looked-After Children are unfortunately commonly interpreted or misused by services in such a way as to ultimately not provide best-evidenced care, an implementation issue which could at least in part be addressed by clearer upfront information about mental health needs.

Actionable Change for Commissioners

ICB and Local Authority Leadership and Governance

Recommendation 6

Commissioners should receive nationally set training to ensure a basic understanding of trauma, mental health, and neurodiversity; evidence-based practice; and service-evaluation expectations. This must be based on research evidence, not on pseudoscience.

Commissioners come from a wide range of professional backgrounds. Often, this background is not specific to the mental health field. Yet, they are tasked with important decisions about mental health service provision. To reduce the postcode lottery, it is essential that commissioners have access to nationally-set training, to improve foundational understanding in evidence-based decision-making and practice in the mental health field, to support their conversations with providers.

Recommendation 7

ICS and local authority commissioners and Corporate Parenting Boards should be expected to do their due-diligence in ensuring interventions and services are evidence-based.

Decision-makers should be particularly diligent in ensuring they are not being sold pseudoscience (with the misuse of the neuroscience of trauma being a key candidate). Solely asking a local provider is not due-diligence, given the known proliferation of non- evidence-based practice and professional biases in this area. DfE and DHSC should provide clearer national statements and guidance about this, and may consider funding a small group of experts to provide national guidance for local implementation of evidence-based practice.

Actionable Change for

Children's Social Care

Recommendation 8

Social workers and professional advisors must receive high-quality training around mental health, which is driven by evidence, to support mental health literacy.

This includes a key understanding of the overlap but differences between trauma, mental health, and neurodevelopment.

Often, there is confusion or misunderstandings in the children's social care system about key terminology around trauma, mental health, wellbeing, neurodiversity and neurodivergence. This can impede the ability to effectively support children with their mental health needs, but can also cause confusion when working with other professionals. Standardised training - including embedded within the degree - would help to address this.

Recommendation 9

All children's social care staff and foster and kinship carers should receive high-quality mandatory training, ideally delivered by the CAMHS team, on talking to children about mental health, discussing getting mental health support, and supporting a child or young person through therapy.

Children's social workers are not responsible for providing diagnostic assessments or mental health interventions to young people in care. However, they can play a central role in providing day-to-day support, crisis management, and advocacy. Because of their centrality to supporting young people (and caregivers), relevant social care staff must receive training in recognising mental health needs in their young people and in referral processes. This training would helpfully be conducted by the mental health team to support shared understanding.

Recommendation 10

All children in care accessing mental health support (particularly 16 and 17 year olds) should be provided with an independent advocate who is completely independent of the local authority.

Advocates should all receive nationally recommended training on rights, and on supporting young people, as well as local training on provision. Advocates are not there to provide direct mental health support, but to support young people in understanding their rights and supporting access to mental health services, and navigating other often-complex systems. They can provide additional support to the IRO, but ensure young people have access to an advocate that is independent of the local authority.

Recommendation 11

Social care and CAMHS should co-develop referral forms and social care staff should receive training in completing these forms.

These templates should remove assumptions and simply provide information on what is observable to the social care staff member. By assumptions, we mean assumptions that may be made about mental health because they are in care, or assumptions that all problems are attachment-based or trauma-based. Instead, referrals should focus on observable behavioural and/or emotional concerns, and relevant reports of need by the young person themself. Referrals should not assume that the child's mental health needs are caused by particular events in their lives – this can be explored with the young person in their later assessment. Mental health services are also unlikely to require a full detailed history of the young person's pre-care experiences as part of an initial referral. Instead, successful referrals generally provide clear and brief descriptions of the presenting concern. An example of a referral form is provided in the Appendix 2.

