

VULNERABLE CHILDREN  
KNOWLEDGE REVIEW 2

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# Improving the emotional and behavioural health of looked after children and young people

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# Centre for Excellence and Outcomes in Children and Young People's Services

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There is close and ongoing cooperation with the Association of Directors of Children's Services, the Local Government Association, the NHS Confederation, the Children's Services Network, the Society of Local Authority Chief Executives and Ofsted.

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# Improving the emotional and behavioural health of looked after children and young people

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## Foreword

I am delighted to introduce this knowledge review. It is one of three reviews that aim to help all those working with and for children and young people to improve the life chances of vulnerable 'looked after' children. C4EO started its work on this theme in 2009, some time before the new coalition government was elected in May 2010. The review process we undertake in order to distil the very best learning and evidence from national literature and data, combined with effective local practice, is cumulative, resulting in our full knowledge reviews. Policy priorities are currently being determined by the coalition government and we have amended the review in order to ensure that it reflects the current political context.

I am confident that the evidence of 'what works' contained in this review and in the other two reviews, with their clear and unremitting focus on improving outcomes for vulnerable children, will help all those working with children and young people throughout the public, voluntary and private sectors.

Christine Davies CBE  
C4EO Chief Executive



## Summary

This knowledge review aims to tell us what works in improving the emotional and behavioural health of looked after children and young people, on the basis of a rapid and systematic review of research literature and analysis of key data. As recommended in the scoping study on which this review builds, we focus on the interventions for which the evidence base is most developed and relevant to the review subject. This review therefore focuses on 'enhanced foster care' (an umbrella term under which specific intensive foster care intervention programmes such as multi-dimensional treatment foster care sit). Although not designed specifically as an intervention to be used with looked after children and young people, we focus on the general lessons to be drawn from multi-systemic therapy and mentoring. We also consider the importance of relationships to looked after children and young people and the role of professionals and others involved in their care in relation to emotional and behavioural health. The review aims to provide evidence that will help service providers improve services, and ultimately outcomes for looked after children and young people and their families.

Reviews on improving the educational outcomes of looked after children and increasing the number of care leavers in safe, settled accommodation are included within the theme of vulnerable (looked after) children and are available on the C4EO website ([www.c4eo.org.uk](http://www.c4eo.org.uk)).

This review was carried out by the Institute of Education on behalf of the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO). The data work was conducted by the National Foundation for Educational Research (NFER).

## What did we find out?

### Key messages from our knowledge review

- Children and young people say that when they are cared for in an environment where they feel they belong, their emotional wellbeing and self-esteem is supported.
- Evidence suggests that placement stability is enhanced by accessible interventions and support for looked after children and young people.
- Children and young people need continuity of support from their social worker and other professionals.
- Looked after children and young people's emotional health and wellbeing can be helped by challenging the negative stereotypes associated with being in care, especially in schools.
- Foster carers and birth parents want better access to peer support networks, ongoing training to deal with emotional needs and more information on access to services, in particular mental health services.
- Treatment and multi-dimensional treatment foster care may be effective in reducing offending behaviour and the number of care placement moves. The training and support of foster carers is key to the young person receiving the required support from all services.
- There is some evidence that using multi-systemic therapy can result in improved emotional health, educational outcomes and family relations and decreased offending behaviour.
- The small amount of research on mentoring suggests that mentoring can have a modest positive impact on children and young people. The research suggests that mentoring is most successful when the mentor has come from a helping background or profession (such as teaching) and has ongoing support and training.
- Overall, there is a lack of evaluation research on interventions that specifically aim to improve the emotional and behavioural health of looked after children and young people. Although there is some positive evidence for the effectiveness of multi-systemic therapy, enhanced foster care and mentoring (the three interventions considered in this review), the initial results in the international literature suggest that they may not necessarily be more effective than other interventions. Research in progress may clarify some of these issues.

### Who are the key stakeholders?

- looked after children and young people
- foster carers
- birth families

- social workers
- school-based professionals
- mental health workers and psychologists
- residential staff.

## **Their contributions are valuable in the process of improvement**

- **Looked after children and young people** participate in therapeutic services but there is a lack of research on their views of those services, especially looked after children and young people who have had less successful outcomes. Many looked after children and young people arrive into the care system with high levels of emotional and behavioural health needs and how these needs are responded to affects their lives. Looked after children and young people who are not in education and have a history of placement disruption are most likely to drop out of services; thus, steps must be taken to identify those who need additional support. It is important that their access to educational support and psychological services is improved and that carers are made more aware of the support that is on offer.
- **Foster carers** are responsible for providing looked after children and young people with a caring and supportive environment to enhance their sense of belonging. Children and young people want to feel part of a family and to experience everyday family life. Allowing time for foster carers to build relationships with children and young people and maintaining good relationships with social workers is important. This is needed so that they can provide the emotional and practical support required to make an impact on the quality of children and young people's lives, which in turn can improve the emotional and behavioural health of children and young people. Carers are keen to take part in training to help support the emotional and behavioural needs of children and young people and appreciate greater communication with other foster carers. Foster carers want to be seen as professionals and paid adequately and fairly, particularly when working with challenging looked after children and young people with complex emotional and behavioural health issues.
- **Birth family** contact is an important issue for looked after children and young people. In some instances, regular and meaningful contact can have a positive impact on their emotional and behavioural health. Research suggests that lack of contact with siblings is one of the worst aspects of being in care, especially for those who have been in care for less than two years. However, because of the complex issues involved with how looked after children and young people enter care, contact with birth families needs to be sensitively negotiated. Supporting birth parents to become more effective parents, for example by offering them training on coping with challenging behaviours, can help parents with the difficulties associated with having a child taken into care. For some looked after children and young people, contact with birth families is not desirable because of the emotional and behavioural health consequences that

that contact can bring, while in other cases they may wish to pursue contact despite these difficulties.

- **Social workers** need to be reliable and accessible so that looked after children and young people can gain access to the services they require. Good communication with looked after children and young people is crucial. They need to know that their social worker is available to support them at times of transition, such as going into care, leaving care and moving towards independent living. Despite the minimum visiting requirements of social workers for children and young people in foster care, there is some evidence that when there is a lack of regular contact, because there are no obvious problems, children and young people feel unable to raise issues with their social worker *because* of the drop in contact during these times.
- **School-based professionals** have an important role to play. Placements with foster carers and school places and/or other forms of educational support need to be coordinated by professionals working together across agencies. Educational professionals can provide pastoral as well as educational support through the designated teacher responsible for looked after children in schools and other staff. Schools can also have a part to play in reducing the stigma and resulting bullying that can be associated with being in care because it impacts on the self-image and self-esteem of children and young people.
- **Health professionals** provide emotional help and support particularly through Children and Adolescent Mental Health Services (CAMHS). Mental health workers and psychiatrists are key professionals. Speedy and easy referral and access to these services are crucial to improving the wellbeing of looked after children and young people.
- **Residential staff** at children's homes can have a positive impact on looked after children and young people's emotional and behavioural health, by building and maintaining good relationships with them. It is also important that they develop relationships with parents and carers so that they can reinforce the work they have done with the children and young people. Training on therapeutic skills and focusing on emotional and behavioural health issues can benefit both the staff and the children and young people and help to build meaningful relationships and a 'better' community in the children's home.

## What data is available to inform the way forward?

Current data on the emotional and behavioural health of individuals is relatively limited. No comprehensive source of existing national data on the emotional and/or behavioural health of looked after children and young people has been identified, although data to be collected by local authorities using the Strengths and Difficulties Questionnaire (the SDQ, completed by children's carers with the consent of the child) should, in the future, provide a more general picture than the single (although detailed) Office for National Statistics survey of just over 1,000 children aged 5 to 17 currently provides.

C4EO's interactive data site [SCIE TO ADD LINK] enables local authority managers to evaluate their current position in relation to a range of key national indicators and to easily access publicly available comparative data on disabled children.

## The evidence base

The evidence base for this review consists of four main sources:

- An update of the research review (Dickson *et al* 2009) with additional new references as suggested by the Theme Advisory Group. This review includes evidence from systematic reviews on interventions to improve children and young people's emotional and behavioural health and primary research on looked after children and young people's experiences of being in care.
- Stakeholder views gained through (a) a parents and carers panel, (b) consultation with birth parents, (c) a young people's podcasting workshop and (d) service provider workshops.
- Validated local practice gathered from the looked after children and young people's sector and assessed by an expert panel as having a positive impact on outcomes.
- Data from national datasets, including data from known government publications and data published by the Office for National Statistics.

## Knowledge review methods

This knowledge review is the culmination of an extensive knowledge gathering process. It builds on a scoping study and research review, which are available on the C4EO website ([www.c4eo.org.uk](http://www.c4eo.org.uk)).

Research literature was identified by the systematic searching of key health and social care databases, including PsycINFO, Medline and Social Care Online. The review team used a 'best evidence' approach to systematically select the most relevant and high-quality reviews to include in the review. This approach attempts to eliminate bias in the selection of literature, to ensure that the research findings are objective. Reviews and meta-analyses on looked after children and young people and children and young people with emotional and behavioural disorders, aged 0 to 25, published since 2000 and in English, were included in the review.

Data contained within the data annexe was obtained by a combination of search methods but primarily by obtaining online access to known government publications and access to data published by the Office for National Statistics.

The knowledge review also contains four examples of local practice sent in from the sector, which have been assessed and validated by specialists in looked after children and young people. The full versions of the practice examples contained within this review, and those published since the review was written, are available on the C4EO website at [www.c4eo.org.uk](http://www.c4eo.org.uk)

C4EO has also gathered evidence from service providers and users. This has included: first, feedback from the C4EO parents and carers panel on the executive summary of the research review on 'improving the emotional and behavioural health of looked after children and young people'; second, feedback from a consultation event with a group of four birth parents who have or have had children in care; third, feedback from a group of

nine young people who were involved with two of Action for Children's looked after care projects; and fourth, views from the 109 delegates (mainly service providers) who attended discussion groups on looked after children's emotional and behavioural health at the C4EO 'vulnerable children' knowledge workshops. Service users and providers have also contributed to many of the studies included within the review.

## 1. Introduction

This review aims to draw out the key ‘what works?’ messages on improving the emotional and behavioural health of looked after children and young people. The review seeks to answer three questions:

- What do we know about the importance of relationships for looked after children and young people? (Review Question 1)
- What do we know about the accessibility, acceptability and effectiveness of enhanced foster care,<sup>1</sup> multi-systemic therapy<sup>2</sup> and mentoring? (Review Question 2)
- What do we know about the role of professionals and birth families in supporting looked after children and young people’s emotional and behavioural health? (Review Question 3)

Reviews on improving the educational outcomes of looked after children and increasing the number of care leavers in safe, settled accommodation are also available on the C4EO website. C4EO is also undertaking work on cost effectiveness (which is outside the remit of these reviews). This will place a cost on the interventions and services that local authorities deliver to children, young people and their families. The work includes the design of an outcomes-based model, which can be applied to individual services. The model is being applied to a number of validated practice examples and work on this will be published from autumn 2010 onwards.

C4EO will use the reviews to underpin the support it provides to children’s services to help them improve service delivery, and ultimately outcomes for children and young people.

## Definitions of key terms

The following definitions were agreed by the Theme Advisory Group, a group of experts in looked after children policy, practice and research:

### Looked after children and young people

For the purposes of this study, the following groups were defined as ‘looked after children and young people’:

- 0- to 25-year-olds who are or have been in medium- or long-term care (more than six months) – wherever they are placed (e.g., in residential care, in foster care, in a young offenders’ institution) – and their families

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<sup>1</sup> ‘Enhanced foster care’ is an umbrella term under which specific intensive foster care intervention programmes such as multi-dimensional treatment foster care sit.

<sup>2</sup> Although not designed specifically as an intervention to be used with looked after children and young people, we focus on the general lessons to be drawn from multi-systemic therapy.

- 0- to 25-year-olds who are or have been looked after for several short-term (up to six months) periods in local authority care (either under a Care Order or on a voluntary basis)
- 0- to 25-year-olds who have left or are preparing to leave medium- or long-term local authority care.

In practice, the literature rarely specifies this level of detail, largely describing children as in care or looked after. In addition, we are aware that looked after children are not a homogeneous group but rather they include the full range of children from different backgrounds and with different needs and abilities and disabilities.

## Acceptability and accessibility of interventions

The 'acceptability of interventions' refers to how acceptable interventions are to service users and carers, and to other people (e.g. staff) involved in delivering them. The 'accessibility of interventions' refers to how easy it is to access services or interventions.

## Effectiveness of interventions

The 'effectiveness of interventions' refers to how effective interventions are (in a practice setting), usually assessed by measuring outcomes in various dimensions. For example, a service designed to help looked after children and young people achieve better educational outcomes might be assessed by direct long-term outcomes (e.g. number of GCSE passes) or by indirect shorter-term indicators (e.g. attendance at school).

## Emotional and behavioural health

In the review the focus was on the non-physical aspects of health, often categorised as 'mental' or 'social'. We used the World Health Organization's definition of health, incorporating mental and social *wellbeing* and not merely the absence of problems, difficulties or clinically defined disorders. For Review Question 2, the focus was tightened to include only studies that reported specific interventions aimed at improving the emotional and behavioural health of looked after children and young people. This influenced the definition of emotional and behavioural health because interventions tend to focus more narrowly on emotional and behavioural disorders of looked after children and young people to the exclusion of promoting wellbeing in the broader sense. This has the benefit of mirroring more closely the formulation of national indicator 58: emotional and behavioural health of looked after children (HM Government 2008).

## Interventions

'Interventions' were defined as a specific activity with specified outcomes that included evaluation of any design. The rationale for this was that the scope should identify practices that are sufficiently well defined to be subject to synthesis at

review. As indicated above, beyond this, definitions varied somewhat between sub-questions of the review.

Specifically for Review Question 2, the term 'intervention' was defined as a specific therapeutic practice aimed at improving the emotional and behavioural health of looked after children. Young people also wanted professionals to help them gain access to information, advice and services, including mental health services (Allen 2003; Morgan 2009a). It therefore focused on what practitioners do, rather than the organisation of services. The review looked at reviews of research on all children and young people with emotional and behavioural health needs, rather than only looked after children and young people, and on specific interventions as opposed to system-wide approaches (such as introducing looked after children and young people into a child welfare system). While system-wide approaches may concern the emotional and behavioural disorders of looked after children and young people, they are not always linked directly to outcomes addressing emotional and behavioural disorders and usually have a wide remit to improve the overall performance and accountability of the child welfare system. Thus, the scope for Review Question 2 excludes broad societal approaches to both valuing and respecting looked after children and young people as citizens, and examines approaches directed at improving child welfare for all children and young people in order to improve outcomes for the most disadvantaged (a preventive or trickle-down effect).

## Enhanced foster care

We used the term 'enhanced foster care' as an umbrella label under which specific intervention programmes sit. Enhanced foster care is distinguished from usual foster care by its intention to support children and young people with complex needs and challenging behaviour, including offending behaviour, who are unable to live at home either because of behavioural problems or because of other factors (Hahn *et al* 2005).

The scoping review by Fish *et al* (2009 p 19) provided an indication of the kinds of programmes that could be expected to fall under the general umbrella of enhanced foster care. They identified research that had many labels. For example, 'early intervention foster care', 'enhancing school readiness', 'preventive intervention in foster care', 'day treatment' and 'school-based group therapy'. They also identified two 'named' interventions relevant to supporting the emotional and behavioural health of looked after children and young people:

- *treatment foster care*, which refers to a range of approaches but is characterised by (a) providing parenting training in behaviour management methods for both the foster carers and the biological (or adoptive) parents and (b) supporting them to provide a structured and therapeutic living environment for the young person
- *multi-dimensional treatment foster care*, which falls within treatment foster care but is more structured and includes (a) the coordination of a range of emotional and behavioural health interventions delivered in the foster home with looked after children and young people's families, and through individual therapy, skill training, and academic support with looked after children and young people, (b)

a programme supervisor who oversees and coordinates the interventions that are implemented across multiple settings, (c) the involvement of each child's biological family from the beginning of the placement and (d) the provision of ongoing support through daily telephone calls with treatment foster parents.

However, we were interested in many types of enhanced and treatment foster care approaches, which could potentially fall under these categories; therefore, rather than specifying in advance which type of interventions to include in the review, we used Hahn *et al's* (2005) definition of different types of enhanced foster care, which uses 10 distinguishing characteristics that unite these approaches:

- treatment of only one or two children within the homes of carefully selected substitute families
- low caseloads (i.e. number of young people–foster family pairings monitored by each programme staff member [five to fifteen])
- frequent, treatment-oriented supervision of the treatment parents, which promotes a therapeutic relationship with the child
- provision of treatment services that are well documented for each child
- preparing treatment parents to function as professionals through intensive pre-service and in-service training, good pay, and frequent performance evaluations
- intensive support services to treatment foster carers
- crisis intervention services
- education liaison
- health screening and medical services
- coordination of each child's system of care (Hahn *et al* 2005).

To be included in the review as a study on enhanced foster care, evaluated interventions had to:

- be explicit that foster care is provided with the intention of supporting children and young people with emotional and behavioural disorders
- provide support and training to enable foster carers to have a therapeutic relationship with the child.

## Multi-systemic therapy

'Multi-systemic therapy' is a multi-component community-based treatment programme for children and young people with severe psychosocial and behavioural problems designed by Henggeler and colleagues at the University of South Carolina in the late 1970s (Henggeler and Borduin 1995). Multi-systemic therapy is not designed for use specifically with children and young people who are in care. The name 'multi-systemic' refers to its aim to target multiple systemic factors that have an impact (either positive or negative) on a young person's emotional and behavioural

health. These factors include the various social structures that affect a young person, including family, peer groups and other organisations such as schools.

The distinguishing characteristics of this approach are that:

- treatment is individualised – to address specific needs of young people and families
- treatment is highly intensive – therapists have low caseloads, are available to treat families 24 hours a day, and provide around 60 hours of contact over a period of up to six months
- treatment is multifaceted – combining family and cognitive-behavioural therapy strategies with a range of other family support services
- treatment is comprehensive – identifying and targeting strengths and weaknesses in all of the various family and community systems that may influence a young person's behaviour.

Its aims are to:

- reduce problem behaviours such as offending behaviour, drug misuse and other anti-social behaviours
- reduce the need for custody and residential placements
- provide a long-term solution to children and young people's problem behaviours by strengthening protective factors in a young person's social environment that will last beyond the treatment programme.

The authors describe the unique characteristics of this form of therapy as follows: 'Multisystemic therapy is distinguished from other intervention approaches by its comprehensive conceptualisation of clinical problems and the multi-faceted nature of its interventions' (Henggeler and Borduin 1995 p 121).

Interventions may be labelled as multi-systemic therapy or not. However, to be included in the review as a study on multi-systemic therapy, evaluated interventions had to:

- be short term (three to six months)
- include a therapeutic component such as family therapy or cognitive-behavioural therapy
- work with other systems in an individual's social network that are contributing to their emotional and behavioural disorders
- involve support from therapists with low caseloads who are available to programme participants 24 hours a day, seven days a week.

## Mentoring

'Mentoring' is a somewhat broader category and more difficult to define than both enhanced foster care and multi-systemic therapy, not least because mentoring-type relationships can occur both naturally and as a result of a mentoring intervention (Clayden and Stein 2005 p 1). While a precise definition is difficult to find in the literature, Rhodes (1994 pp 188–189) notes the type of relationships the term 'mentoring' has generally been used to describe:

- a relationship between an older, more experienced mentor and an unrelated, younger protégée
- the mentor typically provides ongoing guidance, instruction and encouragement
- the relationship is aimed at developing the competence and character of the protégée
- over the course of the relationship, a special bond of mutual commitment, respect, and loyalty may develop.

Freedman (1988) provides further characterisation of mentoring relationships, identifying from research into mentoring programmes for young people in the United States, two types of significant mentor–mentee relationships: 'primary' relationships, which are characterised by 'attachments approximating kinship', 'great intimacy' and a willingness on the part of mentors to 'take on the youth's full range of problems and emotions'; and 'secondary' relationships, characterised by a greater emotional distance and being more task oriented, providing support and positive reinforcement akin to a 'friendly neighbour' (Freedman 1988 p 3).

As the aim of this review is to focus on interventions with the aim of supporting the emotional and behavioural health of looked after children and young people, naturally occurring mentoring relationships were excluded. To be included, mentoring programmes had to declare an aim of supporting or improving the emotional and behavioural health of children and young people with emotional and behavioural disorders. However, the full spectrum of relationships as described by Freedman has been included.

Further definitions are provided in the data annexe.

## Types of evidence used

The research included in this review was identified either in the scoping study (Fish *et al* 2009) or by a search for reviews on the impact of the three interventions identified in the scope of enhanced foster care, multi-systemic therapy and mentoring. The research team ruled out obviously irrelevant research studies by screening study titles. Coding took account of each study's features – including research design, relevance to the scoping review questions and country of origin. The review team appraised these key items to ensure that the evidence presented is the most robust available. The scoping study concluded that an overall synthesis of all three questions was not possible and that a synthesis of Review Questions 1 and

3 would not be productive. Review Questions 1 and 3 were addressed with evidence drawn from research studies and views and opinions of the stakeholders with whom C4EO has consulted (see Appendix 6 for further details). Review Question 2 was addressed by a review of reviews that went beyond looked after children and young people and the reviews in the scoping study.

Data contained within the data annexe was obtained by a combination of search methods but primarily by obtaining online access to known government publications and access to data published by the Office for National Statistics.

The review also contains four examples of local practice that were gathered from the sector and assessed as having a positive impact on outcomes by specialists in looked after children and young people (see Appendix 5 for C4EO's validated local practice process and assessment criteria).

Evidence was also gathered from service providers and users by C4EO. This included: first, feedback from the C4EO parents and carers panel on the executive summary of the research review on which this knowledge review builds; second, feedback from a consultation event with a group of four birth parents who have or have had children in care; third, feedback from a group of nine young people who were involved with two of Action for Children's looked after care projects; and fourth, the views of service providers attending the C4EO 'vulnerable children' knowledge workshops (see Appendix 6 for more details). Service users and providers were contributors to many of the studies included within the review too.

## 2.Context

### Policy context

High rates of emotional and behavioural disorders have been identified among children and young people who are looked after (Melzer *et al* 2003). Many children arrive in care for the first time with a high level of emotional and behavioural needs (Sempik *et al* 2008), so their difficulties cannot only be attributed to the care system itself and must also reflect adverse experiences in the home environment. Inadequate or abusive parenting can lead to significant attachment difficulties, which affect children's ability to form strong and supportive bonds with others, and may require specific therapeutic interventions combined with support and training for foster carers. Poor emotional and behavioural health can affect outcomes in other areas, such as educational achievement (Ward and Holmes 2008). Troubled children are unlikely to be effective learners.

Despite the introduction in many local areas of specialist mental health teams for looked after children and young people, there remains a shortage of therapeutic services for children in care (CAMHS Review 2008; GB. Parliament. HoC. Children, Schools and Families Select Committee 2009). However, increasing attention is being paid to ways of addressing emotional and behavioural problems and promoting emotional wellbeing, both for children in general and for those who are looked after.

Relevant initiatives that support the emotional wellbeing of looked after children include the Healthy Care Programme, which supports around 80 local authorities to develop partnership working and a more holistic approach to improving looked after children's health. Awareness about the importance of promoting the health and welfare of looked after children is growing. The way in which agencies should work together to contribute to this is supported by work on a range of guidance: public health guidance is being developed by the National Institute for Health and Clinical Excellence/Social Care Institute for Excellence (NICE/SCIE) and is due to be published in 2010; and statutory guidance on promoting the health of looked after children was published jointly by the-then Department for Children, Schools and Families (now Department for Education) and the Department for Health in November 2009 (DH and DCSF 2009) and is statutory on Primary Care Trusts and strategic health authorities in England as well as local authorities. A new national indicator was introduced by the previous government (NI 58) requiring all local authorities in England to provide information on the emotional wellbeing of all children aged four to sixteen years inclusive who have been looked after in the year ending 31 March as part of an annual SSDA903 data return to the Department for Education. This data is collected through one part of the Strengths and Difficulties Questionnaire, which is completed by the child's main carer and a summary figure for each child (the total difficulties score) is submitted to the Department for Education. Data relating to this indicator was published for the first time in autumn 2009.

A number of specific interventions targeted at children and young people with particularly challenging behaviour and complex needs were introduced by the

previous government in England as pilot programmes over the last few years, with local authorities bidding for government support to establish the programme in their area and participate in a national evaluation. The Multidimensional Treatment Foster Care in England (a form of enhanced foster care) programme, which began in 2003 and is currently being evaluated, focuses initially on adolescents but later extends to include separate programmes for children aged seven to eleven and 'preventive' programmes for young children aged three to six. The Youth Justice Board has piloted the Multidimensional Treatment Foster Care in England model (described as an 'intensive fostering scheme') with serious and persistent juvenile offenders in three English local authorities, testing its effectiveness in preventing reconviction. Multi-systemic therapy, which also targets children and young people with severe psychosocial and behavioural problems but who are not looked after, is likewise being piloted in a number of English local authorities and is subject to an ongoing evaluation.

## Research context

The scoping study that was undertaken at the beginning of the review process reported that: 'The studies included in this topic area, both within and between questions, are so disparate that it cannot plausibly be subject to a single review' (Fish *et al* 2009 p 3).

Many research studies have been undertaken on emotional and behavioural health but they do not provide a unified view of the evidence to answer the review questions by the Theme Advisory Group. Most of the evidence available relates to the question of the efficacy of interventions of enhanced foster care, multi-systemic therapy and mentoring for emotional and behavioural health. Many of these studies have been undertaken in the United States yet multi-systemic therapy is a very specific programme where there are issues about its effectiveness and applicability in different cultural contexts. Also, the evidence available is changing with, in the case of multi-systemic therapy, a major update of a systematic review by Littell (personal communication) under way.

The evidence reviewed has drawn mostly on studies undertaken in the United States. Although controlled trial evaluations of both Multidimensional Treatment Foster Care in England and multi-systemic therapy pilot programmes have been commissioned by the government in England, these are still ongoing and therefore have not been subject to systematic review.

A small number of other studies undertaken in the UK may, however, provide useful information to contextualise the findings from the review and indicate how similar interventions are being implemented in the UK. They include an evaluation of the Community Alternative Placement Scheme in Scotland (specialist fostering as an alternative to secure accommodation) and a national evaluation of community mentoring projects in England and Wales for potential young offenders, funded by the Youth Justice Board. Both schemes are described briefly below.

Although findings from the independent evaluation of the Multidimensional Treatment Foster Care in England pilot programme in England are not yet available,

administrative data is available on the Multidimensional Treatment Foster Care in England website – see [www.mtfce.org.uk/library.htm](http://www.mtfce.org.uk/library.htm). The 2009 annual project report describes the impact of the programme on the 193 children and young people who had been through the programme since the first placement in April 2004, up until the end of March 2009 (National Implementation Team 2009). They included slightly more boys than girls, had an average age of 12.5 years and the majority (86.4 per cent) were white British. Forty-four per cent had joined the programme directly from residential care and 33.7 per cent from foster care, with a minority moving from birth or extended family, secure settings or hospital. Girls were significantly more likely to have a history of being sexually abused, and boys to have a history of physical abuse.

For the 72 young people who had successfully ‘graduated’ (completed the programme and moved on to a family-based placement), audit data showed improvements compared to the year prior to admission in outcomes such as number of cautions and convictions, self-harming and violent behaviour, and reported emotional and behavioural disorders in school. However, some difficulties remained. For example, reported emotional and behavioural disorders in school had reduced from 72.9 per cent of the sample at entry to the programme but were still reported among 62.9 per cent (almost two-thirds) immediately after ‘graduating’.

Issues of acceptability and accessibility were raised by the fact that 36 of those entering the Multidimensional Treatment Foster Care in England programme had left early, that is, before three months. However, this group had higher levels of previous placement disruption and were less likely to be in school when admitted to the programme than were ‘graduates’. They also had less contact with the full range of programme staff. This suggests that such young people should be targeted on admission, with work to promote their engagement with the whole Multidimensional Treatment Foster Care in England team and efforts to arrange some structured educational provision. Some teams did work on this with their local Looked after Children Education Services).

A costing study (Holmes *et al* 2008) was unable to calculate the set-up costs of the Multidimensional Treatment Foster Care in England programme, but concluded that the costs of maintaining children in the programme were comparable to other types of placement for children with a similarly high level of needs.

## Evaluation of the Community Alternative Placement Scheme

The Community Alternative Placement Scheme was set up in 1997 by NCH Action for Children (Scotland) to provide family placements for young people who would otherwise enter or remain in secure care. It offered relatively high fee levels and comprehensive support for foster carers, and sought to extend the boundaries of foster care by placing young people who were usually judged to be too difficult to manage in families. The then Scottish Office funded an independent evaluation of the project’s first three years of operation, which included a follow-up of 20 young people two years after initial placement and comparison with a group of young people placed in secure care (Walker and Hill 2002). The project was successful in

recruiting and keeping highly motivated carers, but outcomes for young people were mixed. Most placements did not end in accordance with the planned duration or goals and some finished abruptly, although others provided stable positive experiences on an enduring basis. Securing suitable educational placements proved a major challenge, especially when young people moved to carers outside their home authority.

Although placements were originally intended to last for six months, this was revised upwards to six to twelve months and in practice most young people who settled with their foster families were found to require even longer placements. This was partly because it took time for carers to build the level of trust that would enable them to help young people address longstanding problems. There was also a lack of suitable follow-on placements for young people to move on to. Improving access to additional educational support and psychological services for young people emerged as important factors, as did intensive support to carers (available on a 24-hour basis), reasonable remuneration, specialist training and access to respite care.

Assessments of progress made over the two years in relation to behaviour, emotional difficulties, self-esteem, training or work indicated that young people placed with the Community Alternative Placement Scheme were, on average, doing no better and no worse than those who had been admitted to secure accommodation. Each form of service catered for certain needs well. Secure care was better at managing young people in crisis and keeping them safe, the Community Alternative Placement Scheme at tackling longer-term needs such as learning to take responsibility for behaviour and cope with community living. From a policy perspective, it is important to decide where an enhanced fostering project such as this fits within the spectrum of services, and whether the primary aim is to replace secure care as a short-term placement or to provide the longer-term care that is required by many young people considered for or admitted to secure accommodation.

## National evaluation of Youth Justice Board mentoring projects

Between 2001 and 2004, the Youth Justice Board supported over 80 community mentoring projects in England and Wales. Between them, the projects recruited over 3,000 volunteers (mainly women) to act as mentors, and matched them with nearly 3,000 young people (average age 14, over three-quarters of them male). Over half of the young people in a subsample who were interviewed had emotional and behavioural disorders of clinical seriousness.

The mentoring projects were 'competency focused', setting out to teach basic literacy, numeracy and social or life skills. They targeted young people who had offended, or were at risk of offending. An independent evaluation was undertaken (St James-Roberts *et al* 2005), which collated records from the individual projects on delivery and outcomes, and compared a sample of mentored young people with a matched non-mentored comparison group. It reported that half the mentoring relationships ended earlier than planned (those lasting over 10 months had the most successful outcomes), and that the single most important barrier to the participation

of young people in mentoring programmes was the unwillingness of the young people who were targeted to take part. It is suggested that schemes need to be more responsive to the goals and wishes of young people themselves, while not 'rewarding' offending behaviour. When young people did engage, the mentoring projects succeeded in some respects, such as reintegration into training and/or education and increasing involvement in the local community. However, there was no evidence of improvements in young people's behaviour, literacy or numeracy compared to the comparison group, and the costs of the mentoring programmes (despite using unpaid community volunteers) were higher than alternatives that produced similar benefits, such as the Youth Justice Board education, training and employment schemes. The evaluation concluded that there is little evidence to support the wider implementation of such mentoring programmes as a 'standalone' means of tackling or preventing youth crime, although some of the key features of mentoring (such as establishing supportive one-to-one relationships) could be incorporated into other forms of intervention.

## Views of looked after children and young people on mental health

Although there is not much research on how children and young people in care define mental health, studies have asked looked after children and young people about their views. One study with 12- to 19-year-olds reported that they particularly appreciated the informal approach of mental health services offered by the voluntary sector as well as being given a choice in whether or not they participated in counselling or therapy, or another service (Stanley 2002; Davies and Wright 2008). Choice is an inherent part of user-led services and children and young people may have different priorities to their carers. One study found that children and young people in care were more likely to identify internal emotional problems, whereas their carers tended to focus on externally visible problem behaviours (Beck 2006).

### 3. The evidence base

This section provides an overview of the extent of the evidence base. The evidence base for this review consists of four main sources:

- an update of the research review (Dickson *et al* 2009) with additional new references as suggested by the Theme Advisory Group
- stakeholder views gained through (a) a parents and carers panel, (b) a consultation with birth parents, (c) a young people's podcasting workshop commissioned to inform this review and (d) service provider workshops (details of this data collection, which did not aim to be representative, are in Appendix 6)
- validated local practice gathered from the looked after children and young people's sector and assessed by an expert panel as having a positive impact on outcomes. (C4EO methodology includes a rigorous process for validating local practice, which is described in Appendix 5.)
- data from national datasets, including data from known government publications and data published by the Office for National Statistics.

The Theme Advisory Group nominated references for inclusion in this review, which helped to fill gaps identified in the previous review (Dickson *et al* 2009) particularly the addition of residential staff views and studies that explicitly asked looked after children and young people about their emotional and behavioural health. These references were assessed by the review team for relevance, and the resulting new references were incorporated into the review. In total, six new references relating to two of the review questions were included in the views review:

- four new references were included in answer to Review Question 1 (Morgan 2007, 2009a, b, c and d)
- two new references were included in answer to Review Question 3 (Harris *et al* 2009; SIRC 2009)
- no additional systematic reviews on the impact of enhanced foster care, multi-systematic therapy or mentoring were identified to answer Review Question 2.

In addition to new references, an additional eight sources of evidence, in the form of stakeholder views and local validated practice examples, which also included service provider views, were incorporated into the review. While these cannot be described as being representative, they are important in indicating key current concerns and issues in ways that the research alone cannot do. One of the sources was used to answer Review Question 1 and the remaining seven were used to answer Review Question 3. All of the additional evidence gathered has been included in the update of this review and has substantially contributed to the findings.

All of the studies drawn on to answer Review Questions 1 and 3 and all of the systematic reviews used to answer Review Question 3 were critically appraised for quality and relevance. The majority of studies and systematic reviews were of 'high'

or 'medium' quality. No studies or reviews appraised to be of 'low' quality were excluded from the review but were instead used to support existing findings, rather than to generate new ones.

**Strengths** of the review included:

- identifying the best available evidence from research and national datasets to inform specific questions
- comprehensive and documented searching for relevant information
- an analysis of the quality and strength of evidence
- receiving guidance from an advisory group on the issues of greatest importance in early childhood research, policy and practice
- conducting a review of reviews, which allowed us to provide a comprehensive overview of evidence on more than one type of intervention in a limited timeframe and to identify individual studies already included in the reviews without having to conduct further searches.

**Limitations** of the review included:

- the very tight deadlines that the review had to meet, which limited the ability of the team to extend and develop the evidence base through reference harvesting and hand searching
- a limitation to studies published in English only.

## 4. The importance of relationships for looked after children and young people

This chapter focuses on the quality of looked after children and young people's relationships with other people, which emerged as a key factor in looked after children and young people's emotional and behavioural health.<sup>3</sup>

### Key messages

- Looked after children and young people say that receiving emotional and practical support enhances their self-esteem, sense of belonging and emotional wellbeing.
- The quality of looked after children and young people's relationships with their foster carers and other professionals (particularly social workers) is key to emotional health. They value being part of a family where they feel loved and are treated as a member of their foster carer's family. Maintaining stable placements enables foster carers to enjoy meaningful relationships with the children and young people for whom they care.
- Maintaining contact with birth family members, particularly siblings, is very important. This is facilitated when looked after children and young people receive support in dealing with the possible emotional consequences of contact.
- The quality of relationships with professionals, and receiving support from them, is very important. Professionals need to be reliable and accessible.
- Professionals should listen to and actively involve children and young people in decisions that affect their lives. However, they should also take account of their age and cognitive development, and be realistic and honest with them about the extent of their influence.
- Looked after children and young people often experience negative social consequences as a result of being in care, such as stereotyping and bullying, which can be addressed through raising awareness, particularly in schools, and dispelling myths and misunderstandings about why children become looked after.

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<sup>3</sup> The original review question was 'What are looked after children and young people's views on what constitutes emotional and behavioural health and how do they compare with those of policy-makers, children's services personnel and independent sector providers?'. However, the scoping study on which this review is based found that there was insufficient evidence to address the question. In consultation with the Theme Lead, the review team therefore looked more broadly at looked after children and young people's views on what is important to them in a care placement, and how this might affect their quality of life and emotional and behavioural health.

## Relationships between looked after children and young people and those who support them

The quality of looked after children and young people's relationships can improve their everyday experience of emotional and behavioural health (Martin and Jackson 2002; Schofield 2003; Skuse and Ward 2003; Knight *et al* 2006). Looked after children and young people come into contact with a range of different professionals throughout their lives, many of whom have an impact on them. This section provides a brief summary of looked after young people's experiences and opinions on this as well as drawing on qualitative research evidence.

The experiences of looked after children and young people add much to our understanding of their needs. However, it is important to remember that some of the evidence used in this section is drawn from a workshop with nine looked after young people (carried out by Action for Children for this review), rather than on research literature.

### Relationships with foster carers

Often, children and young people come into care with a range of emotional needs. Findings from across the studies included in the review indicate that looked after children and young people need carers to actively demonstrate that they care for them, by providing an environment where they feel cared for and supported, a sense of belonging and emotional and practical support. This will help to promote the stability that is so important in improving their outcomes.

Morgan (2009b) reported on looked after children and young people's views on the positive aspects of being in care. The overwhelming consensus was that they valued being part of a family where they felt loved. Looked after children and young people felt that being treated by their foster carers as an equal member of the family was an essential part of feeling that they belonged. The following analysis by Schofield (2003) also illustrates this:

What was also central in defining a real family was the experience of being treated the same as other children, particularly birth children of the foster carers. It was important to be seen as equally loved and loveable, with the message, 'you don't have to be a blood relative to belong'. (author analysis – Schofield 2003 p 151)

Similar views were reported in another study: 'I feel like I'm part of the family and not just a foster child. I think it is important to feel like this' (participant data – Morgan 2009c p 49). Action for Children's consultation (commissioned by C4EO) also identified that they wanted to be part of a family, experiencing everyday family life (Action for Children 2009). Key aspects of being part of a family included:

- doing family activities such as shopping/going out/holidays
- help with budgeting/finances
- support in getting to appointments

- family members having time for you
- keeping confidential stuff confidential
- being kind/understanding/patient/trustful
- being approachable and treating you with respect.

The young people also felt that carers should want to be a carer (not just be doing it for the money) and be able to meet their emotional needs. One young person gave the following example of emotional support:

I used to have a psychologist who used to come over and help explain things in my head. I had to tell her everything and my carer was right next to me and pushed me to explain myself as clearly as I possibly could. My foster mum supported me, being there for me. (Action for Children 2009 p 3)

Martin and Jackson (2002) also reported that most of the highly achieving looked after children and young people in their study spoke of a special relationship with at least one person, within or outside the care system, who made time to listen to them and make them feel valued. Meanwhile, Allen (2003) found that young people also required support with practical aspects of independent living. Where this was missing, 'the issues they had to contend with ... could tip the balance against them remaining in their work, training or educational situations' (Allen 2003 p 31).

However, building stable relationships with carers can be difficult when children and young people have to move placements and build new relationships with different carers. As one looked after young person said: 'I was lonely. I was fed up of moving around all the time. I just wanted to be loved by someone' (participant data – Knight *et al* 2006 p 400).

Giving looked after children and young people opportunities to develop strong, stable relationships with their carers is therefore vital for their emotional wellbeing (Knight *et al* 2006).

## Relationships with birth families

The studies in the review (Butler and Charles 1999; Munro 2001; Skuse and Ward 2003; Timms and Thoburn 2006) indicated that an important issue for looked after children and young people both in general, and in relation to their emotional and behavioural health, was being separated *from* and remaining in contact *with* family members (including siblings). As would be expected, the relationship looked after children and young people had with their birth families could be complex, but overall, looked after children and young people drew a link between the lack of contact with birth families and the negative impact this had on their emotional and behavioural health. As Morgan (2009b) reported:

Children told us being away from brothers or sisters was the worst thing about being in care for them. ... Young people who had spent over six years in care were least likely to say that missing being with their family was the worst thing about being in care. As one person put it, 'being in care

at a young age means you know no difference – coz you don't know family'.  
(author description – Morgan 2009b p 8)

Many looked after children and young people had a need to maintain contact with their birth parents or members of their birth family because it supported their self-identity, but they often felt that their desire to maintain contact was not addressed by professionals, including foster carers. The challenge for professionals working with looked after children and young people is to find an appropriate balance between supporting continued relationships with a child's parents, relatives, siblings, previous carers and friends and ensuring the safety and stability of their care placement (Timms and Thoburn 2006).

## Relationships with professionals

Some studies included looked after children and young people's views on the professionals they encountered in the care system, predominantly social workers. While looked after children and young people did not make any direct links between the quality of their relationships with professionals and their emotional and behavioural health, good relationships with social workers were clearly important to them:

The social worker was seen as very powerful and, when the relationship worked well, as a very strong ally. (author description – Munro 2001 p 131)

What makes a good social worker? The list included i) they're there when you need them, ii) they are able to build up a good relationship 24-7, iii) they always listen to you, they always come to see you on time and iv) if they say they will check something out for you, they will always come back to you with an answer. (author description – Morgan 2009d p 4)

Looked after children and young people also wanted professionals to help them gain access to information, advice and services, including mental health services (Allen 2003; Morgan 2009a).

Looked after children and young people wanted continuity in their relationship with professionals, in order to improve the quality of their experiences while in care, and to feel that professionals were listening to them and respectful of their views (Baldry and Kemmis 1998; Munro 2001; Skuse and Ward 2003). The Kirklees Blueprint project described below demonstrates the importance of listening to young people and involving them in joint decision-making. It provides young people with opportunities to influence the decisions that most affect them, within agreed boundaries, showing that that it can not only improve the quality of their lives but it can also help to foster a stronger sense of self-worth. Joint decision-making in this example is one way of addressing the power imbalance that looked after children and young people may feel while in care by taking their views, experiences and opinions seriously.

### **Validated Local Practice example**

The **Kirklees Blueprint project** was set up to improve the participation of looked after children and young people in their statutory review process. The aim of the project is to enable looked after children and young people to be fully engaged in the organisation of their lives, not just to provide their views when invited to do so. An innovative aspect of the project is the different ways in which looked after children and young people can now be involved in their review process, including the use of video contributions and completing online forms. Everyone involved in running the project has been trained. Training has emphasised the need to ensure that reviews are more 'positive child-friendly experiences' and as a result more looked after children and young people are consistently taking part and are enjoying the review process more.