Actionable change for

Mental Health Teams

Including NHS-funded CAMHS, social care based, and third sector mental health teams

Referral processes, assessment, & access:

Recommendation12

When a child in care first has contact with a mental health service (whether NHS, social care or third sector based), it is essential that the service conduct a thorough mental health assessment, using standardised mental health screening tools (see example measures in Appendix 1). Services should not develop their own tools.

Recommendation 13

Mental health services should not reject a referral on the grounds of it being a 'social care issue', unless a comprehensive mental health assessment has been completed showing no mental health concern.

Complex presentations are never only social care or only mental health, and children in care have a right to access their local mental health provision.

Recommendation 14

Mental health services should not be able to automatically reject or close a case due to placement instability.

They should work with the young person and their social care team to think about what can be done (for example, is there a particular issue identified by the young person that could be worked on – such as their sleep, or developing emotion regulation skills). If there is no option for treatment, a clear and agreed plan needs to be made between the clinician, social worker, and caregiver (and young person, where possible), about next-steps. Instability in placements is often driven by high mental health need, so automatically rejecting these referrals risks forcing young people into a cycle of inequity.

Recommendation 15

CAMHS must provide robust feedback where a referral is rejected, to facilitate learning on what mental health services are looking for and what is outside of their scope. Feedback must be discussed with the social care professionals, to ensure there is a plan for how this will be communicated to the young person.

Recommendation 16

CAMHS should have a priority access route for children in care placed 'out-of-area', so that the young person is able to access the CAMHS within the local area where their placement is based, not where their local authority is based.

There should be national funding available to support this, with dispersal to those areas who 'host' higher numbers of children placed 'out-of-area'. That said, this provision should only be used if the child is placed at such a distance that it would be logistically not possible for them to access the local authority area mental health service (and online delivery is not possible, or not preferred by the child). If they are placed 'out-of-area' but still close to their local authority area (e.g., a neighbouring borough), continuity of care should be prioritised and support maintained/continued. Of course, efforts must be made to reduce the numbers of children being placed 'out-of-area', as outlined in key work by organisations such as Become (see their Gone Too Far campaign).

Recommendation 17

Mental health teams should have clear and actionable service guidelines for the transition into adult mental health services, which complements the social care transition plan and is ideally co-developed by multi-agency stakeholders (with input from care-leavers).

Transition planning for adult mental health services should begin as early as possible. Services should not be able to cease treatment mid treatment plan because a young person turns 18 years old, unless a clear handover to an adult service has occurred. Ideally, services would go up to 25 years old. In which case, the same requirements should apply, so as not to simply create a later 'cliff edge'.

Training needs and service evaluation:

Recommendation 18

Doctorate of Clinical Psychology (DClinPsy) training programmes should renew their efforts and emphasis on evidence-based treatments, in a way which challenges misconceptions about evidence and treatment guidelines that may develop amongst trainees or within services.

Clinical psychologists often hold influential leadership positions in mental health services and teams. Whilst there are already national standards that expect this training to be predominantly teaching evidence-based treatments, there are increasing reports of moves away from this. We recommend a review of this as an urgent priority. All DClinPsy programmes should have a primary focus on evidence-based practice; as well as include foundational skills for working with complexity in evidence-based ways; and in comprehensive assessment and formulation of need. The same is also true for Psychiatrists and Psychiatry training.

Recommendation 19

Mental health services should prioritise high quality training in evidence-based complex assessments and formulations and in NICE-recommended psychotherapies; as well as access to regular supervision (including with experts in trauma-focused therapies).

Recommendation 20

All mental health services, regardless of sector, should be required to openly report on the effectiveness of their service, via agreed KPIs, including success at meeting goal-based outcomes and success at reducing mental health symptomology. Adult IAPT have a clear model of this which could be replicated in cross-sector child mental health services.

Summary

The challenges of the children's social care and mental health sectors can feel overwhelming. It is crucial that policymakers and commissioners recognise the impact of underfunding of both children's social care and mental health provision – not only on young people and caregivers, but also the staff within them. Ignoring this, and continuing with systems that do not address the mental health needs of some of our most vulnerable young people, not only has consequences for individuals and families, but also has major societal and economic implications.