## Relationships with peers and wider society

Young people identified the quality of their relationships with peers and society in general as being important to their emotional and behavioural health. They suggested that other people's perceptions of being in care could be a barrier to developing relationships. While some looked after children and young people felt that society treats them 'the same as everyone else', others experienced prejudice:

Some people don't want to know you, but some people do because they think you are the same as them, which you are. People have different views: some think we're all trouble, others understand something must have gone wrong at home. (participant data – Morgan 2009b p 22)

They think you're rowdy, noisy and have an ASBO [anti-social behaviour order]. It's not that true. You go through emotional, angry and difficult stages but get to change your life around and get through them. Another group said people give you weird looks, and most people assume you take drugs: 'they always think the worst of U'. (author description and participant data – Morgan 2009b p 22)

Action for Children asked a small group of looked after children and young people: 'Why do you think people in care get stereotyped? What would make a difference?'. The group made a direct link between the stigma attached to being in care and their mental health. They described scenarios where ignorance of other children at school could lead to bullying, thereby threatening their mental wellbeing: '

In school people get bullied because they're in care. People have not been educated about care, it's ignorance. (Action for Children 2009 p 4)

If people don't understand being in care then they might end up bullying and put people into depression and they might end up killing themselves. It can put them into a mental hospital. (Action for Children 2009 p 4)

## Conclusion

This section summarised looked after children and young people's views on what is important to them and how this might improve their emotional and behavioural health. The key themes emphasise the importance of the consistency and quality of relationships with carers and professionals and the role that these relationships play in the children and young people's immediate and long-term emotional and behavioural wellbeing. Being supported to maintain contact with and sustain relationships with chosen family members, peers and friends is also very important for their emotional wellbeing.

The views of looked after children and young people about their experiences of stigma and prejudice, especially when it leads to bullying, suggest that raising awareness about the experience of being in care could improve their emotional and behavioural health. One of the first places to do this could be in schools, where information about why some children need to be looked after could be incorporated into the curriculum.

## 5. The accessibility, acceptability and effectiveness of enhanced foster care, multi-systemic therapy and mentoring

This section sets out the evidence on what we know about the accessibility, acceptability and effectiveness of enhanced foster care, multi-systemic therapy and mentoring (see Section 1 for definitions of these interventions). While the evidence on the efficacy of these interventions is not conclusive, there is some evidence that all three interventions can improve the emotional and behavioural health of children and young people and, through extension, looked after children and young people.

We have considered reviews identified in the scoping study, plus further reviews identified through systematic searching. Thus, the evidence that informs this chapter is limited to the primary studies included in those reviews. The latest search was conducted in 2007, therefore primary studies published after this date will not have been available for inclusion. Please note that in many cases these reviews and the studies within them apply to all emotional and behavioural health, rather than to looked after children and young people specifically. In addition, in studies that do focus on or include looked after children and young people, the looked after status has often arisen because the children and young people have been hospitalised or have committed or are considered at risk of committing a criminal offence, rather than as a direct result of parental neglect or abuse.

### Enhanced foster care

#### Key messages

- The overall findings of two of the three reviews on treatment foster care and multi-treatment foster care (which sit under the general term of 'enhanced foster care') (Hahn *et al* 2005; Macdonald and Turner 2008), conclude that the evidence of efficacy is inconclusive. However, individual study outcomes of these reviews report that treatment foster care and multi-treatment foster care may be particularly effective in relation to offending behaviour and reducing foster care placement moves.
- Some caution is required in applying the research evidence currently reported in the reviews as the majority of studies on multi-treatment foster care that have been considered within this review, have been conducted by the programme developers who evaluated its use in one region of the United States. Practitioners may find it helpful to read recent primary studies on the use of multi-treatment foster care in other regions, most pertinently the audit data from an ongoing full evaluation of multi-treatment foster care<sup>4</sup> (National Implementation Team 2009) in English settings. This suggests that some

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<sup>4</sup> Evidence from the English pilots has not been considered within this section, as it does not draw on primary studies. However, key findings from the 2009 annual report are given within Section 2 of this review, for readers' information.

positive outcomes are being achieved (see Section 1 or [www.mtfce.org.uk/library.htm](http://www.mtfce.org.uk/library.htm) for further details).

- The review by Hahn *et al* (2005) reported that the recruitment, training and retention of foster carers are the most commonly cited barriers to the successful implementation of therapeutic foster care discussed in the literature.
- The studies in their review suggested that the retention of foster carers was increased when they received financial payment, training and support. They also found that in order to ensure that treatment foster care programmes were more effectively delivered, strong working relationships based on open communication needed to be developed between foster carers and treatment staff.

Three reviews in the scoping study addressed enhanced foster care and all three focused on therapeutic interventions for children and young people who were already looked after as well as those who were at risk of entering care. The reviews differed in the type of studies they included, the outcomes they were interested in and the type of synthesis they conducted. For example, the review by Craven and Lee (2006) included different types of empirical studies on a range of interventions for looked after children and young people in an attempt to identify and classify therapeutic interventions for foster children. Hahn *et al* (2005) were narrower in their focus and conducted a narrative synthesis of studies that evaluated the effects of treatment foster care on violent outcomes among 'at-risk' juveniles. The review by Macdonald and Turner (2008), which aimed to assess the impact of treatment foster care, included a broader range of psychosocial and behavioural outcomes but restricted their review to meta-analysing, or pooling the statistical findings from randomised controlled trials only.

## What do the reviews say about the impact of enhanced (treatment and multi-treatment) foster care overall?

Overall, the reviews indicate that there is some evidence that treatment and multi-treatment foster care improve emotional and behavioural health outcomes for looked after children and young people.

The individual findings of the reviews on the effectiveness of enhanced foster care include the following:

- Craven and Lee (2006): in all, out of the 18 interventions, six (one of which was multi-treatment foster care) were considered well supported and efficacious;<sup>5</sup> three (all enhanced foster care) – early intensive foster care, respite care and intensive intervention – were determined to be supported by the research

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<sup>5</sup> Criteria included: (a) the treatment has a sound psychologically accepted theoretical basis, (b) the treatment has at least two randomised controlled outcome studies demonstrating the treatment's efficacy with at-risk children and foster children and (c) there is no clinical or empirical evidence indicating that the treatment constitutes a substantial risk of harm to those receiving it.

literature and probably effective; and nine were supported and acceptable. Interventions recognising the unique experience of foster children and foster family dynamics were found to be lacking in the current literature.

- Hahn *et al* (2005): there was insufficient evidence to determine the effects of cluster therapeutic foster care<sup>6</sup> on the reduction of violence for pre-adolescent children with severe emotional disturbance (for the reduction of violence).
- Hahn *et al* (2005): there was evidence that indicates that treatment foster care and multi-treatment foster care reduce violence in adolescent populations with a history of chronic offending behaviour.
- Macdonald and Turner (2008): data suggests that multi-dimensional treatment foster care may be a useful intervention for children and young people with complex emotional, psychological and behavioural needs, who are at risk of being placed in non-family settings that restrict their liberty and opportunities for social inclusion.

## What do the reviews say about the impact of enhanced foster care on specific outcome measures?

The more specific evidence on the impact of enhanced foster care on different types of outcome includes the following:

### Some reports of evidence of impact

*(Note: findings were not necessarily consistent across reviews.)*

There was some evidence to suggest that treatment and multi-treatment foster care reduce offending behaviour and increase placement stability, both of which are key outcomes.

- *Offending behaviour:* there was evidence that treatment and multi-treatment foster care reduced referrals for offending behaviour, rates of detention and violence for children and young people who already had high rates of offending behaviour. The factors most closely associated with fewer crimes post intervention were for those boys who:
  - received the closest supervision
  - had the most contact with care-taking adults
  - had the most consistent discipline
  - had the least association with peers engaged in offending behaviour.
- *Placement stability:* there was evidence to suggest that being placed in enhanced foster reduces the number of foster care placements and increases placement stability overall.

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<sup>6</sup> Cluster therapeutic foster care involves clusters of foster-parent families cooperating in the care of children with severe emotional disturbance.

## Few or no reports of evidence on impact

- *Emotional and behavioural health outcomes*  
Only a limited number of studies identified from the three reviews reported on the impact of enhanced foster care on emotional and behavioural health outcomes. Where some impact was reported, the reviews raised justified concerns about the methodological weaknesses of the findings, which means that conclusive evidence cannot be drawn for this outcome.
- *Educational, training and employment outcomes*  
The evidence base on the impact of multi-treatment foster care on educational, training and employment outcomes is limited to three studies from a single review. Although some evidence of impact was found (see practice example below), further research in this area needs to be conducted.
- *Family and peer relations*  
Only one study provided data on this outcome. This suggests that there is a gap in the literature for this outcome, and further research on the effectiveness of enhanced foster care in improving family and peer relations needs to be conducted.

## Not studied

- *Substance misuse*  
None of the studies included in the reviews reported on the impact of enhanced foster care on substance misuse or reported that targeting substance misuse was a feature of any of the enhanced foster care interventions.

## Example from the research

Leve *et al* (2005) conducted a randomised controlled trial that aimed to assess the impact of multi-treatment foster care on lowering offending behaviour rates for girls. They described the interventions as following basic multi-treatment foster care components: (a) daily (Monday–Friday) telephone contact with the foster parents, (b) weekly group supervision and support meetings for foster parents, (c) an individualised, in-home, daily point-and-level programme for each girl, (d) individual therapy for each girl and (e) family therapy (for the family of origin) focusing on the parent. The results of the trial suggested that the multi-treatment foster care intervention was more effective than the control condition in reducing incarceration and offending behaviour rates. The authors also found a moderate effect size on levels of school attendance, and that girls in multi-treatment foster care spent more time completing homework than the control group. The authors concluded that the study represented a first step in developing an effective intervention for girls in the juvenile justice system.

## What do the reviews say about the effect of mediator variables on the impact of enhanced foster care?

All of the reviews focused on the effectiveness of interventions of programmes under the enhanced foster care umbrella on emotional and behavioural health outcomes. Reviews synthesising studies on the delivery and/or key characteristics of enhanced foster care and its impact on emotional and behavioural health outcomes were not identified from the scoping study or additional searches. Instead, we interrogated the data included in the effectiveness reviews to identify whether individual characteristics of the population or differences in relation to the intensity and/or fidelity of the intervention mediated the impact of enhanced foster care. We did not find any data on these mediating variables and only some data on the accessibility and acceptability of enhanced foster care (see below).

## Accessibility and acceptability of enhanced foster care

The research studies included reports that:

- issues around the selection, training and support of foster carers were barriers to the successful implementation of therapeutic foster care
- the retention of foster carers was increased when they received both financial payment and training and support
- strong working relationships based on open communication needed to be developed between foster carers and treatment staff
- additional support for treatment foster carers can help them to support looked after children and young people and their families access appropriate services.

## Multi-systemic therapy

Multi-systemic therapy is an intervention designed to keep families together rather than as an intervention for looked after children. The literature reviewed considered its efficacy in treating emotional and behavioural disorders experienced by children and young people. There is no research evidence about its effectiveness as an intervention designed specifically for looked after children.

### Key messages

- The majority of reviews concluded that although there are positive reports of the efficacy of multi-systemic therapy for improving outcomes for emotional and behavioural disorders, the evidence to date does not conclusively demonstrate whether it is more effective than other interventions.
- Positive reported effects include those related to emotional health, educational outcomes, criminal activity, self-reported offending behaviour and family relations.

- Some authors of the reviews reported that fidelity to the implementation of the specific programme is key to effectiveness, while others argued for the adaptation of programmes developed in other countries for local contexts.
- There are concerns that the majority of multi-systemic therapy studies have been conducted by the authors of multi-systemic therapy, and that this may have influenced the outcomes of these trials. Research in progress may clarify this.

Seven reviews on the impact of multi-systemic therapy were identified. Four reviews were statistical meta-analyses<sup>7</sup> of findings from evaluations of multi-systemic therapy (Woolfenden *et al* 2002; Curtis *et al* 2004; Littell *et al* 2005; Waldron and Turner 2008) and a further three involved systematic narrative syntheses (Austin *et al* 2005; Harpell and Andrews 2006; Painter and Scannapieco 2009). Three of the reviews did not focus on multi-systemic therapy exclusively (Woolfenden *et al* 2002; Austin *et al* 2005; Waldron and Turner 2008). The review by Austin *et al* (2005) included only one study on multi-systemic therapy (Henggeler *et al* 1999a) and the remaining two were meta-analyses (Woolfenden *et al* 2002; Waldron and Turner 2008), making understanding of the findings in relation to multi-systemic therapy at the review level somewhat difficult. An update of the review by Littell *et al* (2005) is currently under way.

The Austin and Waldron reviews focused specifically on adolescents with substance abuse problems. The Harpell and Woolfenden reviews included only studies on young people with specific anti-social behavioural problems such as conduct disorder. The Painter review focused specifically on young people with serious mental health problems. The Curtis and Littell reviews included a broader range of participants with a variety of social, emotional and behavioural problems such as juvenile offenders, substance abusers and those requiring psychiatric hospitalisation.

## What do the reviews say about the impact of multi-systemic therapy overall?

The majority of reviews (n=4) concluded that, to date, evidence of the effectiveness of multi-systemic therapy for improving emotional and behavioural health outcomes was inconclusive. Although some evidence of effectiveness was found for particular emotional and behavioural health outcomes, such as offending behaviour, the majority of multi-systemic therapy studies were conducted by the authors of multi-systemic therapy and this may have influenced the positive findings. In addition, none of the reviews in this area specifically focused on looked after children and young people, making it difficult to draw overall conclusions for this group.

The authors of the reviews reported the following conclusions about the impact of multi-systemic therapy:

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<sup>7</sup> Statistical meta-analyses combine the results of multiple statistical studies.

- Austin *et al* (2005): multi-systemic therapy is a promising intervention for treating adolescent substance use problems.
- Curtis *et al* (2004): as an empirically established treatment for violent and chronic juvenile offenders, multi-systemic therapy appears to be worthy of wider implementation and continued evaluation.
- Harpell and Andrews (2006): multi-systemic therapy could be a very powerful alternative to usual legal and social services.
- Littell *et al* (2005): it is not clear whether MST has clinically significant advantages over other services.
- Painter and Scannapieco (2009): multi-systemic therapy is a logical way to treat the multiple needs of children, adolescents and their families in the child welfare system, including minority ethnic children.
- Waldron and Turner (2008): family models, including multi-systemic therapy, are probably efficacious, pending replications by independent research teams. No clear pattern has emerged for the superiority of one treatment model over another.
- Woolfenden *et al* (2002): evidence suggests that family and parenting interventions, including multi-systemic therapy for young offenders and their families, have beneficial effects on reducing time spent in institutions.

## What do the reviews say about the impact of multi-systemic therapy on specific outcome measures?

The more specific evidence on the impact of multi-systemic therapy on different types of outcome includes the following:

### Some reports of evidence of impact

*(Note: findings were not necessarily consistent across reviews.)*

- *Emotional health*  
The findings from reviews found that although there were individual examples of the impact of multi-systemic therapy on emotional and behavioural health, the overall evidence for this outcome was both limited and unclear.
- *Educational outcomes*  
The reviews were unable to determine whether multi-systemic therapy was more effective than other types of therapeutic interventions, for improving educational outcomes. The reviewers noted that although one of the two studies reporting on this outcome did find an increase in school attendance for those in the multi-systemic therapy group, the findings were not sustained at the end of one year.
- *Criminal activity and self-reported offending behaviour*  
It appears from the totality of review evidence that multi-systemic therapy may be effective in reducing criminal activity and self-reports of offending behaviour but there was not definitive confirmation of significantly greater effects than other services.

- *Family relations*  
Some reviews concluded that there was evidence that family relations improved as a result of participating in multi-systemic therapy.

### **Few or no reports of evidence of impact**

- Behavioural health
- Substance abuse
- Peer relations
- Out-of-home placements.

### **Not studied**

- *Employment and training*  
None of the reviews reported on this outcome.

## **Example from the research**

In an independent study, Ogden and Halliday-Boykins (2004) conducted a randomised controlled trial of multi-systemic therapy to determine the degree to which favourable outcomes obtained in the United States would be replicated in Norway. Multi-systemic therapy for youths with serious anti-social behaviour was implemented as detailed in the treatment manual (Henggeler *et al* 1998) with no major modifications to the original intervention model being made. The authors reported that multi-systemic therapy was associated with decreased behavioural problems in youths as well as increased youth social competence. They also found that multi-systemic therapy also produced decreases in out-of-home placement (combining all types of placements). In addition, carers in the multi-systemic therapy condition reported marginally significantly greater satisfaction with treatment than did their control counterparts.

## **What do the reviews say about the effect of mediator variables<sup>8</sup> (e.g. programme adherence, intensity, acceptability and accessibility) on the impact of multi-systemic therapy?**

Similar to the evidence considered within the subsection on enhanced foster care, none of the multi-systemic therapy reviews was primarily concerned with the implementation of multi-systemic therapy. However, we were able to identify data on contextual variables that mediate the impact of multi-systemic therapy.

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<sup>8</sup> Mediator variables describe how effects will occur by accounting for the relationship between the independent and dependent variables.

## Some reports of evidence of impact

(Note: findings were not necessarily consistent across reviews.)

- *Intervention fidelity*  
This refers to how far the intervention was conducted according to how it was originally designed. There was some evidence that multi-systemic therapy was more effective when it was more rigorously adhered to by multi-systemic therapy counsellors.

## Few or no reports of evidence of impact

- Intervention intensity.

## Is evidence available from the multi-systemic reviews about the impact of issues of acceptability and accessibility?

The review by Austin *et al* (2005 p 78) concluded that multi-systemic therapy was an intervention that maximised accessibility by being delivered in the home and community and was 'critical to effectively engaging and retaining young people and families with complex needs'. The authors also reported that multi-systemic therapy was particularly effective in limiting drop-outs from treatment, which is important since 'dropout has been consistently associated with poor treatment outcomes among adolescents with substance abuse problems' (p 78). In contrast, Harpell and Andrews (2006) suggested that problems with treatment fidelity might be caused by the resistance of some individuals to multi-systemic therapy.

## Mentoring

### Key practice messages

- Mentoring may have a modest positive effect on a wide range of outcomes, particularly educational and psychosocial outcomes. The evidence is strongest for preventative interventions with young people who are 'at risk' because of socio-economic disadvantage.
- The evidence suggests that the greatest benefit will be attained by using a set of recommended guidelines with committed mentors who have experience in helping roles, by recruiting and training mentors appropriately, by ensuring that mentoring is structured and monitored, and by focusing on the quality of the relationship between mentor and mentee, rather than specific outcome goals.

Only one review – Dubois *et al* (2002) – considered the research on mentoring. The evidence base on mentoring is therefore less developed than for enhanced foster care and multi-systemic therapy. This review assessed the effect of mentoring programmes on children and young people and the effects of variations in programme components on outcomes. Studies included in the review needed to be evaluations of mentoring (exclusively), have some form of equivalent control or

comparison group and have a sample with a mean age of less than 19. Mentoring was defined as 'a relationship between an older, more experienced mentor and a younger protégée' (Rhodes 1994, cited in Dubois *et al* 2002 p 162).

## What does the review say about the impact of mentoring overall?

The findings of the review on the effectiveness of mentoring include the following:

- There is evidence of only a modest or small benefit of programme participation across all outcomes for the average young person.
- Programme effects are enhanced significantly when greater numbers of both theory-based and empirically based 'best practices' are utilised and when strong relationships are formed between mentors and young people.
- Young people from backgrounds of environmental risk and disadvantage appear most likely to benefit from participation in mentoring programmes.
- Outcomes for young people at risk due to personal vulnerabilities have varied substantially in relation to programme characteristics – poorly implemented programmes may actually have an adverse effect on such young people.

## What does the review say about the impact of mentoring on specific outcome measures?

The more specific evidence on the impact of mentoring on different types of outcome includes the following:

### **Some reports of evidence of impact**

- Emotional and behavioural health
- School attendance
- Offending behaviour
- Anti-social behaviour (hitting others)
- Substance abuse
- Family relations.

### **Few or no reports of evidence of impact**

- Behavioural health outcomes
- Educational attainment
- School behaviour
- Peer relations.

## Not studied

- Criminal activity
- Foster care placements
- Employment.

## Example from the research

Grossman and Tierney (1998) conducted a randomised controlled trial to investigate the effectiveness of a Big Brothers, Big Sisters mentoring project. The programme paired unrelated adult volunteers with young people from single-parent households. The volunteer and young person agreed to meet two to four times per month for at least one year, with a typical meeting lasting three to four hours. The programme was not targeted at ameliorating specific problems, but rather at providing the young person with an adult friend. The aim of the friendship forged with a young person by the Big Brother or Big Sister was to build a framework through which the mentor could support and aid the young person. The authors found that at the end of the 18-month study period, participants enrolled in the programme were less likely to have started using drugs or alcohol, felt more competent about doing school work, attended school more, got better grades and had better relationships with their parents and peers than they would have had they not participated in the programme. The authors concluded that the study did not provide evidence that any type of mentoring works, but rather that mentoring programmes which facilitate the types of relationships that were observed in the Big Brothers, Big Sisters project could have positive and tangible benefits for young people.

## What does the review say about the effect of mediator variables (e.g. setting, programme adherence, mentor training) on the impact of mentoring?

The modest effects found on the impact of mentoring programmes by Dubois *et al* (2002) were present for children and young people across a range of demographics such as age, gender, race/ethnicity and family structures.

### Some reports of evidence of impact

- Setting: lower effect sizes were found for programmes that were based in schools as opposed to other settings such as the workplace or community.
- Monitoring of programme implementation: larger effect sizes were found for programmes that reported use of procedures for monitoring implementation in comparison to those that did not.
- Mentors with a background in a helping role or profession (e.g. teacher) were a significant moderator of effect size for both fixed-effects and random-effects models.

- A difference was found with regard to the provision of ongoing training during mentor and mentee relationships.
- Specifically, those programmes in which mentors received ongoing training reported larger effects than those in which this type of training was not indicated to have been made available.
- Provision of structured activities for mentors and young people and inclusion of a parent support or involvement component were also significant moderators of effect size. Provision of structured activities remained a significant moderator.
- Expectations regarding frequency of contact were a significant moderator of effect size, with larger effect sizes reported in evaluations of programmes that did include this type of expectation in comparison to other programmes.
- Mentoring showed a greater impact for at-risk middle school students.

### **Few or no reports of evidence of impact**

- Whether mentoring programmes were stand-alone or multi-component programmes
- Geographical location
- Whether programmes had general (i.e. psychosocial) or more focused goals aimed at changing behaviour (i.e. instrumental) goals
- The use of procedures for screening prospective mentors
- The use of matching of mentors and young people on the basis of relevant criteria
- The use of matching based on gender, race/ethnicity or interests
- Supervision and support groups for mentors
- Expectations regarding the duration of relationships
- Frequency of contact or length of relationship expected
- Intervention intensity.