For commissioners and services, when there are financial pressures and increasing complexity it becomes more, not less, important to ensure we are focusing on evidence-informed solutions. High quality assessments, the building of trust, the delivery of evidence-based interventions, and the monitoring of effectiveness are all foundational principles of good mental health care. Young people in care deserve to be seen for the individuals they are – and not have their access to high-quality mental health care impacted by biases and overgeneralisations because they are in care.

Services are full of committed and highly-skilled professionals. With the right training, right commissioning, and a re-set that moves away from pseudoscience and myths and misconceptions about the mental health of young people in care, good practice is possible. Indeed, it already exists in parts of England. Our hope is that these national recommendations prompt important conversations, and ultimately change, in those areas that currently (often inadvertently) are not providing best-evidenced mental health care.

Appendix 1

Example mental health assessment & screening tools

Note. This table provides an overview of some potential diagnostic and symptom/screening checklists, which have evidence of good psychometric properties and have been used in research with care-experienced young people and can be useful in clinical practice. It is not designed to be an exhaustive list of available measures. Websites like corc.uk.net provide information on a large range of measures suitable for young people.

Example Diagnostic Interviews

Development and Wellbeing Assessment (DAWBA)

Purpose:
Interview and questionnaire format to identify DSM and ICD psychiatric diagnoses for 2–17 year olds.

Versions
- Parent/carer interview
- Interview with 11–17 year olds
- Questionnaire for teachers.

Other language versions:
Approx. 20 official translations available. Translated versions all available on website.

Time Commitment:
Parent/carer interview:
~1 hour

Young person interview:
~30 minutes

Teacher questionnaire:
~10 minutes

Skip rules help reduce time by skipping sections unlikely to be relevant based on initial screening.

Further Information:
The creators now recommend using the online version of the tool, which costs £10 (~US$13). Though there is a small fee, it saves time and resources for services.

The tool doesn't require a psychologist or psychiatrist to administer and is designed for use by individuals with limited experience in child mental health. Most of the time commitment falls on the carer and young person.

However, as it is a diagnostic tool, responses should still be interpreted by a qualified mental health professional.

Website:: dawba.info
For information about online version:
support@youthinmind.com

Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS)

Purpose:
Semi-structured diagnostic interview for the identification of DSM affective disorders, such as depression and anxiety disorders, in 6-18 year olds.

Versions:

- Interview with caregiver and young person, with capacity to incorporate information from school or elsewhere.

- There are various potential supplementary components to the interview, depending on the focus and outcome of screening phase.

Other language versions:
Translated into multiple languages, including Farsi, Icelandic, Korean, Japanese, Mandarin, Portuguese.

Time Commitment:
~60–90 minutes.

Further Information:
Freely available for non-commercial purposes (e.g., clinical usage).

Should be administered by a trained clinician.

Website::
https://www.pediatricbipolar.pitt.edu/resources/instruments

Strengths and Difficulties Questionnaire (SDQ)

Purpose:
Screening tool for internalizing (emotional difficulties and peer problems) and externalizing (conduct problems and hyperactivity) difficulties, in 2-17 year olds.

Note, there is a general lack of normative and validation data on 2 year olds.

Versions:

- 25 items
- Parent/carer report: 2-4 year olds and 4-17 year olds
- Young person self report: 11-17 year olds
- Teacher/educator report: 2-4 year olds and 4-17year olds
- Newer versions for 18+ year olds (self report and informant report)
- Subscales can also be used, including a subscale for conduct problems.

Other language versions:
Translated into >50 languages, spanning every continent. Translated versions available at website.

Time Commitment:
~10 minutes.

Further Information:
Freely available.

Not diagnosis specific but potentially useful as routine screener to identify young people who would benefit from further assessment of their mental health needs.

Website::
sdqinfo.org

Child Revised Impact of Events Scale (CRIES-8)

Purpose:
Screening tool for PTSD symptoms;
8+ year olds.

Versions:

- 8-item young person report. The items cover re-experiencing and avoidance symptoms.
- Note, a 13 item version is also available (CRIES-13), which includes items for altered arousal symptoms.
- The CRIES-8 performs as well as the CRIES-13.
- There is no carer-report version.

Other language versions:

- Translated into >20 languages
- Translated versions available on website.

Time Commitment:
<5 minutes

Further Information:
Used extensively with different trauma-exposed populations.

Very brief validated screening tool, that can be completed by the young person in 2 minutes, and may form a useful part of an assessment for trauma-exposed children, such as those in out-of-home care.

Available at:
childrenandwar.org

Note – if a clinician wanted a more detailed tool that covers all PTSD symptom clusters, there are many validated PTSD symptom checklists available in young person and carer-report formats, such as the Child & Adolescent Trauma Screen and Child PTSD Symptom Scale for DSM-5. These take longer to complete but cover all symptom clusters.

Child and Adolescent Trauma Screen-2 (CATS-2)

Purpose:
Screening tool for PTSD symptoms, which includes a trauma history checklist and covers all core symptoms of both PTSD and complex PTSD for 7–17 year olds.

Versions:

- 20-item symptom screener.
- CATS-2 is available in young person report and caregiver report, for children 7–17yrs.
- For children 3–6yrs, the original caregiver report CATS should be used, which assesses core PTSD symptoms.

Other language versions:
Unknown.

Time Commitment:
~10 minutes.

Further Information:
Freely available.

Validated screening tool, which covers PTSD and complex PTSD symptoms and is freely available. Unlike the CRIES-8 it covers all symptoms and also has a caregiver report version. It also includes a 15-item trauma history checklist.

Available below, or via direct contact with the author team:
https://www.nkvts.no/content/uploads/2022/12/CATS-2-Caregiver-English-.pdf

https://oklahomatfcbt.org/wp-content/uploads/2023/04/CATS-2-Selfreport-English-DSM-scoring-only.pdf

Original CATS is available at:
https://istss.org/clinical-resources/child-adolescent-trauma-assessments/child-and-adolescent-trauma-screen/

Short Mood and Feelings Questionnaire (SMFQ)

Purpose:
Screening measures for depression symptoms for 6-19 yos.

Versions:

- SMFQ is 13 items, and there is a longer 33-item version too. Available in young person and caregiver report.

Other language versions:
Translations include Arabic, Spanish, and German.

Time Commitment:
~5–10 minutes

Further Information:
Freely available.

Long and short version, and relevant scoring information can be found at:

https://www.corc.uk.net/outcome-experience-measures/mood-and-feelings-questionnaire-mfq/

Revised Child Anxiety and Depression Scale (RCADS)

Purpose:
Measures anxiety and depression symptom severity in 8-18 yos Covers symptoms of social phobia, panic disorder, separation anxiety, generalized anxiety, obsessive compulsive disorder.

Versions:

- Available in young person self-report and parent/carer report.
- 25-items

(original version is 47-items, provides scoring breakdown that is disorder specific) .

Other language versions:
Translations include Arabic, Danish, Hindi, and Spanish.
See childfirst.ucla.edu for all versions.

Time Commitment:
~10 minutes.

Further Information:
Freely available.

47-item and 25-item versions available at corc.uk.net and childfirst.ucla.edu

Brief Infant-Toddler Social and Emotional Assessment (BITSEA)

Purpose:
Screening tool to assess emotional and behavioural difficulties, and social-emotional development; 12-36 month olds.

Versions:
- Carer report
- 42 items

Other language versions:
Dutch, Japanese, Spanish, Turkish.

Time Commitment:
~10 minutes.