## 6. The role of professionals and birth families in supporting looked after children and young people's emotional and behavioural health

This section presents the views of foster carers, residential staff, birth parents and service providers on their roles in supporting looked after children and young people to improve their emotional and behavioural health and how this could be improved.

Evidence is drawn from 11 research studies and views and opinions of the stakeholders consulted by C4EO (see Appendix 6 for further details).

### Key messages

- Foster carers are better able to support the looked after children and young people in their care when they have access to a named professional with the time and resources to work with them.
- Provide opportunities for foster carers (and potentially birth parents) to build peer support networks; information on – and support navigating – the mental health referral system; and training on how to effectively support looked after children and young people with emotional and behavioural health needs.
- Therapeutic training for residential staff can have a positive impact on the way they work with looked after children and young people, and contribute to building safe and supportive communities.
- Residential staff who value and build positive relationships with looked after children and young people and their families can have a positive impact on the emotional and behavioural health of this group of children and young people.
- Supporting birth families to have meaningful and regular contact could be beneficial to supporting the emotional and behavioural health of looked after children and young people.
- Service providers emphasised the need for early identification and appropriate assessment of looked after children and young people's mental health needs, access to local targeted and non-targeted mental health services and greater access to Child and Adolescent Mental Health Services in order to adequately support the emotional and behavioural health of looked after children and young people.

### Role of foster carers

Foster carers emphasised the importance of their relationship with looked after children and young people (Butler and Charles 1999; Kirton 2001; Schofield and Beek 2005). They wanted to have a positive impact on the lives of looked after children and young people: 'I just hope I've got enough time to help Tania (13) on her way, that's my fear. Will I have enough time to make the difference so that she can grow...?' (participant data – Schofield and Beek 2005 p 11).

Schofield and Beek (2005) were interested in the therapeutic role of foster carers and their ability to provide a 'secure base' for children. They concluded that foster carers had an important part to play in supporting children to establish new ways of relating (i.e. through trust, cooperation and open communication) and linked this to contributing to the emotional wellbeing of looked after children and young people.

Making sure that there is a good pool of carers is essential. This is recognised by Southampton's time-out programme, which has proved to be successful in increasing retention rates among carers.

#### **Validated Local Practice example**

**Dreamwalls**, in Southampton, is a time-out programme that supports carers by ensuring that they have planned breaks. The aim is to prevent foster carers from reaching 'crisis' point before they make a request for respite. The overwhelming success of the programme has been a 95 per cent reduction in the number of carers leaving as a result of 'discontent or burnout'. This not only benefits the emotional and behavioural health of foster carers, but looked after children and young people also benefit from greater placement stability. The programme also provides looked after children and young people with another opportunity to experience support with their personal, social and emotional development.

The Dreamwalls 'time-out' programme aims to support the emotional and behavioural health of looked after children and young people by (a) delivering a supportive and non-stigmatising environment in which young people can grow and develop a sense of autonomy, (b) providing consistent relationships with young people, (c) engaging with young people who are 'hard to reach' and working with them over a significant period of time and (d) valuing the importance of delivering a service that reflects the needs of young people, which keeps them interested and challenged.

## **Role of residential childcare staff**

Residential staff emphasised the need to build trust and relationships with looked after children and young people (Harris *et al* 2009). Developing good relationships with residential staff helps enable the children and young people to learn how to form positive relationships with other people.

The evaluation of the Mulberry Bush School<sup>9</sup> for children in care provided many examples of how positive relationships with staff contributed to better emotional and behavioural health (Harris *et al* 2009). This was evident in the way in which looked after children and young people not only related to other staff members, but also to their peers and carers. For example: 'he wouldn't talk to [the other adults in the house], he just felt he couldn't communicate with anybody else.... But a lot of work was done with him in those six weeks.... I am not the only adult he talks to now' (staff participant data – Harris *et al* 2009 p 3).

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<sup>9</sup> A residential school for children in care.

Staff emphasised that supporting parents and carers individually, to reinforce the work they had been doing with looked after children and young people, was crucial to their wellbeing: 'Mum and Dad have done a lot of work as well ... we could have done as much work as we like, but had nothing changed at home she'd be going back to virtually square one' (staff participant data – Harris *et al* 2009 p 49).

Bury's multi-agency 'Holding Families' project works to ensure that children and young people's emotional and behavioural health needs are addressed within the wider family context.

### **Validated Local Practice example**

The Bury '**Holding Families**' project offers a holistic, intensive treatment service for families where substance misuse is a problem and where the needs of children and adults are dealt with at the same time, within the same project. The project works with children and young people and parents separately and then supports them through regular 'family meetings'. The aim of these meetings is to provide a space that allows young people to express their feelings and concerns and supports parents to hear what their children have to say. One practitioner poignantly reflected on a young person's experiences of communicating with her parents: 'It made the unspeakable speakable. She said "I can remember everything but I can't tell my mum". Having shared that experience we hope they will be able to share better in the future' (participant data – Holding Families project).

The success of the project is attributed to three core components: staff forming partnerships with children and working intensively with them on a 1:1 basis; group and individual work with parents, which helps them to identify the impact of substance misuse on their children; and maintaining a continuum of partnerships, whereby practitioners work effectively with others from different practice backgrounds. The key to the third component is to find ways of ensuring that lines of communication between practitioners remain open. One of the key outcomes of working holistically is seeing parents attempting to change their substance misuse patterns, to communicate more honestly with their children and to form closer relationships.

## **Role of birth parents and contact with birth family members**

In the birth family focus group commissioned to inform this review, birth parents described their concerns about the impact of separation on their children's emotional and behavioural health. They also reflected on the bond between siblings and how lack of contact between them can lead to emotional and behavioural problems. The report from the focus group stated that:

Parents do worry about their children's emotional health. Children were particularly distressed about placement transitions and lack of sibling contact. Moving between care homes and foster care was seen to be particularly stressful for children, leading to a lack of meaningful bonding. This was also seen to have a negative impact on their schoolwork.

Parents also felt that they needed support from professionals to ensure that they have useful contact with them. The summary report of birth parents' views included the following statements:

One mother felt that contact was causing anxiety and stress for her son as social services would often cancel or change arrangements at short notice. Also more information-sharing is needed between parents and social workers in order to make contact 'happy and meaningful'.

One mother found it difficult to emotionally support her children as the content of her contact letters were often vetoed by social services.

It is important to recognise that although birth family contact does need to be handled sensitively to ensure that it is in the best interest of the child, consistent and supported contact can be a factor in providing effective care. The views of looked after children and young people also supported the desire to maintain contact with siblings and to be afforded a choice in whether they wished to continue having a relationship with their birth parents as it could potentially have a positive impact on their sense of identity and belonging.

## Role of social workers

While carers understood that social workers face pressures in their role, they also voiced a need to receive continuity of support from them. They felt that having the opportunity to build working relationships with social workers would help them provide better support to looked after children and young people, and that inconsistent support from different social workers was unhelpful (Sellick 1994; Sinclair *et al* 2005; Addy and MacKechnie 2006; Maclay *et al* 2006).

[The c]urrent social worker is more than helpful, understands the child and is always there to help. (participant data – Sinclair *et al* 2005 p 93)

[The social worker] only seems to come in a crisis [and] often has not done things that [were] requested. (participant data – Maclay *et al* 2006 p 35)

Foster carers also wanted social workers and social services to provide them with more information about the child that they were caring for, particularly in relation to any emotional and behavioural health issues. Hardwick (2005) looked specifically at supporting looked after children and young people who had experienced child sexual abuse and the difficulties foster carers faced in those circumstances:

They [carers] discussed the reluctance of social workers to talk about any sexual abuse experienced by the child. When disclosure occurred within the placement, the foster carers felt that, for the social worker that was the end of the matter. The resulting emotional and behavioural problems were apparently not acknowledged. (author description – Hardwick 2005 p 39)

## Importance of training and peer support

### Foster carers

Training was highly valued by foster carers, who made a direct link between training and being able to provide a better standard of care to looked after children and young people. They wanted training, similar to social workers, to enable them to support and improve the emotional and behavioural health of looked after children and young people (Sellick 1994; Fleming *et al* 2005; Hardwick 2005; Children in Scotland 2006).

Now we're going on more courses, which is great, child protection, sexual abuse, quite a lot, which is marvellous because I find the more I know the more relaxed I feel. (participant data – Sellick 1994 p 52)

C4EO's consultation with a group of parents and carers asked: 'Are you being supported to address any emotional and behavioural health needs of your children?' and 'How can parents and carers be helped to support the emotional and behavioural health of looked after children better?'. Participants said:

"I do know of some families who have benefited enormously from attending training days on subjects such as coping with challenging behaviour or sessions on how to raise self-esteem." (mother of three children aged 9, 11 and 13)

"[We need] education of parents that this support may be needed, so no stigma is attached." (mother of two children aged 6 and 9)

Studies included foster carers' views about their experiences of wider support networks. This was often framed in terms of foster carers being able to talk to other foster carers who understand the unique aspects of the role. Issues included the duality of the role, which crosses both the public (social services) and private (caring for children) domains and the need to discuss issues about looked after children and young people in confidence:

My husband and I needed some support from a foster carer. I think that's very important because there are times when you want to get away from it ... you don't want to tell a social worker that because you know he's going to go away and write something down. (participant data – Sellick 1994 p 71)

The issue of caring sometimes being a stressful experience that requires additional support was raised. Gaining the support of other carers who were also in similar situations provided carers with an opportunity to identify common ground and find new ways of parenting, enabling them to rely less on the support of social workers:

The foster care group provides an example of one method of addressing the foster carers' needs and, indirectly, those of a highly vulnerable group of children – one that appeared to be long awaited and greatly appreciated by the foster carers. (author description – Hardwick 2005 p 42)

Studies suggested that the support of other foster carers was an important resource and can help facilitate better care for children, positively impacting on their emotional and behavioural health.

## Joint training for foster carers and other professionals

Service providers who attended C4EO knowledge workshops supported the idea that carers and other professionals need training if the emotional and behavioural health needs of children and young people are to be addressed more directly. They agreed with foster carers that joint training could be a useful approach. They also advocated for greater looked after children and young people involvement, to ensure that training professionals is more relevant to the needs and concerns of looked after children and young people. They identified the following needs:

Support carers in understanding the behaviour of young people.

Multi-agency training – it helps people to learn.

The role of children and young people themselves in training professionals is important – e.g. involvement in foster carer assessments.

## Residential childcare staff

Residential staff also highlighted the importance of training. Reports by National Children's Home (2008) and Ofsted (2009) provided examples of how focusing specifically on emotional and behavioural health issues can benefit staff as well as looked after children and young people. Learning skills such as empathy, congruence, genuineness, and unconditional positive regard was found to be useful for staff working with looked after children and young people in a residential care setting:

The therapeutic training has hugely improved our ability to meet young people's behavioural needs. (author description – Ofsted 2009)

I have been able to get deeper with the Young People, which helps to build better relationships. The big change is the community being built together with team work. (participant data – National Children's Home 2008 p 140)

You've got to make it clear that behaviour doesn't define them ... you get underneath to the real person. (staff participant data – SIRC 2009 p 7)

The Bury 'Holding the Space' project is an example of how therapeutic skills can be used in a residential care setting. Rather than reacting to poor behaviour, it encourages staff to work with children to understand and improve how they relate to themselves (emotionally) and interact with others (behaviourally).

### **Validated Local Practice example**

**'Holding the Space'** is a multi-model intervention delivered in residential care settings with looked after children and young people who have experienced sexual and emotional abuse. The intervention includes training staff in person-centred approaches, using a therapeutic groupwork method ('council') and provides creative art and transpersonal therapies. The focus of supporting children and young people in residential care settings has moved towards seeing their behaviour as symptomatic of underlying issues as a result of the experience of trauma. Children and young people report that they feel listened to and know that they are cared for since they have received the intervention. The initiative has led to an increase in the number of looked after children and young people accessing and continuing with therapeutic services through Child and Adolescent Mental Health Services. The innovative use of both individual and group approaches to working with looked after children and young people appears to provide a safe space where both staff and the children and young people can reflect on their emotions, behaviour, and how they are communicating. This has helped to provide a trusting and healing environment.

## **Early identification of looked after children and young people's emotional and behavioural issues**

One of the key issues that emerged from the views of service providers was the importance of early identification and assessment of looked after children and young people's emotional and behavioural needs. At the C4EO knowledge workshops, providers debated how best to collect and use data about looked after children and young people's mental health status. Service providers commented on the accuracy, appropriateness and timely use of the Strengths and Difficulties Questionnaire and the extent to which assessment of mental health needs should be a routine part of the care experience. They suggested the following ways of improving the early identification of emotional and behavioural problems of looked after children and young people:

Carers need training in completing the SDQ [Strengths and Difficulties Questionnaire].

Services need to identify priority areas where they would like to collect data, including emotional health and wellbeing of LACYP [looked after children and young people].

The suggestions provided by service providers touch on the need to train and assist carers (and teachers) in effectively supporting the emotional and behavioural health of looked after children and young people. This should be part of the overall package of support provided to children and young people when they come into care.

## **Accessibility of mental health services**

Three studies provided data on foster carers' views on the accessibility and acceptability of mental health services (Callaghan *et al* 2003; McDonald *et al* 2003; Addy and MacKechnie 2006). The lack of information about the availability of mental

health services was cited as the main barrier to accessing services in the study by Addy and MacKechnie (2006). The authors presented the following suggestion from a foster carer on how best to overcome these barriers: 'I think you should get a leaflet or something telling you where you can go for help' (participant data – Addy and MacKechnie 2006 p 17). The study by Callaghan *et al* (2003) also reported foster carers' views on navigating Child and Adolescent Mental Health Services: 'And of course they tell you they can't see the child until they're in a stable placement, but how on earth is the child supposed to get stable until they get help?' (participant data – Callaghan *et al* 2003 p 53). In addition, the study by McDonald *et al* (2003) provided data on foster carers' concerns about mental health referral procedures: 'There were some inconsistencies in the way in which foster carers found out about the new service. Four foster carers raised a number of concerns about their referral' (participant data – McDonald *et al* 2003 p 827).

Birth parents made similar points about the difficulties of accessing mental health services. They expressed some dissatisfaction with services provided and in one instance had sought alternative (private) forms of help: "When needed I tried to access children's mental health services which took months for an appointment. In the end I paid privately to see a psychotherapist for my child" (mother of two children aged 6 and 9 at C4EO birth family focus group).

## **Community-based services that can support those caring for looked after children and young people**

Service providers stressed the importance of interventions that indirectly support the emotional and behavioural needs of looked after children and young people. They suggested having localised professional services, made accessible by being visible in settings such as schools, hospitals, youth centres, and possibly part of looked after services for children. Suggestions for foster carer support included:

- a drop-in service
- holidays instead of respite care – to avoid children feeling rejected
- an emotional wellbeing coordinator in each borough
- targeted mental health in schools (currently being piloted)
- infant–parent mental health interventions
- a psychologist based in the leaving care team to provide cognitive-behavioural therapy in situ, rather than as a result of a formal appointment system.

One local authority provided external commissioning of services outside the traditional Child and Adolescent Mental Health Services. These included therapeutic foster care, young people's inpatient psychiatric care and specialised therapeutic intervention.

## Multi-agency working

The views of carers, residential staff and the validated local practice examples have emphasised the need to work together to better support the emotional and behavioural health of looked after children and young people. Service providers who took part in group discussions at C4EO knowledge workshops shared the following practical examples:

In Sefton [there is a] regular multi-agency meeting of senior managers/representatives with the focus on problem-solving issues in relation to individual cases. This promotes joint ownership and shared understanding, as well as moving plans on for individual LACYP.

A joint appointment (LA [local authority] and PCT [Primary Care Trust]) has been made to a very senior management post, with CAMHS responsibility.

Emotional and behavioural issues/support are not just the responsibility of CAMHS [Child and Adolescent Mental Health Services] but all services.

A commitment to 'joined-up' working from professionals involved in working with looked after children and young people is one way to ensure that their emotional and behavioural needs are addressed, taken seriously and considered to be important to everyone, not just mental health professionals.

## Conclusion

A range of views were expressed regarding how to effectively support the emotional and behavioural health of looked after children and young people. Parents and carers felt that training would enhance their emotional and behavioural knowledge and skill for the benefit of looked after children and young people. Residential staff were able to reflect on their experience of therapeutic training skills, which reinforced to them the importance of using those skills to improve the quality of relationship they had with looked after children and young people. Carers and parents also talked about being able to confidently negotiate the mental health system so that they would be able to support looked after children and young people by accessing services when they needed it. Last, service providers emphasised the need for early and routine identification of any emotional and behavioural health difficulties, to provide a range of services that are more accessible to young people, through routes such as schools and youth groups as well as Child and Adolescent Mental Health Services and to encourage all professionals to take responsibility for the emotional and behavioural health of looked after children and young people.

## 7 Conclusions and main messages

This section presents the review's main findings and conclusions.

### Specific interventions to improve children and young people's emotional and behavioural health

The review summarised the findings of systematic reviews (and their included studies) on research into three main forms of intervention for children and young people with emotional and behavioural health difficulties – enhanced foster care, multi-systematic therapy and mentoring.

#### For enhanced foster care:

- The evidence is not conclusive but there are reports that models of enhanced foster care, particularly treatment foster care and multi-treatment foster care can be effective, particularly in offending behaviour and reducing placement moves.
- Selection, training and support of and communication with treatment foster carers are key to enabling foster carers access to other services.
- While recognising that much of the published research on multi-treatment foster care, included in this review, is based on its use in the United States, limiting its applicability to other geographical settings, the full evaluation of its implementation in English settings has not yet been completed (however, audit data suggests that some positive outcomes are being achieved).

#### For multi systemic therapy:

Multi-systemic therapy is not a programme designed for use with looked after children and there is no research evidence about the effectiveness with this group of children. However, generally we know the following:

- Positive effects related to improved emotional health, educational outcomes and family relations and decreased criminal activity and self-reported offending behaviour have been reported.
- Although these positive reports of the effectiveness of multi-systemic therapy for improving emotional and behavioural health outcomes have been reported in the international literature, the evidence to date is inconclusive as to whether multi-systemic therapy is more effective than other approaches.
- There is disagreement about whether adapting the multi-systemic therapy programme for local contexts improves or reduces its effectiveness.
- Multi-systemic therapy is a specific programme and authors report that adhering to the programme as it was designed is key to programme effectiveness. Others argue for the adaptation of programmes developed in other countries for local contexts.

- There are concerns that the preponderance of multi-systemic therapy studies have been conducted by the authors of multi-systemic therapy, and that this may have influenced the outcomes of these trials. Research in progress may clarify this.

### **For mentoring:**

- Mentoring may have a modest effect on a wide range of outcomes, particularly educational and psychosocial outcomes.
- The evidence is strongest for preventative interventions with young people who are 'at risk' because of socio-economic disadvantage.
- The evidence suggests that the greatest benefit will be obtained by using a set of recommended guidelines with committed mentors who have experience in helping roles, by recruiting and training mentors appropriately, by ensuring that mentoring is structured and monitored and by focusing on the quality of the relationship between mentor and mentee, rather than specific outcome goals.

## **Views on meeting the needs of looked after children and young people**

- Looked after children and young people say that receiving emotional and practical support enhances their self-esteem, sense of belonging and emotional wellbeing.
- The quality of looked after children and young people's relationships with their foster carers and other professionals (particularly social workers) is key to their emotional and behavioural health. Being treated as a member of their foster carer's family is very important to looked after children and young people. Maintaining stable placements is key to enabling foster carers and the children and young people who they care for to have meaningful relationships, which support any emotional and behavioural health issues experienced by the child or young person.
- Being able to maintain contact with birth family members, particularly siblings, is very important for their emotional health. This is easier when looked after children and young people receive support in dealing with the emotional consequences of contact with birth family members.
- The quality of relationships with professionals, and receiving support from them, are very important. Looked after children and young people need professionals to be reliable and accessible.
- Listening to and actively involving children and young people, and involving them in decisions that affect their lives, are important. However, professionals need to take account of their age and cognitive development, and be realistic and honest with them about the extent of their influence.
- Looked after children and young people also want professionals to help them gain access to information, advice and services, including mental health services (Allen 2003; Morgan 2009a).

- Looked after children often experience negative social consequences as a result of being in care, such as stereotyping and in bullying. This can be addressed through increasing awareness of this, particularly in schools, and dispelling myths and misunderstandings about why children become looked after.
- Having access to a named professional who has the time and resources to work with them, helps foster carers to better support the children and young people in their care.
- Providing opportunities for foster carers (and potentially birth parents) with: opportunities to build peer support networks; information on – and support navigating – the mental health referral system; and training on how to effectively support looked after children and young people with emotional and behavioural health, is important.
- Therapeutic training for residential staff can have a positive impact on the way they work with looked after children and young people and contribute to building safe and supportive communities.
- Residential staff who value and build positive relationships with looked after children and young people and their families can have a positive impact on the children and young people's emotional and behavioural health.
- Supporting birth families to have meaningful and regular contact could be beneficial to supporting the emotional and behavioural health of looked after children and young people.
- Service providers emphasise the need for early identification and appropriate assessment of looked after children and young people's mental health needs, access to local targeted and non-targeted mental health services and greater access to Child and Adolescent Mental Health Services in order to adequately support the emotional and behavioural health of looked after children and young people.

## Professional roles

- **Placement stability** – in order for foster carers to have meaningful relationships with looked after children and young people and to support them with any emotional and behavioural health issues, greater emphasis on the achievement of stable placements is required.
- **Named professionals** – carers can be better supported to care for looked after children and young people if they have access to a named professional who is given the time and resources to work with foster carers.
- **Peer support** – opportunities for foster carers and birth parents to build peer support networks could have a positive impact on the emotional and behavioural health of looked after children and young people.
- **Access to services** – foster carers and birth parents need information on and support navigating the mental health referral system.