Further Information:
Free for individual clinicians, but 'fees may apply' for clinical organisations.

eprovide.mapi-trust.org

Sections of this table are replicated with permission from Hiller, R. et al. (2023). Accommodating complexity: The need for evidence-informed mental health assessments for children in out-of-home care. Journal of the American Academy of Child and Adolescent Psychiatry

Appendix 2

Example social care & CAMHS shared referral template

Please note: This template is just an example of a referral form between social care and CAMHS. Any actual referral form should be co-developed by the local authority and CAMHS teams and adapted to the specific focus, to ensure it meets everyone's needs and is easy to understand.

Child/Young person

First name:	**Last name:**	**Date of Birth:**	**Age:**
Address:		**Ethnicity** (from provided list)**:**	
		Religion:	
Referrer (Name, Role, Organisation, Contact details, Email, Phone)**:**		**Date of referral:**	

Vulnerable child status	**Yes**	**No**	**Don't know**
Is the child subject to a Child Protection Plan?			
Has the child been subject to a Child Protection Plan in the past?			
Is the child a 'child in care' (i.e., under the care of a local authority)?			
Is the child subject to a Special Guardianship Order?			
Does the child have an Education and Health Care Plan (EHCP)?			
Is the child under a Youth Offending Service (YOS)?			
Is the child previously known to CAMHS?			

Carer (Name, Relationship to child/YP. Contact details, Email, Phone)**:**

GP:

Other professionals involved:

School/college:

What specific concerns do you have? Briefly describe current observable issues (e.g. behaviour, emotions, self-harm, social skills, peers, school). Avoid broad terms like 'developmental trauma'.

What has worked well for these or earlier issues?

What have been barriers to better outcomes? Specify whether your view, another professional's view, or child or carer view.

What treatments have they previously had and how have these/haven't these helped?

What would a good outcome look like? Specify your own view, and the views of the young person and (where possible) caregiver

What current safety plan is in place?

Are there any other current or past contextual factors that you think are important to share in advance? Keep brief and consider what the child may and may not want shared.

Are there any accessibility issues to consider? For example – interpreter, wheel chair access, communication support.

Key References

1. Department for Education. (2022). *Children looked after in England including adopted. Author.* https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2021-to-2022

2. Bywaters, P. and Skinner, G. (2022) 'The Relationship Between Poverty and Child Abuse and Neglect: New Evidence', London, Nuffield Foundation.

3. Oswald, S. H., Heil, K., & Goldbeck, L. (2010). History of maltreatment and mental health problems in foster children: A review of the literature. *Journal of Pediatric Psycholo*gy, 35(5), 462-472.

4. Teicher, M. H., Gordon, J. B., & Nemeroff, C. B. (2022). Recognizing the importance of childhood maltreatment as a critical factor in psychiatric diagnoses, treatment, research, prevention, and education. *Molecular Psychiatry, 27*(3), 1331-1338.

5. Wijedasa, D., Yoon, Y., Schmits, F., Harding, S., & Hahn, R. (2022). *A survey of the mental health of children and young people in care in England in 2020 and 2021.* https://mhcat.blogs.bristol.ac.uk/publications

6. Become. (2024). *Gone Too Far.* Author. https://becomecharity.org.uk/become-the-movement/our-campaigns/gone-too-far/

7. Bronsard, G., Alessandrini, M., Fond, G., Loundou, A., Auquier, P., Tordjman, S., & Boyer, L. (2016). The prevalence of mental disorders among children and adolescents in the child welfare system: A systematic review and meta-analysis. *Medicine, 95*(7), e2622

8. Sprecher, E…Hiller, R.M. Sufficiency of current practice: How well does the Strengths and Difficulties Questionnaire detect clinically elevated PTSD, anxiety, and depression symptoms in children in care? Paper Under Review.

9. Ford, T., Vostanis, P., Meltzer, H., & Goodman, R. (2007). Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. *The British Journal of Psychiatry, 190*(4), 319-325.