- **Training** – it is important to provide opportunities for foster carers and birth parents to access training relevant to supporting looked after children and young people with emotional and behavioural disorders.
- **Therapeutic skills** – training that focuses on enhancing the therapeutic skills of staff working in residential settings improves the quality of their relationships with looked after children and young people, which can have a beneficial impact on their emotional and behavioural health.

## Conclusion

High rates of emotional and behavioural disorders have been identified among looked after children and young people. These emotional and behavioural disorders lead to poorer outcomes in all areas of children and young people's lives, making it vital that all agencies and organisations involved in supporting these looked after children and young people through the services they provide, do so using the best available evidence of what works to improve their outcomes.

The results of this review of reviews suggest that enhanced foster care, multi-systemic therapy and mentoring can be effective. However, the evidence of positive results is relatively weak and we do not know whether these interventions are more effective than others. We do know, however, that the quality of relationships between looked after children and young people and their carers, and with other professionals including social services, is crucial in improving and contributing to their emotional and behavioural wellbeing.

The themes identified from stakeholders and the validated practice examples reflect the research evidence, and suggest that effective support of looked after children and young people's emotional and behavioural health involves:

- valuing looked after children and young people's experiences by building meaningful relationships that seek to improve the current quality of their lives
- respecting looked after children and young people's views about what matters to them through supportive therapeutic relationships and by involving them in decision-making and service provision
- addressing the wider context of emotional behavioural health issues by understanding the importance of working with looked after children and young people *and* their parents
- supporting carers and professionals to work *with* looked after children and young people by training them in the necessary skills to enable this to happen.

## Data annexe

### Key messages

- Information on the emotional and behavioural health of looked after children and young people (national indicator [NI] 58) has been collected since 2008–09, using the Strengths and Difficulties Questionnaire (SDQ). There were some issues with the accuracy and comprehensiveness of the 2008/09 data, but it is hoped that with stricter validation rules this will improve for the 2009–10 collection.
- In comparison with all children, a higher proportion of looked after children and young people have been subject to permanent exclusion from school, although the proportion of looked after children and young people subject to permanent exclusion has been decreasing since 2005.
- More looked after children and young people than their peers have been convicted of an offence or subject to a final warning or reprimand.

### Introduction and availability of data

The main focus of this priority is improving the emotional and behavioural health of looked after children and young people (NI58). Since 2008–09, the Department for Education has required local authorities to submit data on the emotional and behavioural health of looked after children as part of its annual return for the SSDA903 statistical collection on children looked after as at 31 March. The information on the emotional and behavioural health of looked after children and young people is gathered through the use of the Strengths and Difficulties Questionnaire (SDQ). This is administered in local authorities to looked after children and young people aged 4 to 16, but there are some limitations with this data source (see subsection 'Nature and scope of the data' later in this data annexe).

This data annexe presents further discussion about the data currently available on the emotional and behavioural health of looked after children and young people. It provides:

- a summary of the search strategy for identifying data
- an overview of the nature and scope of the data that was found, with a brief commentary on the quality of this data, and any gaps that have been identified
- some examples of the type of charts and diagrams that could be produced, showing, for example, comparisons between outcomes for looked after children and all children.

A summary table of the data sources of readily available, published data for looked after children at a national, regional and/or local authority level is produced in Appendix 4.

## Search strategy

There are a number of archival databases in the UK, such as the National Digital Archive of Datasets (NDAD) and the UK data archive, some of which have services that facilitate searching or access to macro and micro datasets (including ESDS International). Even so, searching for current and recently published data cannot yet be conducted in the same way as searching for published research findings. Access to newly published data is not supported by comprehensive searchable databases in the same way that literature searches are supported, although the Department for Education, (formerly the Department for Children, Schools and Families) produces a publications schedule for Statistical First Releases and Statistical Volumes.

Data for this data annexe was obtained by a combination of search methods but primarily by obtaining online access to known government publications (such as the Statistical First Releases and Statistical Volumes from the Department for Education) and access to data published by the Department of Health and Office for National Statistics, other government departments, the National Health Service and other national, regional and local bodies. It should be noted that links to statistical sources that were live at the time of searching may not remain live at the time of publication.

## Nature and scope of the data

Data on looked after children was collated by local authorities until 2002–03 by CLA100, AD1, OC1 and OC3 returns and then through the SSDA903 return, and until 2008/09, also via OC2 returns (DCSF 2009a). While this facilitates the provision of some trend data, it is important to recognise that the OC2 returns are on an aggregate basis at local authority level, providing, for example, information on the number of children who are looked after, the ethnicity of children who are looked after, attainment levels and physical health (including access to dentistry) of the various cohorts of children and young people. Until recently, however, comprehensive data was not recorded at an individual child level, so it was not possible to assess (for instance) the average health of 10-year-old white boys in local authority care. Outcomes and trends in outcomes that are currently presented in published statistics are primarily from cross-tabulated data and do not allow for more illuminative multivariate analysis, although access to the child-level data held on the SSDA903 returns would allow for more complex multivariate analysis – see [www.dcsf.gov.uk/rsgateway/DB/STR/d000894/index.shtml](http://www.dcsf.gov.uk/rsgateway/DB/STR/d000894/index.shtml) (DCSF 2009b) for further information.

The SSDA903 collects data on individual children (including those as yet unborn, but known to the local authority) using a unique local authority generated identifier that follows the child through the care system. Alongside this form, local authorities are required to use the SDQ (a short behavioural screening questionnaire) to obtain data on emotional symptoms, conduct problems, hyperactivity or inattention, friendships and peer problems; ‘plus an “impact supplement” to assist in the prediction of emotional health problems’ (DCSF 2008a). It is completed by the child’s carer (or, if for any reason that is not appropriate, by their social worker or other responsible adult – although not a teacher) with the consent of the child.

Data on all looked after children from age 4 to 16 inclusive is collected, but is only submitted in the SSDA903. In 2008–09 however, there were some issues with the quality of the SDQ data submitted. This indicator is calculated as the average score for children with a completed SDQ, however these were completed for just 65 per cent of the eligible cohort and within this there was a higher than expected proportion of zero scores. For the 2009–10 data collection, there will be stricter validation rules in order to address these limitations (DCSF 2009a).

Some further issues for this data scoping study relate to the ways in which certain types of data are recorded. While work has taken place to ensure that information on ethnicity is consistent and comparable between OC2 and SSDA903 returns, the School Census (which feeds into the National Pupil Database) and the Children in Need Census, data on disability, for instance, is still not routinely collected through most children's services returns. Indeed, no disability data for individual children will be recorded on the SSDA903 returns for 2008–09, although this has been recorded on the Children in Need Census from 2008–09 onwards.

Data on the mental and emotional health of young people looked after by local authorities in England has been identified from only one source apart from the national indicator data; a survey conducted in 2002 by the Social Survey Division of the Office for National Statistics on behalf of the Department of Health. While the report on this provides data on young people aged 5 to 17, it was based on a relatively small sample (just over 1,000) and has not been followed up in subsequent studies, so does not provide any trend data (Meltzer *et al* 2003).

## Trend and regional data

Findings from the Centre for Longitudinal Studies (Jackson *et al* 2002) suggest that there is a stronger association between looked after children and disturbed behaviour than is found in the wider population: data from a cohort study indicated that some 8 per cent of the looked after children and young people population had been referred to Pupil Referral Units compared with only 0.1 per cent of non-looked after children and young people. What do we know about the demographics of looked after children and how many of them may have some form of emotional or behavioural difficulty?

Data has been identified in relation to emotional and behavioural health for looked after children (NI58); substance misuse (NI115)<sup>10</sup>, which may provide some indicator data on behaviour; and also on demographics of looked after children and young people and their educational outcomes at key stages 1 to 4.

## Looked after children: demographic information

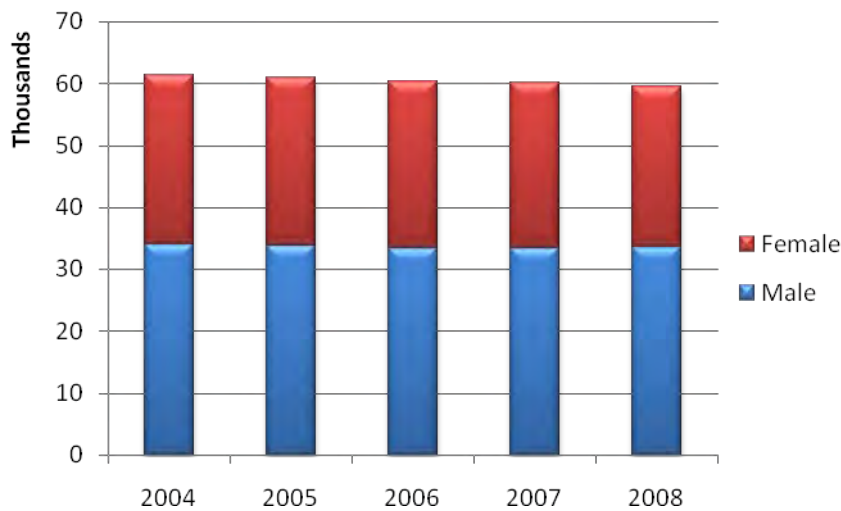
Of the 60,000 or so children and young people who were recorded as being looked after in each year from 2005 to 2009, over half in each year were male (see Figure

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<sup>10</sup> NI115 is to reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances.

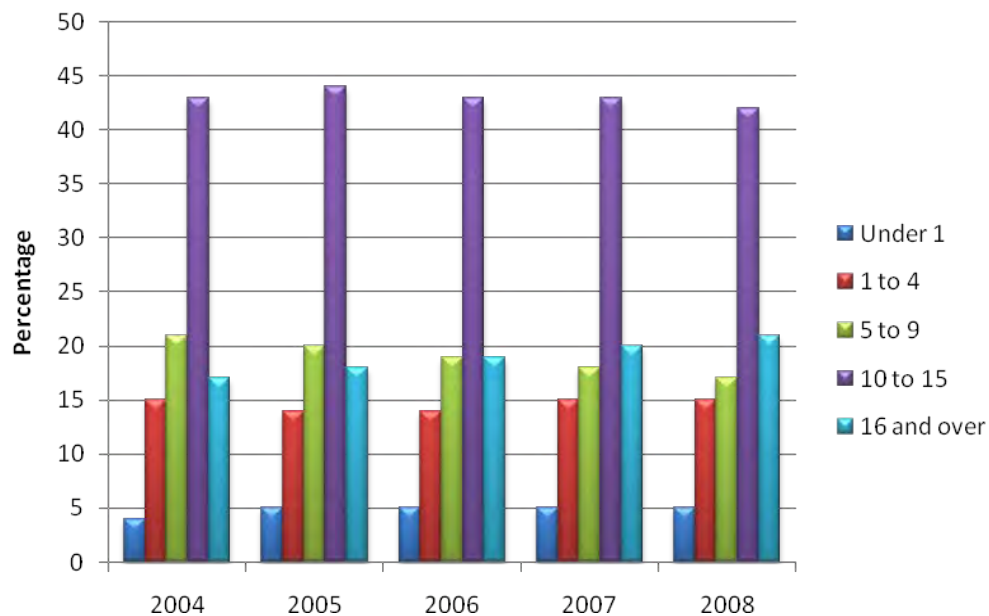
1) and over 40 per cent were aged between 10 and 15 (see Figure 2). There was little observable change in the proportion of each age group who were looked after; although there were small decreases in the proportion of children recorded as looked after in the age groups five to nine, and 10 to 15, and small increases in the proportion aged one to four and 16 and over.

**Figure 1. Looked after children 2005 to 2009: by sex**



Source: DCSF 2009a

**Figure 2. Looked after children 2005 to 2009: by age**

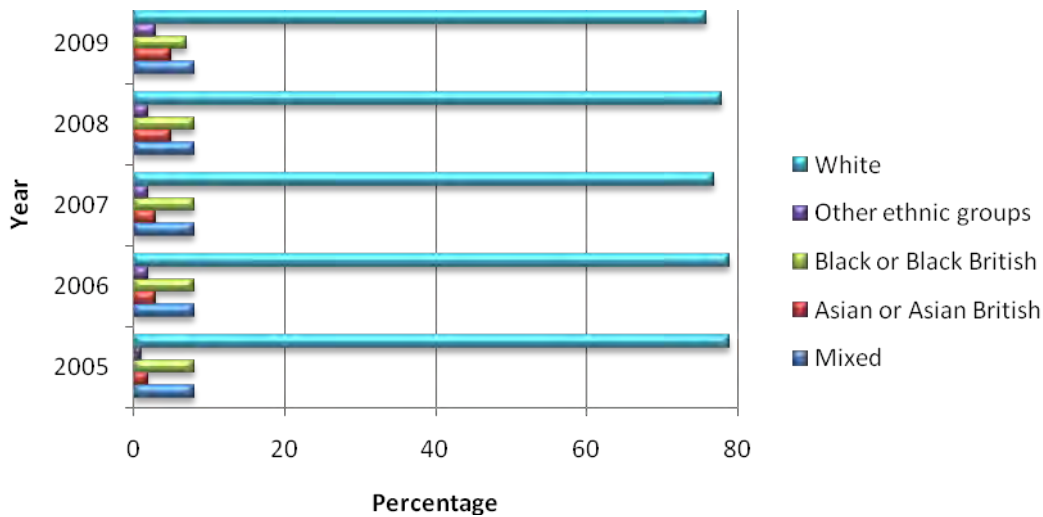


Source: DCSF 2009a

The highest proportion of looked after children came from a white ethnic background; over three-quarters of all looked after children in each year were from this group. Of

those from different minority ethnic groups, the greatest percentage came from black or mixed-race backgrounds (around 8 per cent in each case). Although the proportions of children from each of the minority ethnic groups who were looked after remained relatively stable between 2005 and 2009, there appeared to be some minor increases in the number of Asian and 'other' ethnic group children becoming the responsibility of the local authority (see Figure 3).

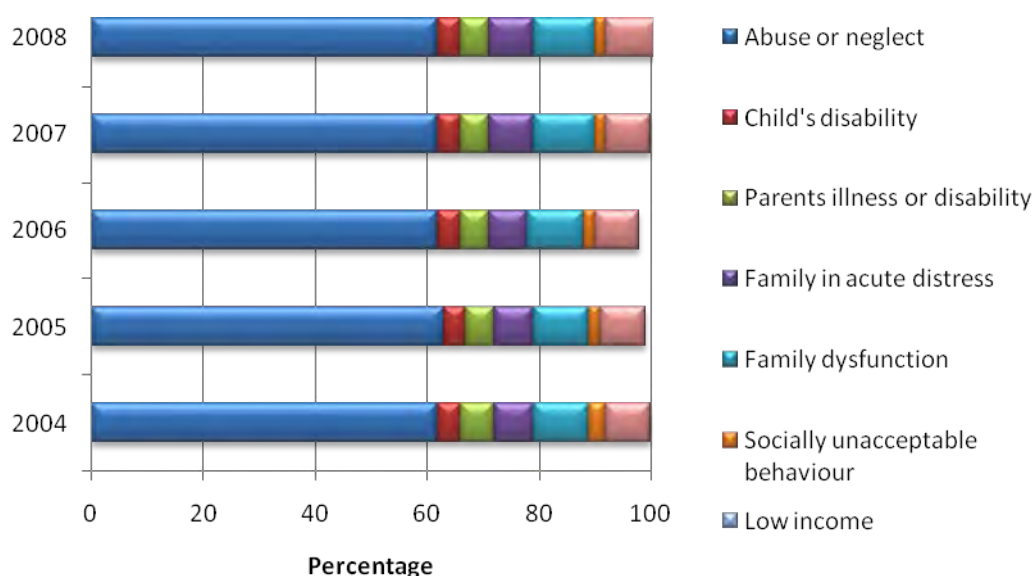
**Figure 3. Looked after children 2005 to 2009: by ethnicity**



**Source:** DCSF 2009a

The reasons for children and young people becoming looked after appear, predominantly, to be related to abuse and neglect. This was the category of need that was identified for over 60 per cent of looked after children at the time when they were taken into care (see Figure 4); but it may not be the sole reason for which they remained in care. Family dysfunction, family in acute distress and absent parenting were the other main reasons for children being looked after. Although low income was recorded as the primary reason for up to 130 cases in each year from 2005 to 2009, the proportion of such cases was less than 0.2 per cent of the total, and so does not appear in Figure 4.

**Figure 4. Looked after children 2005 to 2009: by reason for being taken into care**



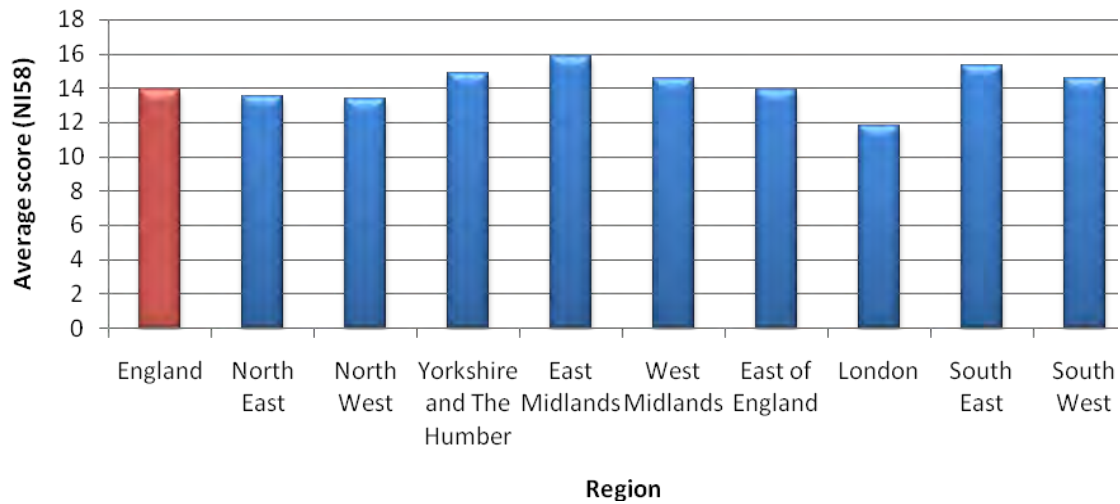
**Source:** DCSF 2009a

## Looked after children: mental health disorders

NI58 is the emotional and behavioural health of looked after children, which since 2008–09 is measured by the SDQ. The national indicator figures show that the average score on the SDQ in 2008–09 was 13.9 out of a possible score of 40 (see Figure 5). The highest score was the East Midlands (15.8) and the lowest score was London (11.8). However, as mentioned earlier, this is the first time that figures relating to this national indicator have been published, and the figures should be treated with caution. There were some issues with the data collection, including a higher than expected proportion of looked after children and young people scoring a zero, and that scores were only provided for 65 per cent of looked after children and young people. For future years, it is hoped that, with stricter validation rules, data for NI58 will be more accurate.

It is also worth noting that the SDQ is a short, five to ten-minute assessment, and consequently does not provide comprehensive information about the emotional health and wellbeing of looked after children and young people. In addition, scores are presented as aggregated statistics, and are not broken down by background characteristics, such as gender, ethnicity or special educational needs.

**Figure 5. Looked after children 2008: by Government Office Region**

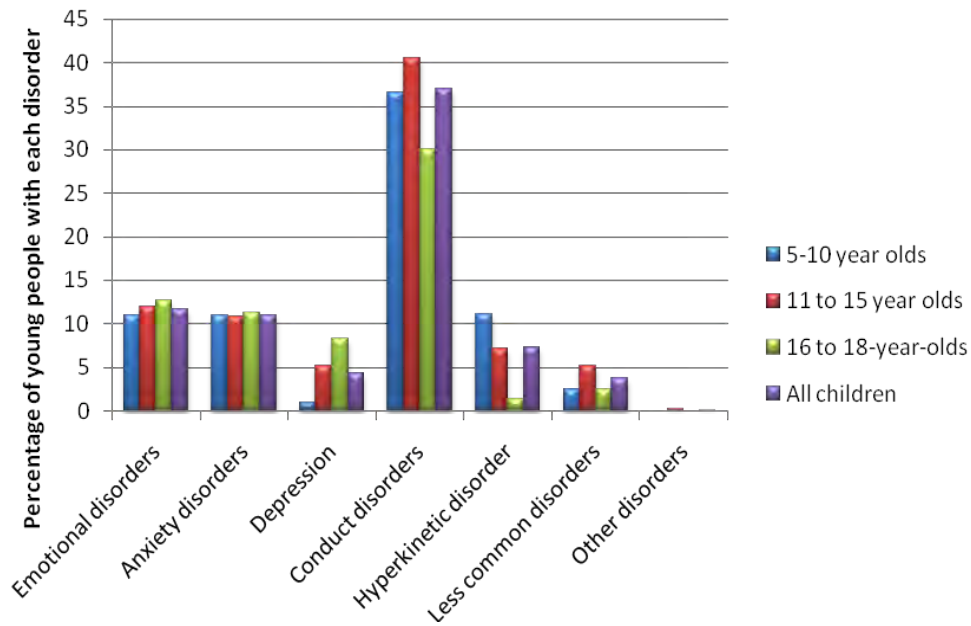


**Source:** DCSF 2009a

Data collected on the SDQ provides a more recent and general picture than the single (although detailed) mental health survey of just over 1,000 children and young people aged five to eighteen collected by the Social Survey Division of the Office for National Statistics on behalf of the Department of Health in 2001–02. The data was collected from carers (foster carers, parents and residential care workers), teachers and the young people themselves (if over the age of 11). The data presented in the following figures was taken from published figures for that survey and it is worth noting that children could present with more than one emotional disorder. As such, therefore, the figures presented here should be seen as an indication of prevalence across the age range, rather than a measure of occurrence from which improvements or decline in emotional and behavioural health could be assessed.

As can be seen from Figure 6, conduct disorders are by far the most prevalent across all of the age groups, exceeding the proportion demonstrating emotional or anxiety disorders. Although the percentage of looked after children and young people demonstrating anxiety disorders is fairly constant at around 11 per cent of the study participants across each of the age bands, depression and depressive disorders appear more prevalent among 16- to 18-year-olds.