10. Carter, B., Shelton, K., Holmes, L…Hiller, R. (In Press). The mental health and wellbeing of care-experienced young people during early and later adolescence. *Clinical Child Psychology & Psychiatry.*

11. Hiller, R. M., Halligan, S. L., Meiser-Stedman, R., Elliott, E., Rutter-Eley, E., & Hutt, T. (2021). Coping and support-seeking in out-of-home care: a qualitative study of the views of young people in care in England. *BMJ open, 11*(2), e038461.

12. Hiller, R. M., Halligan, S. L., Meiser-Stedman, R., Elliott, E., & Rutter-Eley, E. (2020). Supporting the emotional needs of young people in care: A qualitative study of foster carer perspectives. *BMJ Open, 10*(3), e033317.

13. Mannes, J...Duschinsky, R. (2024). *Tackling inequalities in access to mental health support for children with social work involvement and those living in poverty.* National Children's Bureau.

14. McGuire, R., Meiser-Stedman, R... & Hiller, R. M. (2024). Access to best-evidenced mental health support for care-experienced young people: Learnings from the implementation of cognitive therapy for PTSD. *British Journal of Clinical Psychology.*

15. McGuire, R., Halligan, S. L., Meiser-Stedman, R., Durbin, L., & Hiller, R. M. (2022). Differences in the diagnosis and treatment decisions for children in care compared to their peers: An experimental study on post-traumatic stress disorder. *British Journal of Clinical Psychology, 61*(4), 1075-1088.

16. Coughlan, B...Woolgar, M., Duschinsky, R. (2024). Children's social workers' perspectiveson mental health and working with child mental health teams: Systematic review and narrative synthesis. Pre-print PsyArXiv. PPR: PPR852293.

17. Woolgar, M., & Scott, S. (2014). The negative consequences of over-diagnosing attachment disorders in adopted children: The importance of comprehensive formulations. *Clinical Child Psychology and Psychiatry, 19*(3), 355-366.

18. Verhage, M. L., Tharner, A., Duschinsky, R., Bosmans, G., & Fearon, R. P. (2023). Editorial Perspective: On the need for clarity about attachment terminology. *Journal of Child Psychology and Psychiatry, 64*(5), 839-843