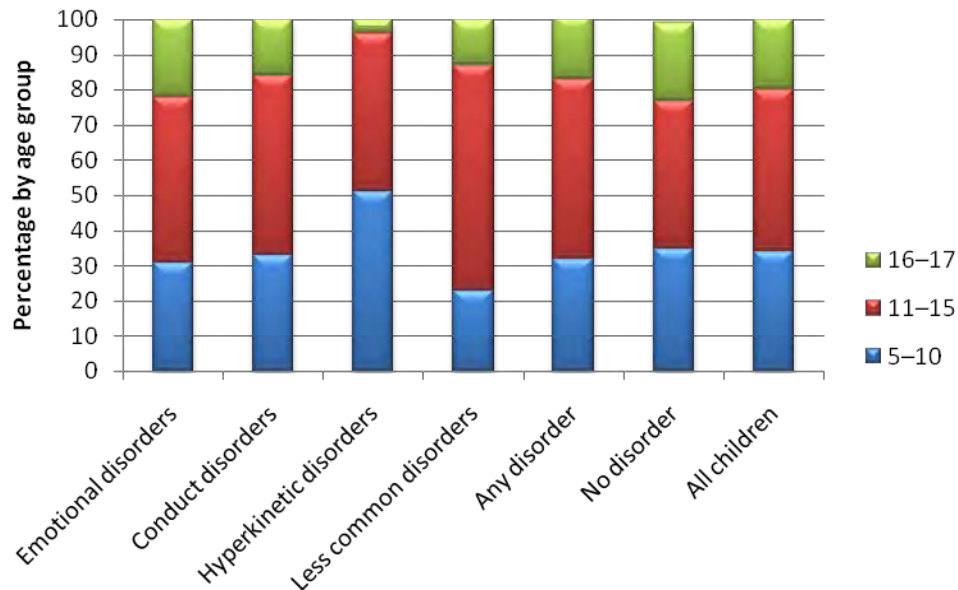
**Figure 6. Percentage of children with emotional disorders: by age group**



**Source:** Meltzer *et al* 2003

Further analysis by type of disorder suggests that hyperkinetic disorders are less evident among older children than younger children (see Figures 6 and 7) and, indeed, they appear to be the second commonest disorder among younger children, aged five to ten (see Figure 6).

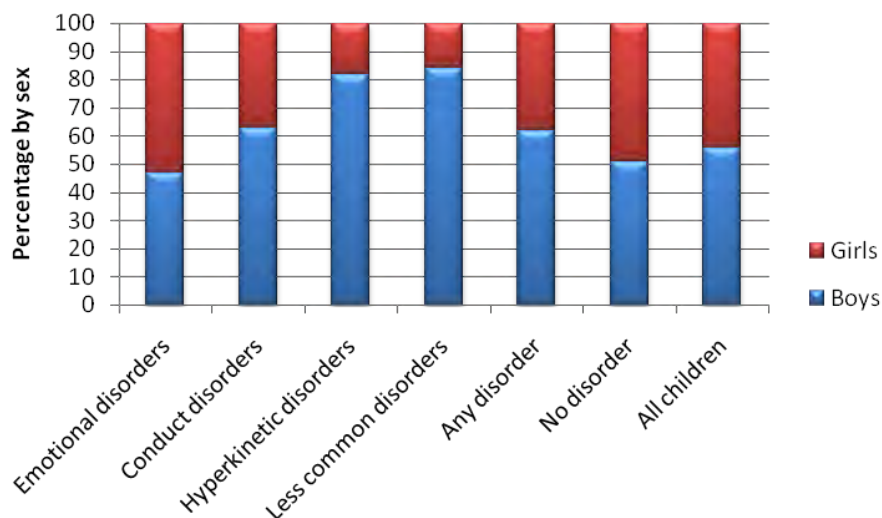
**Figure 7. Percentage of children with emotional disorders: by type of disorder and age**



**Source:** Meltzer *et al* 2003

Differences in type of disorder are also evident by sex. Although boys and girls are more or less equally represented among those with no disorder, boys dominate the population of those with hyperkinetic disorders, while proportionately more girls demonstrate an emotional disorder (see Figure 8).

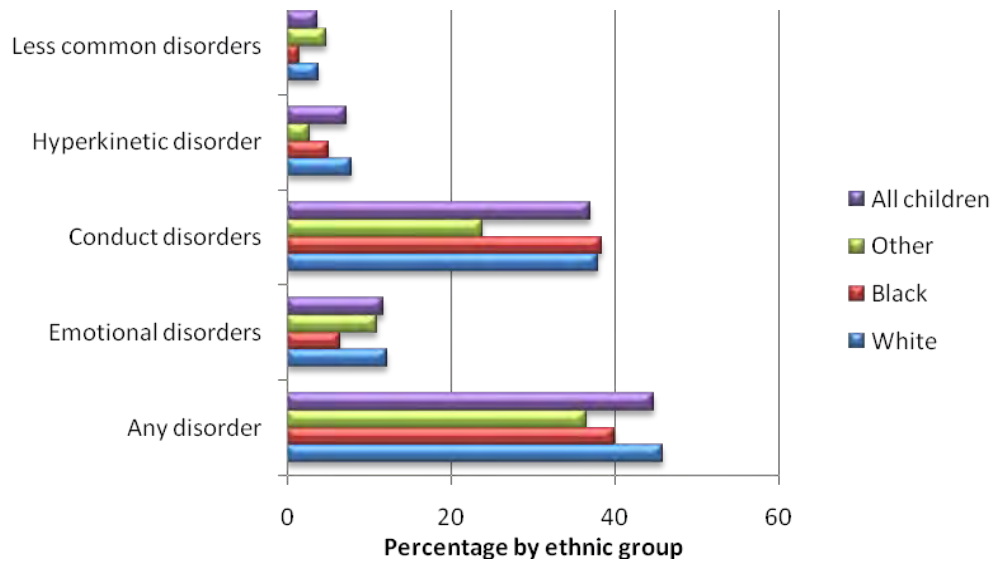
**Figure 8. Percentage of children with emotional disorders: by type of disorder and sex**



**Source:** Meltzer *et al* 2003

Figure 9 provides an overview of disorders by ethnic group. Children from any one ethnic group may have been diagnosed with more than one disorder, so comparative analysis is complex. Nonetheless, the data suggests that, among those with emotional disorders and hyperkinetic disorders, a higher proportion appear to be of White ethnic origin, while among those with conduct disorders, those from White and Black ethnic origins seem to be equally represented.

**Figure 9. Percentage of children with emotional disorders: by type of disorder and ethnicity**

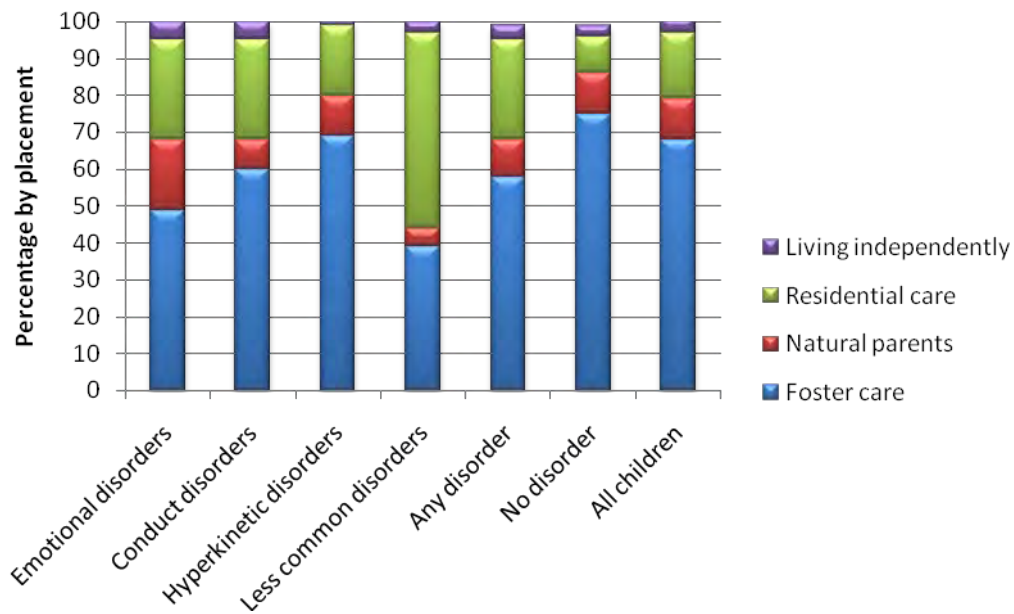


**Source:** Meltzer *et al* 2003

*Note that the number of children with any mental disorder is less than the sum of the numbers of children with each disorder because children could have been assessed as having more than one type of disorder.*

By comparison with children with no disorder, a higher proportion of children with mental health disorders appear to be placed in residential care. This is particularly evident for those with less common disorders (see Figure 10), including autistic spectrum disorders, tics and twitches, and eating disorders (Meltzer *et al* 2003).

**Figure 10. Percentage of children with emotional disorders: by type of placement**

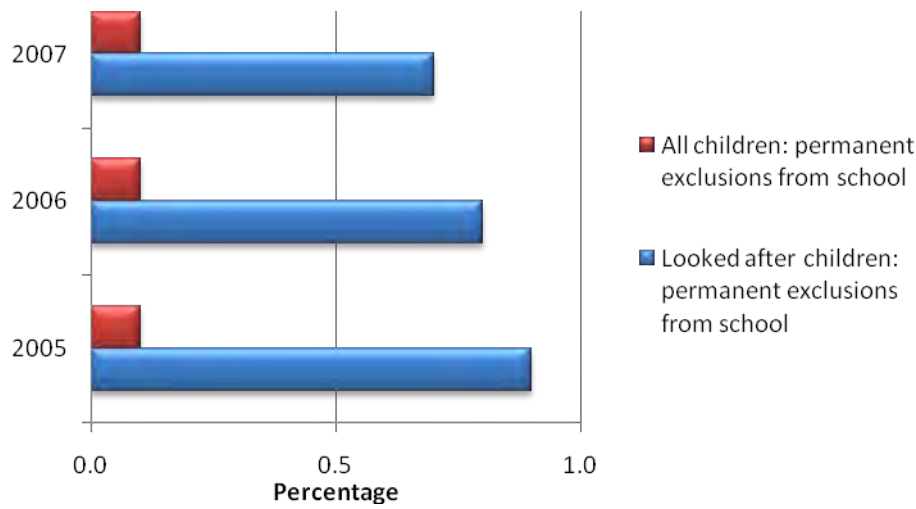


**Source:** Meltzer *et al* 2003

### Outcome data: permanent exclusions from school, offending and substance misuse

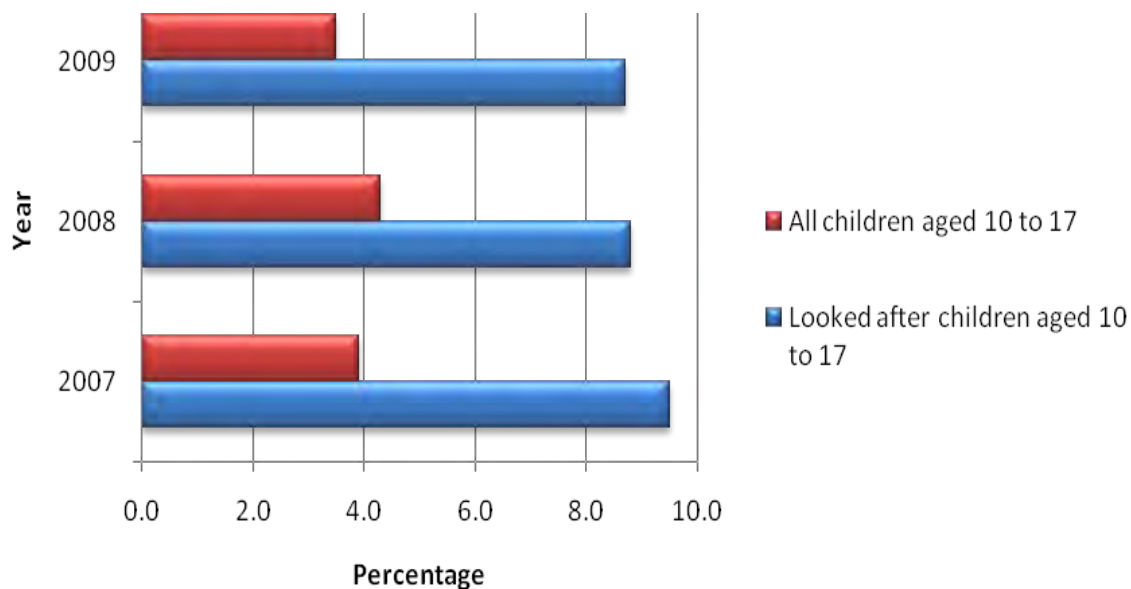
By comparison with all children, a higher proportion of looked after children and young people have been subject to permanent exclusion from school, although the proportion of looked after children and young people subject to permanent exclusion has been decreasing since 2005 (see Figure 11). More looked after children and young people than their peers were convicted of an offence or subject to a final warning or reprimand over the three-year period from 2007 to 2009 (Figure 12).

**Figure 11. Permanent exclusions from school from 2005 to 2009: by status**



**Source:** DCSF 2008b, 2010

**Figure 12. Offending by children looked after continuously for at least 12 months from 2007 to 2009**



**Source:** DCSF 2010

The proportion of children and young people in care who were identified as having at least one episode of substance misuse over the past year has remained constant since 2006 at 5 per cent (DCSF 2008b, 2010). Data on substance misuse for all children is not collected in the same way, so comparative analysis is difficult.

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## Glossary of research terms

This glossary provides a list of systematic review terms used by the EPPI-Centre.

**Data extraction** So that each study in a systematic review can be scrutinised, and its quality and relevance systematically appraised, details of the methods and results are captured using a set of usually predetermined questions and answers.

**Empirical** Derived from observation and/or experiment (as opposed to 'conceptual' or 'theoretical').

**Evidence-informed policy and practice** The use of sound research evidence in an explicit and systematic way to inform decisions, policy-making or practice.

**Keywording** In order to be able to describe the available literature on a given topic in a 'systematic map', brief information on a limited number of characteristics of studies is coded. This coding is called 'keywording', just as you have keywords to describe studies in journals and on bibliographic databases.

**Mediator variable** Any variable that can mediate the effect of an intervention, for example individual characteristics such as age, gender, race or intervention differences such as intensity, length or type of delivery.

**Meta-analysis** The statistical data from a group of studies is pooled and reanalysed as one large dataset. This enables conclusions to be drawn when each individual dataset is too small to provide reliable evidence.

**Narrative** Using words/text to describe facts or events or theories and concepts, to establish connections and construct arguments.

**Screening** Comparing individual studies against explicit criteria to assess whether they are relevant for answering a review's question.

**Search strategy** An explicit strategy is used to locate relevant studies via a number of different resources such as electronic databases, relevant journals, specialist websites and specialists in the field.

**Synthesis** The part of the systematic review process in which the findings of multiple studies are combined. It involves a transformation of the primary data in order to arrive at an overall conclusion that is more than just a summary of its parts. The synthesis combines evidence to see what can reliably be said on the basis of existing, relevant studies in answering the review question.

**Systematic map** Part of the review process that systematically identifies and describes the research that has been undertaken within the boundaries of the review question.

**Systematic review or systematic review of reviews** A review of research or review of existing reviews of research that aims to be principled, methodical and

explicit. A systematic review and a systematic review of reviews address a clearly defined research question and use explicit and standardised methods to identify and review the literature.

**User** Anybody who uses research, including, for example, policy-makers, practitioners, users of services and researchers.

**Weight of evidence** The EPPI-Centre's framework for appraising individual studies. A conclusion about overall study 'weight' is reached by considering its methodological soundness; the appropriateness of the study design to answering the review question; and relevance of the focus of the study.

## Definitions

### Definitions of interventions included in the review

**Enhanced foster care** is described by Hahn *et al* (2005 p 72) as interventions in which 'Youth who cannot live at home are placed in a foster home in which foster parents are trained to provide a structured environment for learning social and emotional skills'.

**Mentoring** has generally been used to describe a relationship between an older, more experienced mentor and an unrelated younger protégée. The mentor typically provides ongoing guidance, instruction and encouragement in the hope of developing the competence and character of the protégée over the course of the relationship.

**Multi-systematic therapy** is an intensive family- and community-based treatment programme designed to make positive changes in the various social systems (home, school, community, peer relations) that contribute to the serious anti-social behaviours of children and adolescents who are at risk for an out-of-home placement.

### Other definitions

**Out-of-home placements** are placements outside of the home, such as in foster care, young offenders' institutions or hospital.

## Appendix 1: Knowledge review methods

The review includes literature identified by a C4EO scoping study (cite) as being relevant to the review questions. The scoping study used systematic searching of key databases and other sources to identify literature which was then screened and coded. Apart from reference harvesting, no further searching for material other than that located by the scoping review was undertaken for this review. However, literature recommended by the Theme Advisory Group and C4EO has been considered for inclusion.

The review team used a 'best evidence' approach to select literature of the greatest relevance and quality for the review. This entailed identifying:

- the items of greatest relevance to the review questions
- the items that came closest to providing an ideal design to answer the review questions
- the quality of the research methods, execution and reporting.

The team reviewed all priority items and summarised their findings in relation to the review questions. The reviewer also assessed the quality of the evidence in each case. In judging the quality of studies, the team was guided by principles established to assess quantitative research (Farrington *et al* 2002) and qualitative studies (Spencer *et al* 2003).

## Appendix 2: Scoping study process

The study began with the Theme Advisory Group – a group of experts in the policy, research and practice field of vulnerable (looked after) children – establishing the key questions to be addressed and the parameters for the search (see Appendix 3). The scoping study used a broad range of sources to identify relevant material:

- searches of bibliographic databases
- searches of research project databases
- browsing relevant organisations' websites
- recommendations from the Theme Advisory Group.

See 'Search strategy' subsection below for the sources and strategy used.

The research team undertook an initial screening process of the search results, using record titles and abstracts (where available) to ensure that the search results conformed to the search parameters and were relevant for answering the scoping study questions. Items were excluded if:

- they were not about looked after children or care leavers, aged up to 25
- they were published before 2000
- they were not from a peer-reviewed journal or report or not a key text
- they were not empirical research
- they did not relate to a study in Australia, Canada, Ireland, New Zealand, the United Kingdom or the United States
- they did not answer the scoping study questions
- a fuller report was published elsewhere
- they could not be obtained in full text, either at all, or within the scoping study deadline
- they were a duplicate record.

The inclusion/exclusion criteria are shown in Table A1.

**Table A1. Inclusion/exclusion criteria**

The following criteria were applied sequentially from top down.

<b>Inclusion/ exclusion criteria</b>		<b>Guidance</b>
1	<b>EXCLUDE date of publication</b> before 2000	Published before 2000
2	<b>EXCLUDE publication type</b> not peer-reviewed journal or report	Exclude books, dissertation abstracts, trade magazines, policy (unless evaluated), guidance (unless evaluated) Include relevant reports, evaluated policy
3	<b>EXCLUDE location</b> not Australia, Canada, Ireland, New Zealand, the United Kingdom, United States	
4	<b>EXCLUDE population</b> not about looked after children or care leavers, or their care	Upper age limit 25
5	<b>EXCLUDE research type</b> not empirical research	Exclude case study, vignette, opinion piece, commentary, briefing
6	<b>EXCLUDE scope</b>	Use if not excluded above but does not answer one of the review questions
7	<b>EXCLUDE insufficient details</b> to identify reference	
8	<b>EXCLUDE unable to retrieve</b>	Covers records for which full text could not be obtained at all or not in time for this piece of work
9	<b>EXCLUDE full study already reported</b>	For studies where identical methodology and findings are reported in more than one record
10	<b>INCLUDE</b>	Not excluded by above
<b>EXTRA EXCLUSION CRITERION for question 3.2.2, and for 3.2.3 where intervention involved</b>	<b>EXCLUDE not intervention</b>	Intervention is defined as a named, bounded, activity or set of activities with specific objectives that are assessed/evaluated in some way

Additional criteria were applied in relation to sub-questions 3.2.2 and 3.2.3 and the records rescreened. This served to define interventions more strictly as a specific activity with specified outcomes that concerned the emotional and behavioural health of looked after children and young people. The papers included in 3.2.2 and 3.2.3 were also required to include some evaluation of outcomes, whether related to acceptability, accessibility or effectiveness; descriptive accounts were excluded as it was felt that they did not contribute to our understanding of interventions. These measures were intended to narrow the focus and to exclude system-wide approaches (such as an account of introducing looked after children and young people into a child welfare system). While system-wide approaches may concern the emotional and behavioural health of looked after children and young people, they are not always linked directly to outcomes addressing emotional and behavioural disorders and usually have a wide remit to improve the overall performance and accountability of the child welfare system. Policy was excluded unless evaluated.

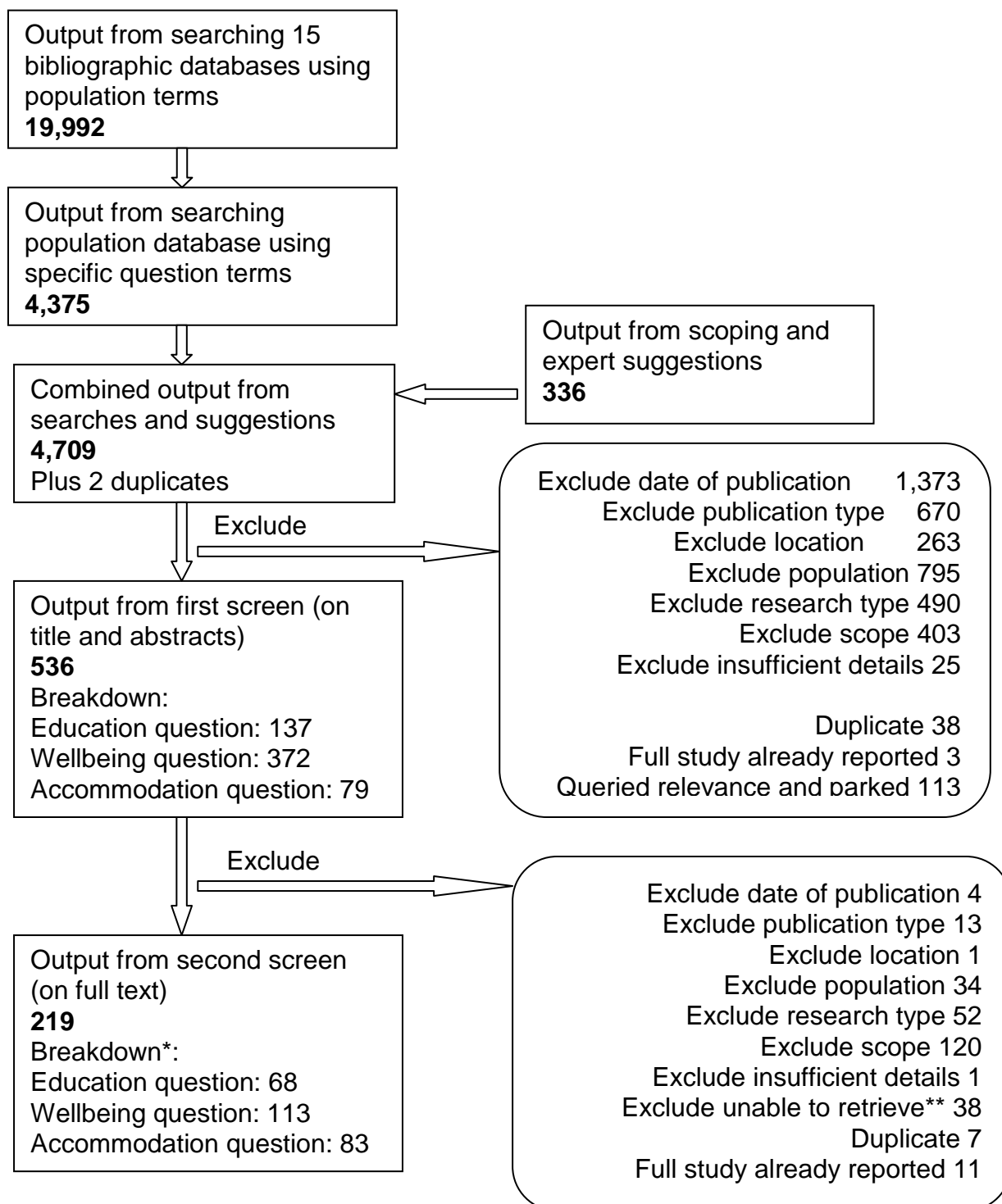
A proportion of records of doubtful relevance according to the available abstract/title were parked for later examination.

Records from the searches that were screened as relevant according to title or abstract were then loaded into the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI)-Reviewer database.

Full texts were retrieved for the second stage of screening, since the team considered that scoping required the use of full texts. All records screened for inclusion were sought. Inclusion/exclusion criteria were then applied to the full text articles. Approximately one-third of retrieved items were excluded using full texts (see exclusion criteria above; see Figure A1). Thirty-eight items could not be retrieved in full text within the scoping study deadline.

**Figure A1. Literature flow chart**

*Note: removal of duplicate references took place throughout; referral between priorities took place at second screening.*



**Notes:**

\* includes material that could not be obtained at all as well as records that could not be obtained in time for this piece of work.

\*\* includes referrals from other priorities.

The content of the **rejected** records included those that focused on:

- adopted children
- policy
- overviews or briefings of the topic
- descriptions of interventions with no indication of outcomes.

The research team then assessed the remaining items and coded them in relation to the following:

- relevance to the review question or questions
- country (Australia, Canada, Ireland, New Zealand, the United Kingdom or the United States)
- study type (including experimental study with comparison/control, non-experimental study, systematic review etc.)
- main methods (including survey, interviews and focus groups, control trial, literature review etc.)
- intervention setting (including foster care, residential care, school, housing services, floating support etc.)
- study population (including looked after children and young people, care leavers, health, education, housing and education staff etc.)
- cross-cutting issues (child poverty and safeguarding).

It was subsequently agreed that the term 'intervention setting' is an ambiguous, and therefore unhelpful, term. It can capture, for example, either the environmental space in which an intervention happens (e.g. a school meeting room) or the context in which the child(ren) are placed. Many studies do not report either and, therefore, the scoping review does not analyse the responses checked on this section of the coding form.

An agreed part of the scoping methodology was to undertake independent coding quality assurance checks on 10 per cent of the references. References were selected randomly from Endnote listings of papers allocated to each sub-question. In addition, all studies excluded on reading the full text were checked (i.e. reviewed by at least two people).

The checks on coding demonstrated a high degree of consistency and reliability in the use of the coding tool. With minor exceptions (e.g. varied understanding of 'intervention setting': see above), the result of double coding was principally to add to the recording of methodological detail.

The check on exclusions at full text again demonstrated the consistent and reliable use of scoping criteria, and did not reveal any systematic bias in the decisions. In three cases, an exclusion decision was subject to further discussion before being resolved.

The process is summarised in Table A2.

**Table A2. Summary of different stages**

	<b>Stage</b>	<b>Material used</b>
1	Question setting	
2	Searching, browsing and recommendations to identify relevant material	
3	Initial screening using inclusion/exclusion criteria	Using title and abstract
4	Entering included studies into EPPI-Reviewer database	
5	Second-stage screening	Using full paper
6	Coding of final included studies	Using full paper
7	Quality assurance on 10% of coded papers	Full paper
8	Assessment of content and scope of included papers	Full paper

The numbers of items found by the initial search, and subsequently selected, can be found in Table A3. The three columns represent:

- items found in the initial searches
- items selected at first screening for further consideration (i.e. those complying with the search parameters after the removal of duplicates)
- items considered relevant to the study at second screening by a researcher who had read the abstract and/or accessed the full document.

**Table A3. Overview of searches for all topics**

<b>Source</b>	<b>Items found</b>	<b>Items selected for consideration</b>	<b>Items identified as relevant to this theme</b>
<b>Databases</b>			
Applied Social Sciences Index and Abstracts (ASSIA)	3,508	128	7
Australian Society and Family Abstracts	59	52	2
British Education Index (BEI)	443	291	7
ChildData	8576	977	57
Cinahl	3889	576	29
Cochrane Library	71	10	1
EMBASE	2,929	277	2
Google	n/a	1	1
Health Management Information Consortium (HMIC)	2,615	154	0
IBSS	900	47	6
Medline	3,325	235	15
PsycINFO	4,539	908	26
Social Care Online	7,673	490	35
Social Services Abstracts	3,114	257	6
Social Work Abstracts	2,044	187	3
Zetoc	1,159	4	1
<b>Internet databases/portals (also see 'Search strategy' section)</b>			
Barnardos	n/a	1	1
British Library Welfare Reform on the Web	n/a	n/a	n/a
CERUKplus	57	47	1

INTUTE	n/a	n/a	n/a
INVOLVE	n/a	n/a	n/a
JSTOR	n/a	n/a	n/a
Research Register for Social Care	Incorporated in Social Care Online search		
<b>Reference harvest 'Taking care of education'</b>	n/a	9	2
<b>Theme Advisory Group recommendations (including texts and organisations)</b>	n/a	56	8

**Notes:** Where n/a is indicated, this is because these resources were browsed rather than searched. Initial output was publication date from the beginning of 1990; this was restricted to the start of 2000 at first screening. Duplicate removal was ongoing throughout the process.

**Total number of relevant records by review question:**

- emotional/behavioural health: 113
- looked after children and young people's views: 45
- services/interventions (acceptability, accessibility, effectiveness): 40
- attitudes and skills of carers and families: 48.

*Note:* studies may be coded as relevant to more than one priority.

**Table A4. Overview of search output for emotional and behavioural health**

<b>Source</b>	<b>Items identified as relevant to this priority</b>
<b>Databases</b>	
Applied Social Sciences Index and Abstracts (ASSIA)	6
Australian Society and Family Abstracts	2
British Education Index (BEI)	0
ChildData	31
Cinahl	20
Cochrane Library	0
EMBASE	1
Health Management Information Consortium (HMIC)	0
Google	0
IBSS	3
Medline	10
PsycINFO	14
Social Care Online	13
Social Services Abstracts	3
Social Work Abstracts	1
Zetoc	1
<b>Reference harvest: 'Taking care of education'</b>	1
<b>Theme Advisory Group recommendations (including texts and organisations)</b>	3

**Note:** as this was derived from aggregated output of all searches, no columns are given for initial output.

## Search strategy

This subsection provides information on the keywords and search strategy for each database and web source searched as part of the scoping study. Searching was carried out by the SCIE social care information specialist.

The list of databases and sources to be searched included the databases recommended for systematic reviews, 40 organisations' databases and subject portals identified by a SCIE scope and recommendations from Theme Advisory Group members. The general approach was as follows.

- A detailed search on looked after children population-relevant terms was carried out across 15 databases. The search strategy was translated for each database and the output was de-duplicated, creating a database of approximately 19,000 records.
- Topic-specific searches were carried out on this combined population database, to create a second database.
- References obtained by recommendation and browsing were added to these records, creating a database of approximately 5,000 records.
- All these records were screened for relevance to all the questions. This approach dealt with significant overlap in topic relevance between the priorities.

All searches were limited to publication years 2000–08, in English language only. The keywords used in the searches, together with a brief description of each of the databases searched, are outlined below.

The following conventions have been used: (ft) denotes that free-text search terms were used, \* denotes a truncation of terms and (+NT) denotes that narrower subject terms were included (where available).

## Stage 1: Compiling the looked after children population set

### Applied Social Sciences Index and Abstracts (ASSIA)

(searched via CSA Illumina 27/08/08)

ASSIA is an index of articles from over 500 international English language social science journals.

- |     |   |     |   |
|-----|---|-----|---|
| #1  | looked after child* (ft)                                  | #12 | special guardianship (ft)   |
| #2  | child* in care (ft)                                       | #13 | leaving care (ft)   |
| #3  | foster care (+NT)   | #14 | care leaver*  |
| #4  | adoption (+NT)  | #15 | secure accommodation  |
| #5  | kinship care (ft)   | #16 | unaccompanied asylum seeking child* (ft)  |
| #6  | children (+NT) or adolescents (+NT) or young people (+NT) | #17 | placement (ft) and #6   |
| #7  | residential care (+NT)                                    | #18 | #1 or #2 or #3 or #4 or #5 or #8 or #10 or #11 or #12 or #13 or #14 or #14 or #15 or #16 or #17 |
| #8  | #6 and #7   |     |   |
| #9  | group homes (+NT)   |     |   |
| #10 | #6 and #9   |     |   |
| #11 | care orders   |     |   |

### Australian Family and Society Abstracts

(searched via Informit 13/11/08)

- |    |                             |    |                       |
|----|-----------------------------|----|-----------------------|
| #1 | child* (ft)                 | #4 | residential childcare |
| #2 | adopt* (ft) or foster* (ft) | #5 | looked after children |
| #3 | #1 and #2                   | #6 | #3 or #4 or #5        |

### British Education Index (BEI)

(searched via Dialog 11/11/08)

The BEI provides information on research, policy and practice in education and training in the UK. Sources include over 300 journals, mostly published in the UK, plus other material including reports, series and conference papers.

- |    |                                |     |  |
|----|--------------------------------|-----|--|
| #1 | looked after children (ft)     | #10 | residential care and (child* (ft) or children) |
| #2 | child* looked after (ft)       | #11 | care order* (ft)                               |
| #3 | child* in care (ft)            | #12 | special guardian* (ft)                         |
| #4 | orphan* (ft)                   | #13 | care leav* (ft)                                |
| #5 | orphans                        | #14 | leav* care (ft)                                |
| #6 | adopted children               | #15 | secure accommodation (ft)                      |
| #7 | foster (ft)                    | #16 | unaccompanied asylum seeking child* (ft)       |
| #8 | foster care or foster children |     |  |
| #9 | residential child care (ft)    |     |  |

#17 placement\* (ft) and (child\* (ft)  
or children)

#11 or #12 or #13 or #14 or  
#15 or #16 or #17

#18 #1 or #2 or #3 or #4 or #5 or  
#6 or #7 or #8 or #9 or #10 or

### **Campbell Collaboration C2 Library**

(searched 14/10/08)

The Campbell Collaboration Library of Systematic Reviews contains systematic reviews and review protocols in the areas of education, criminal justice and social welfare.

The Education and Social Welfare sections were browsed but no relevant records were found.

### **CERUK Plus**

(searched 11/11/08)

The CERUK Plus database provides access to information about current and recently completed research, PhD-level work and practitioner research in the field of education and children's services.

#1 (looked after children) or (care leavers)

### **ChildData**

(searched via NCB Inmagic interface, 01/09/08)

ChildData is the National Children's Bureau database, containing details of around 35,000 books, reports and journal articles about children and young people.

#1 children in care  
#2 looked after child\* (ft)  
#3 child\* looked after (ft)  
#4 orphans  
#5 foster care or foster carers or  
foster children  
#6 kinship care  
#7 adoption or adopted children  
#8 residential care or residential care  
staff  
#9 group home\* (ft)  
#10 children's homes

#11 care orders  
#12 special guardianship  
#13 leaving care  
#16 care leaver\* (ft)  
#17 unaccompanied asylum  
seeking child\* (ft)  
#18 placement  
#19 #1 or #2 or #3 or #4 or #5 or  
#6 or #7 or #8 or #9 or #10  
or #11 or #12 or #13 or #14  
or #15 or #16 or #17 or #18

## **Cochrane Library**

(searched via Wiley Interscience 09/09/08)

- |     |                                |     |  |
|-----|--------------------------------|-----|--|
| #1  | child, institutionalized (+NT) | #11 | care order* (ft)   |
| #2  | looked after child* (ft)       | #12 | special guardianship (ft)  |
| #3  | child* in care (ft)            | #13 | care leaver* (ft)  |
| #4  | child, orphaned                | #14 | secure accommodation (ft)  |
| #5  | orphanages                     | #15 | unaccompanied asylum seeking child* (ft)   |
| #6  | foster home care               | #16 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 |
| #7  | kinship care (ft)              |     |  |
| #8  | adoption (+NT)                 |     |  |
| #9  | residential child care (ft)    |     |  |
| #10 | group homes (+NT)              |     |  |

## **Cumulative Index to Nursing and Allied Health Literature (Cinahl Plus)**

(searched via EBSCO Host 29/08/08)

Cinahl Plus provides indexing for 3,802 journals from the fields of nursing and allied health.

- |    |                                |     |   |
|----|--------------------------------|-----|---|
| #1 | looked after child* (ft)       | #9  | leaving care (ft)   |
| #2 | child* in care (ft)            | #10 | care leaver* (ft)   |
| #3 | 'orphans and orphanages' (+NT) | #11 | secure accommodation (ft)   |
| #4 | foster home care (+NT)         | #12 | unaccompanied asylum seeking child* (ft)                                |
| #5 | kinship care (ft)              | #13 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 |
| #6 | adoption                       |     |   |
| #7 | residential child care (ft)    |     |   |
| #8 | special guardianship (ft)      |     |   |

## **EMBASE**

(searched via Ovid SP 05/09/08)

The Excerpta Medica database (EMBASE) is a major biomedical and pharmaceutical database. There is selective coverage for nursing, dentistry, veterinary medicine, psychology and alternative medicine.

- |    |  |     |  |
|----|--|-----|--|
| #1 | looked after child* (ft)                               | #8  | children's homes (ft)                    |
| #2 | child* in care (ft)                                    | #9  | care orders (ft)                         |
| #3 | orphanage (+NT)  | #10 | special guardianship (ft)                |
| #4 | foster care (+NT)                                      | #11 | leaving care (ft)                        |
| #5 | adoption (+NT) or adopted child (+NT)                  | #12 | care leaver* (ft)                        |
| #6 | residential home (+NT) and (child* or adolescen* (ft)) | #13 | secure accommodation (ft)                |
| #7 | group homes (ft) and (child* or adolescen* (ft))       | #14 | unaccompanied asylum seeking child* (ft) |

#15 #1 or #2 or #3 or #4 or #5 or #6 or #12 or #13 or #14  
or #7 or #8 or #9 or #10 or #11

### **Health Management Information Consortium (HMIC)**

(searched via Ovid SP 03/09/08)

The HMIC database is a compilation of data from two sources – the Department of Health's Library and Information Services and the King's Fund Information and Library Service. Topic coverage is on health services.

#1	looked after child* (ft)	#12	special guardianship (ft)
#2	child* in care (ft)	#13	former children in care or care leavers
#3	children in care	#14	secure accommodation
#4	orphans	#15	unaccompanied asylum seeking child* (ft)
#5	disabilities (+NT)	#16	placement (ft) and children (+NT)
#6	(foster care or foster children or foster parents) (+NT)	#17	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16
#7	kinship care (ft)		
#8	(adoption or adopted children or adoptive parents) (+NT)		
#9	residential child care (+NT)		
#10	children's homes (ft)		
#11	care orders		

### **International Bibliography of the Social Sciences (IBSS)**

(searched via EBSCO Host, 05/09/08)

#1	looked after child* (ft)	#10	care order* (ft)
#2	children in care	#11	special guardianship (ft)
#3	orphanages	#12	leaving care (ft)
#4	orphans	#13	care leaver* (ft)
#5	(foster care or foster child* or foster parent) (ft)	#14	secure accommodation
#6	kinship care (ft)	#15	unaccompanied asylum seeking child* (ft)
#7	adopted children	#16	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15
#8	residential child care (ft)		
#9	children's homes (ft)		

### **JSTOR**

(searched 14/11/08)

JSTOR is an international archive of journal articles and grey literature.

#1 children in care (ft)

## Medline

(searched via Ovid SP 27/08/08)

Medline is the primary source of international literature on biomedicine and healthcare.

- |     |                             |     |  |
|-----|-----------------------------|-----|--|
| #1  | looked after children (ft)  | #12 | secure accommodation (ft)  |
| #2  | child* in care (ft)         | #13 | unaccompanied asylum seeking child* (ft)                                       |
| #3  | looked after child* (ft)    | #14 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 |
| #4  | child, orphaned (+NT)       | #15 | child (+NT) or adolescent  |
| #5  | orphanages (+NT)            | #16 | group homes (+NT)  |
| #6  | foster home care (+NT)      | #17 | #15 and #16  |
| #7  | kinship care (ft)           | #18 | #14 or #17   |
| #8  | adoption (+NT)              |     |  |
| #9  | residential child care (ft) |     |  |
| #10 | special guardianship (ft)   |     |  |
| #11 | leaving care (ft)           |     |  |

## PsycINFO

(searched via Ovid SP 05/09/08)

PsycINFO contains more than 2.5 million records on psychological and behavioural science.

- |     |  |     |  |
|-----|--|-----|--|
| #1  | looked after child* (ft)   | #12 | leaving care (ft)  |
| #2  | child* in care (ft)  | #13 | care leaver* (ft)  |
| #3  | orphans (+NT)  | #14 | secure accommodation (ft)  |
| #4  | orphanages (+NT)   | #15 | unaccompanied asylum seeking child* (ft)   |
| #5  | foster children (+NT) or foster care (+NT) or foster parents (+NT) | #16 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 |
| #6  | kinship care (ft)  | #17 | child (+NT) or adolescent  |
| #7  | adoption (child) (+NT)   | #18 | group homes (+NT)  |
| #8  | adopted children (+NT)   | #19 | #17 and #18  |
| #9  | residential child care (ft)  | #20 | #16 or #19   |
| #10 | care orders (ft)   |     |  |
| #11 | special guardianship (ft)  |     |  |

## Social Care Online

(searched 21/08/08)

Social Care Online is the Social Care Institute for Excellence's (SCIE's) database covering an extensive range of information and research on all aspects of social care. Content is drawn from a range of sources, including journal articles, websites, research reviews, legislation and government documents and service user knowledge.

- |     |                            |     |  |
|-----|----------------------------|-----|--|
| #1  | looked after children      | #12 | care leaver* (ft)  |
| #2  | children looked after (ft) | #13 | secure accommodation and (children or young people)  |
| #3  | child* in care (ft)        | #14 | unaccompanied asylum seeking child* (ft)   |
| #4  | foster care (+NT)          | #15 | placement and (children or young people)   |
| #5  | foster children            | #16 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 |
| #6  | adoption (+NT)             |     |  |
| #7  | adopted children           |     |  |
| #8  | residential child care     |     |  |
| #9  | care orders                |     |  |
| #10 | special guardianship       |     |  |
| #11 | leaving care               |     |  |

## Social Services Abstracts

(searched via CSA Illumina 02/09/08)

Social Services Abstracts is an international database covering social work, social welfare and social policy.

- |    |  |     |  |
|----|--|-----|--|
| #1 | looked after child* (ft)                   | #9  | special guardianship (ft)  |
| #2 | child* in care (ft)                        | #10 | care leaver* (ft)  |
| #3 | orphans                                    | #11 | secure accommodation (ft)  |
| #4 | foster care or foster children             | #12 | unaccompanied asylum seeking child* (ft)                                       |
| #5 | adoption (+NT)                             | #13 | placement and (child (+NT))  |
| #6 | adopted children (+NT)                     | #14 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 |
| #7 | residential care (ft) and (children (+NT)) |     |  |
| #8 | children's homes (ft)                      |     |  |

### **Social Work Abstracts**

(searched via Ovid SP 03/09/08)

Social Work Abstracts covers material published in primarily US-based journals with social work relevance.

- |     |                             |     |  |
|-----|-----------------------------|-----|--|
| #1  | looked after child* (ft)    | #11 | care leaver* (ft)  |
| #2  | child* in care (ft)         | #12 | leaving care(ft)   |
| #3  | orphan* (ft)                | #13 | secure accommodation (ft)  |
| #4  | foster* (ft)                | #14 | unaccompanied asylum seeking child* (ft)   |
| #5  | kinship care (ft)           | #15 | placement and (child* (ft) )   |
| #6  | adoption (ft)               | #16 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 |
| #7  | residential child care (ft) |     |  |
| #8  | children's homes (ft)       |     |  |
| #9  | care orders (ft)            |     |  |
| #10 | special guardianship (ft)   |     |  |

### **Zetoc**

(searched via British Library 03/09/08)

Zetoc provides access to the British Library's electronic table of contents of journals and conference proceedings. This search interface has quite limited functionality.