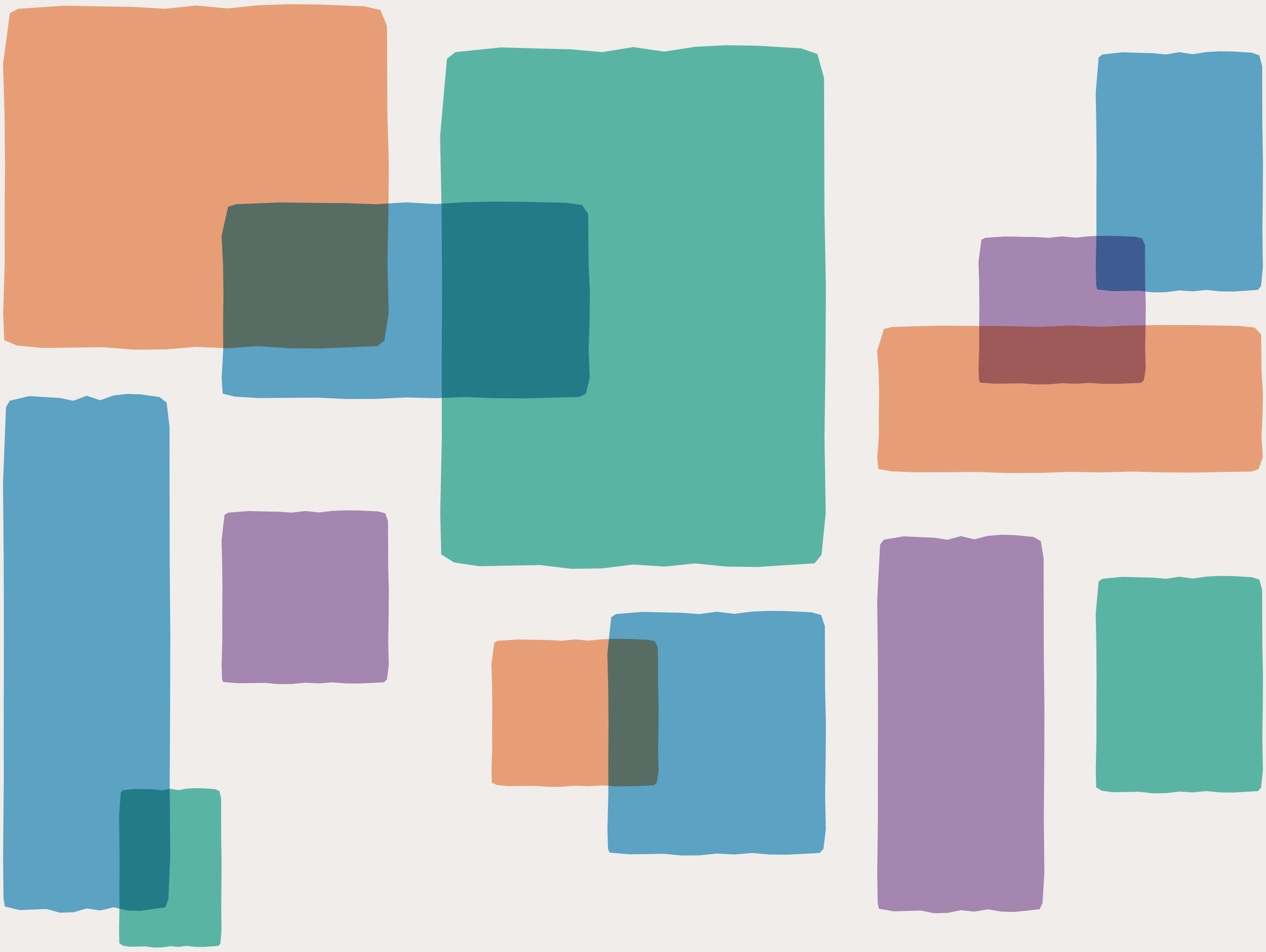
19. Hiller, R. M., Lehmann, S., Lewis, S. J., Minnis, H., Shelton, K. H., Tarren-Sweeney, M., & Taussig, H. N. (2023). Accommodating complexity: The need for evidence-informed mental health assessments for children in out-of-home care. *Journal of the American Academy of Child and Adolescent Psychiatry, 62*(1), 12-18.

20. Ofsted. (2024). The annual report of His Majesty's Chief Inspector of Education, Children's Services and Skills 2023/4. Accessed at: https://www.gov.uk/government/publications/ofsted-annual-report-202324-education-childrens-services-and-skills/the-annual-report-of-his-majestys-chief-inspector-of-education-childrens-services-and-skills-202324#children-in-care

21. Hiller, R. M., Fraser, A., Denne, M., Bauer, A., & Halligan, S. L. (2023). The development of young peoples' internalising and externalising difficulties over the first three-years in the public care system. *Child Maltreatment, 28*(1), 141-151.

22. Tarren-Sweeney, M., & Goemans, A. (2019). A narrative review of stability and change in the mental health of children who grow up in family-based out-of-home care. Developmental Child Welfare, 1(3), 273-294.

23. Davis, J. *Adultification bias within child protection and safeguarding.* HM Inspectorate of Probation. https://static1.squarespace.com/static/5b7ea2794cde7a79e7c00582/t/65518cd5a7588544ea06f0ab/1699843285898/Adultification+bias.pdf



UCL

coramBAAF
adoption • fostering • kinship

UK TRAUMA
COUNCIL

www.uktraumacouncil.org