- |    |                                       |     |   |
|----|---------------------------------------|-----|---|
| #1 | looked after children (ft)            | #7  | care leaver (ft)  |
| #2 | foster care (ft) and health (ft)      | #8  | care leavers (ft)   |
| #3 | adopted children (ft) and health (ft) | #9  | secure accommodation (ft)                                 |
| #4 | residential child care (ft)           | #10 | placement (ft) and children (ft) and care (ft)            |
| #5 | children's homes (ft)                 | #11 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 |
| #6 | special guardianship (ft)             |     |   |

Search output from each database was combined (using OR) in an EndNote library, which was subsequently searched for each priority. The EndNote library was produced from the above references on 05/12/08.

## Stage 2: Topic-specific searches (all later aggregated for screening for all priorities, due to overlap in relevance)

### **Education priority**

- |    |                 |    |                      |
|----|-----------------|----|----------------------|
| #1 | school* (ft)    | #4 | pupil* (ft)          |
| #2 | education* (ft) | #5 | #1 or #2 or #3 or #4 |
| #3 | learning (ft)   |    |                      |

The output from this set was searched using the following terms:

### **Educational outcomes and positive school experiences set**

- |     |                     |     |  |
|-----|---------------------|-----|--|
| #1  | achievement* (ft)   | #14 | friend* (ft)   |
| #2  | qualification* (ft) | #15 | career* (ft)   |
| #3  | examin* (ft)        | #16 | occupation* (ft)   |
| #4  | key stage* (ft)     | #17 | job* (ft)  |
| #5  | college* (ft)       | #18 | employ* (ft)   |
| #6  | university (ft)     | #19 | citizen* (ft)  |
| #7  | degree* (ft)        | #20 | school refusal (ft)  |
| #8  | attendance (ft)     | #21 | school phobia (ft)   |
| #9  | truan* (ft)         | #22 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 or #10 or #11<br>or #12 or #13 or #14 or #15 or<br>#16 or #17 or #18 or #19 or<br>#20 or #21 |
| #10 | stability (ft)      |     |  |
| #11 | dropout* (ft)       |     |  |
| #12 | expulsion* (ft)     |     |  |
| #13 | exclu* (ft)         |     |  |

The output from this set was searched using the following terms:

### **Views set**

- |    |               |    |                            |
|----|---------------|----|----------------------------|
| #1 | opinion* (ft) | #4 | listen* (ft)               |
| #2 | view* (ft)    | #5 | voice* (ft)                |
| #3 | feedback (ft) | #6 | #1 or #2 or #3 or #4 or #5 |

This output was used to answer question 3.1.1.

The education set was searched using the following terms:

### **Educational policy and interventions set**

- |     |                                   |     |                                  |
|-----|-----------------------------------|-----|----------------------------------|
| #1  | virtual school head* (ft)         | #11 | policy                           |
| #2  | education support (ft)            | #12 | green paper* (ft)                |
| #3  | out of school hours learning (ft) | #13 | white paper* (ft)                |
| #4  | specialist* (ft)                  | #14 | Every Child Matters (ft)         |
| #5  | designated teacher* (ft)          | #15 | Children's Act                   |
| #6  | club* (ft)                        | #16 | Care Matters (ft)                |
| #7  | personal education plan* (ft)     | #17 | educational psychologist* (ft)   |
| #8  | mentor* (ft)                      | #18 | mental health professional* (ft) |
| #9  | education at home (ft)            | #19 | camhs (ft)                       |
| #10 | guidance (ft)                     | #20 | achievement ceremon* (ft)        |

#21 #1 or #2 or #3 or #4 or #5 or #6  
or #7 or #8 or #9 or #10 or #11  
or #12 or #13 or #14 or #15 or

#16 or #17 or #18 or #19 or  
#20

The output from this set was searched using the following terms:

**Acceptability, accessibility and effectiveness set**

#1 acceptab\* (ft)  
#2 accessib\* (ft)  
#3 satisfaction (ft)  
#4 service uptake (ft)  
#5 service use (ft)  
#6 engage\* (ft)  
#7 involv\* (ft)  
#8 participat\* (ft)  
#9 effective\* (ft)  
#10 What works (ft)

#11 outcomes (ft)  
#12 evaluat\* (ft)  
#13 making a difference (ft)  
#14 success\* (ft)  
#15 improvement (ft)  
#16 implementation (ft)  
#17 #1 or #2 or #3 or #4 or #5 or #6  
or #7 or #8 or #9 or #10 or #11  
or #12 or #13 or #14 or #15 or  
#16

This output was used to answer questions 3.1.2 and 3.1.3

The education set was searched using the following terms:

**Foster, residential and kinship carers and birth families**

#1 carer\* (ft)  
#2 worker\* (ft)  
#3 assistant\* (ft)  
#4 guardian\* (ft)  
#5 family (ft)

#6 mother\* (ft)  
#7 father\* (ft)  
#8 parent\* (ft)  
#9 #1 or #2 or #3 or #4 or #5 or #6  
or #7 or #8

The output from this set was searched using the following terms:

**Attitudes, skills, aptitudes and behaviours set**

#1 attitude\* (ft)  
#2 skill\* (ft)  
#3 abilit\* (ft)  
#4 behaviour\* (ft)  
#5 behavior\* (ft)  
#6 encourage\* (ft)  
#7 supportive (ft)  
#8 supporting (ft)  
#9 empathy (ft)

#10 promote (ft)  
#11 help\* (ft)  
#12 assist\* (ft)  
#13 facilitate (ft)  
#14 value (ft)  
#15 engage\* (ft)  
#16 #1 or #2 or #3 or #4 or #5 or #6  
or #7 or #8 or #9 or #10 or #11  
or #12 or #13 or #14 or #15

The output from this set was searched using the following terms:

**Training and support for above behaviours set**

#1 training (ft)  
#2 support\* (ft)  
#3 competen\* (ft)  
#4 regist\* (ft)

#5 counselling (ft)  
#6 assess\* (ft)  
#7 #1 or #2 or #3 or #4 or #5 or #6

The output from this set was searched using the following terms:

**Quantitative, correlate set**

- |    |                   |    |   |
|----|-------------------|----|---|
| #1 | quantitative (ft) | #6 | percentage (ft)                           |
| #2 | correlate* (ft)   | #7 | significant difference (ft)               |
| #3 | effective* (ft)   | #8 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 |
| #4 | statistic* (ft)   |    |   |
| #5 | cohort* (ft)      |    |   |

This output was used to answer question 3.1.4.

**Emotional/behavioural health priority**

Population terms EndNote library above was searched using the following terms:

**Emotional/behavioural health set**

- |     |                         |     |   |
|-----|-------------------------|-----|---|
| #1  | children's centre* (ft) | #26 | relationship* (ft)  |
| #2  | family centre* (ft)     | #27 | risk taking (ft)  |
| #3  | confiden* (ft)          | #28 | self harm (ft)  |
| #4  | esteem (ft)             | #29 | stress (ft)   |
| #5  | grie* (ft)              | #30 | suicide (ft)  |
| #6  | happy (ft)              | #31 | personality disorder* (ft)  |
| #7  | happiness (ft)          | #32 | ADHD (ft)   |
| #8  | emotion* (ft)           | #33 | buddy (ft)  |
| #9  | self control (ft)       | #34 | mentor* (ft)  |
| #10 | mental* (ft)            | #35 | counsellor* (ft)  |
| #11 | qaly (ft)               | #36 | psych* (ft)   |
| #12 | quality of life (ft)    | #37 | advoca* (ft)  |
| #13 | resilen* (ft)           | #38 | therap* (ft)  |
| #14 | respect (ft)            | #39 | support worker* (ft)  |
| #15 | wellbeing (ft)          | #40 | key worker* (ft)  |
| #16 | antisocial (ft)         | #41 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 or #10 or #11<br>or #12 or #13 or #14 or #15 or<br>#16 or #17 or #18 or #19 or<br>#20# or #21 or #22 or #23 or<br>#24 or #25 or #26 or #27 or<br>#28 or #29 or #30 or #31 or<br>#32 or #33 or #34 or #35 or<br>#36 or #37 or #38 or #39 or<br>#40 |
| #17 | anxi* (ft)              |     |   |
| #18 | attach* (ft)            |     |   |
| #19 | behav* (ft)             |     |   |
| #20 | bereav* (ft)            |     |   |
| #21 | bully* (ft)             |     |   |
| #22 | conduct (ft)            |     |   |
| #23 | cortisol (ft)           |     |   |
| #24 | depress* (ft)           |     |   |
| #25 | hyperactiv* (ft)        |     |   |

The output from this set was searched using the following terms:

**Positive emotional and behavioural health set**

- |     |                      |     |   |
|-----|----------------------|-----|---|
| #1  | confiden* (ft)       | #14 | respect (ft)  |
| #2  | esteem (ft)          | #15 | wellbeing (ft)  |
| #6  | happy (ft)           | #16 | feeling good (ft)   |
| #7  | happiness (ft)       | #17 | feel good (ft)  |
| #9  | self control (ft)    | #18 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 or #10 or #11<br>or #12 or #13 or #14 or #15 or<br>#16 or #17 |
| #11 | qaly (ft)            |     |   |
| #12 | quality of life (ft) |     |   |
| #13 | resilen* (ft)        |     |   |

The output from this set was searched using the following terms:

**Views set**

- |    |               |    |                            |
|----|---------------|----|----------------------------|
| #1 | opinion* (ft) | #4 | listen* (ft)               |
| #2 | view* (ft)    | #5 | voice* (ft)                |
| #3 | feedback (ft) | #6 | #1 or #2 or #3 or #4 or #5 |

This output was used to answer question 3.2.1.

The emotional/behavioural health set was searched using the following terms:

**Emotional/behavioural health policy and interventions set**

- |     |                          |     |  |
|-----|--------------------------|-----|--|
| #1  | advoca* (ft)             | #14 | Healthy Care (ft)  |
| #2  | mentor* (ft)             | #15 | mental health professional* (ft)   |
| #3  | counsell* (ft)           | #19 | camhs (ft)   |
| #4  | therap* (ft)             | #20 | achievement ceremon* (ft)  |
| #5  | dedicated (ft)           | #21 | guidance (ft)  |
| #6  | specialist (ft)          | #22 | educational psychologist* (ft)   |
| #7  | policy (ft)              | #23 | psychiatrist* (ft)   |
| #8  | legislation (ft)         | #24 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 or #10 or #11<br>or #12 or #13 or #14 or #15 or<br>#16 or #17 or #18 or #19 or<br>#20 or #21 or #22 or #23 |
| #9  | green paper (ft)         |     |  |
| #10 | white paper (ft)         |     |  |
| #11 | Every Child Matters (ft) |     |  |
| #12 | Children's Act           |     |  |
| #13 | secure attachment (ft)   |     |  |

The output from this set was searched using the following terms:

**Acceptability, accessibility and effectiveness set**

- |     |                     |     |  |
|-----|---------------------|-----|--|
| #1  | acceptab* (ft)      | #11 | outcomes (ft)  |
| #2  | accessib* (ft)      | #12 | evaluat* (ft)  |
| #3  | satisfaction (ft)   | #13 | making a difference (ft)   |
| #4  | service uptake (ft) | #14 | success* (ft)  |
| #5  | service use (ft)    | #15 | improvement (ft)   |
| #6  | engage* (ft)        | #16 | implementation (ft)  |
| #7  | involv* (ft)        | #17 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 or #10 or #11<br>or #12 or #13 or #14 or #15 or<br>#16 |
| #8  | participat* (ft)    |     |  |
| #9  | effective* (ft)     |     |  |
| #10 | What works (ft)     |     |  |

This output was used to answer question 3.2.2.

The emotional/behavioural health set was searched using the following terms:

**Foster, residential and kinship carers and birth families**

- |    |                 |    |   |
|----|-----------------|----|---|
| #1 | carer* (ft)     | #6 | mother* (ft)                                    |
| #2 | worker* (ft)    | #7 | father* (ft)                                    |
| #3 | assistant* (ft) | #8 | parent* (ft)                                    |
| #4 | guardian* (ft)  | #9 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 |
| #5 | family (ft)     |    |   |

The output from this set was searched using the following terms:

**Attitudes, skills, aptitudes and behaviours set**

- |     |                 |     |   |
|-----|-----------------|-----|---|
| #1  | attitude* (ft)  | #14 | value (ft)  |
| #2  | skill* (ft)     | #15 | engage* (ft)  |
| #3  | abilit* (ft)    | #16 | bond (ft)   |
| #4  | behaviour* (ft) | #17 | sympath* (ft)   |
| #5  | behavior* (ft)  | #18 | warmth (ft)   |
| #6  | encourage* (ft) | #19 | love (ft)   |
| #7  | supportive (ft) | #20 | belonging (ft)  |
| #8  | supporting (ft) | #21 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 or #10 or #11<br>or #12 or #13 or #14 or #15 or<br>#16 or #17 or #18 or #19 or<br>#20 |
| #9  | empathy (ft)    |     |   |
| #10 | promote (ft)    |     |   |
| #11 | help* (ft)      |     |   |
| #12 | assist* (ft)    |     |   |
| #13 | facilitate (ft) |     |   |

The output from this set was searched using the following terms:

**Training and support for above behaviours set**

- |    |                |    |                                  |
|----|----------------|----|----------------------------------|
| #1 | training (ft)  | #5 | counselling (ft)                 |
| #2 | support* (ft)  | #6 | assess* (ft)                     |
| #3 | competen* (ft) | #7 | #1 or #2 or #3 or #4 or #5 or #6 |
| #4 | regist* (ft)   |    |                                  |

The output from this set was searched using the following terms:

**Quantitative, correlate set**

- |    |                   |    |  |
|----|-------------------|----|--|
| #1 | quantitative (ft) | #6 | percentage (ft)                        |
| #2 | correlate* (ft)   | #7 | significant difference (ft)            |
| #3 | effective* (ft)   | #8 | #1 or #2 or #3 or #4 or #5 or #6 or #7 |
| #4 | statistic* (ft)   |    |  |
| #5 | cohort* (ft)      |    |  |

This output was used to answer question 3.2.3.

**Safe, settled accommodation priority**

Population terms EndNote library above was searched using the following terms:

**Accommodation set**

- |    |                         |     |   |
|----|-------------------------|-----|---|
| #1 | accommodation (ft)      | #9  | floating support (ft)   |
| #2 | housing (ft)            | #10 | tenan* (ft)   |
| #3 | homeless* (ft)          | #11 | B&B (ft)  |
| #4 | flat* (ft)              | #12 | bed and breakfast (ft)  |
| #5 | bedsit* (ft)            | #13 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 |
| #6 | lodging* (ft)           |     |   |
| #7 | hostel* (ft)            |     |   |
| #8 | independent living (ft) |     |   |

The output from this set was searched using the following terms:

**Safe, settled set**

- |    |              |    |                      |
|----|--------------|----|----------------------|
| #1 | safe* (ft)   | #4 | permanen* (ft)       |
| #2 | settled (ft) | #5 | #1 or #2 or #3 or #4 |
| #3 | secur* (ft)  |    |                      |

The output from this set was searched using the following terms:

**Views set**

- |    |               |    |                            |
|----|---------------|----|----------------------------|
| #1 | opinion* (ft) | #4 | listen* (ft)               |
| #2 | view* (ft)    | #5 | voice* (ft)                |
| #3 | feedback (ft) | #6 | #1 or #2 or #3 or #4 or #5 |

This output was used to answer question 3.3.1.

The accommodation set was searched using the following terms:

**Not in settled accommodation set**

- |    |                     |     |   |
|----|---------------------|-----|---|
| #1 | unsafe (ft)         | #7  | lost (ft)   |
| #2 | unsettled (ft)      | #8  | rough sleep* (ft)                                     |
| #3 | temporary (ft)      | #9  | on the street* (ft)                                   |
| #4 | homeless* (ft)      | #10 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 |
| #5 | out of touch (ft)   |     |   |
| #6 | not in contact (ft) |     |   |

This output was used to answer question 3.3.2.

The accommodation set was searched using the following terms:

**Accommodation policy and interventions set**

- |     |                       |     |   |
|-----|-----------------------|-----|---|
| #1  | floating support (ft) | #14 | white paper (ft)  |
| #2  | housing support (ft)  | #15 | Children (Leaving Care) Act (ft)  |
| #3  | housing service* (ft) | #16 | affordable (ft)   |
| #4  | housing officer* (ft) | #17 | low cost (ft)   |
| #5  | benefit* (ft)         | #18 | guidance (ft)   |
| #6  | credit* (ft)          | #19 | joint working (ft)  |
| #7  | grant* (ft)           | #20 | Homelessness Act (ft)   |
| #8  | fund* (ft)            | #21 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 or #10 or #11<br>or #12 or #13 or #14 or #15 or<br>#16 or #17 or #18 or #19 or<br>#20 |
| #9  | dedicated             |     |   |
| #10 | specialist* (ft)      |     |   |
| #11 | policy                |     |   |
| #12 | legislation           |     |   |
| #13 | green paper (ft)      |     |   |

The output from this set was searched using the following terms:

**Acceptability, accessibility and effectiveness set**

- |     |                     |     |  |
|-----|---------------------|-----|--|
| #1  | acceptab* (ft)      | #11 | outcomes (ft)  |
| #2  | accessib* (ft)      | #12 | evaluat* (ft)  |
| #3  | satisfaction (ft)   | #13 | making a difference (ft)   |
| #4  | service uptake (ft) | #14 | success* (ft)  |
| #5  | service use (ft)    | #15 | improvement (ft)   |
| #6  | engage* (ft)        | #16 | implementation (ft)  |
| #7  | involv* (ft)        | #17 | #1 or #2 or #3 or #4 or #5 or #6<br>or #7 or #8 or #9 or #10 or #11<br>or #12 or #13 or #14 or #15 or<br>#16 |
| #8  | participat* (ft)    |     |  |
| #9  | effective* (ft)     |     |  |
| #10 | What works (ft)     |     |  |

This output was used to answer question 3.3.3.

The emotional/behavioural health set was searched using the following terms:

**Foster, residential and kinship carers and birth families**

- |    |                 |    |  |
|----|-----------------|----|--|
| #1 | carer* (ft)     | #6 | mother* (ft)                                 |
| #2 | worker* (ft)    | #7 | father* (ft)                                 |
| #3 | assistant* (ft) | #8 | parent* (ft)                                 |
| #4 | guardian* (ft)  | #9 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 |
| #5 | family (ft)     |    |  |

The output from this set was searched using the following terms:

**Attitudes, skills, aptitudes and behaviours set**

- |     |                 |     |  |
|-----|-----------------|-----|--|
| #1  | attitude* (ft)  | #12 | assist* (ft)   |
| #2  | skill* (ft)     | #13 | facilitate (ft)  |
| #3  | abilit* (ft)    | #14 | value (ft)   |
| #4  | behaviour* (ft) | #15 | engage* (ft)   |
| #5  | behavior* (ft)  | #16 | financ* (ft)   |
| #6  | encourage* (ft) | #17 | fund* (ft)   |
| #7  | supportive (ft) | #18 | #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 |
| #8  | supporting (ft) |     |  |
| #9  | empathy (ft)    |     |  |
| #10 | promote (ft)    |     |  |
| #11 | help* (ft)      |     |  |

The output from this set was searched using the following terms:

**Quantitative, correlate set**

- |    |                   |    |  |
|----|-------------------|----|--|
| #1 | quantitative (ft) | #6 | percentage (ft)                        |
| #2 | correlate* (ft)   | #7 | significant difference (ft)            |
| #3 | effective* (ft)   | #8 | #1 or #2 or #3 or #4 or #5 or #6 or #7 |
| #4 | statistic* (ft)   |    |  |
| #5 | cohort* (ft)      |    |  |

This output was used to answer question 3.3.4.

The output from this set was searched using the following terms:

**Quantitative, correlate set**

- |    |                   |    |  |
|----|-------------------|----|--|
| #1 | quantitative (ft) | #6 | percentage (ft)                        |
| #2 | correlate* (ft)   | #7 | significant difference (ft)            |
| #3 | effective* (ft)   | #8 | #1 or #2 or #3 or #4 or #5 or #6 or #7 |
| #4 | statistic* (ft)   |    |  |
| #5 | cohort* (ft)      |    |  |

This output was used to answer question 3.3.4.

## **For all priorities**

### **Literature suggestions from the Theme Advisory Group and other experts**

These were incorporated into the pool of references that were screened.

### **Policy, government agencies, academic and third sector websites**

The following websites were browsed and searched for each priority, and relevant documents incorporated in the screening EndNote libraries. These websites included government departments and agencies, academic centres, and third sector organisations.

Output figures were not compiled for each website because this work was carried out during background preparation for this project.

<b>Organisation</b>	<b>URL</b>
4 Nations Child Policy Network	<a href="http://www.childpolicy.org.uk/">www.childpolicy.org.uk/</a>
A National Voice	<a href="http://www.anationalvoice.org/">www.anationalvoice.org/</a>
Barnardo's	<a href="http://www.barnardos.org.uk/">www.barnardos.org.uk/</a>
British Association for Adoption and Fostering	<a href="http://www.baaf.org.uk/">www.baaf.org.uk/</a>
Care Services Improvement Partnership Knowledge Community	<a href="http://kc.csip.org.uk/">http://kc.csip.org.uk/</a>
Caspari Foundation	<a href="http://www.caspari.org.uk/">www.caspari.org.uk/</a>
Centre for Policy Studies	<a href="http://www.cps.org.uk/">www.cps.org.uk/</a>
Connexions Direct	<a href="http://www.connexions-direct.com/">www.connexions-direct.com/</a>
DEMOS	<a href="http://www.demos.co.uk/">www.demos.co.uk/</a>
Department for Children, Schools and Families	<a href="http://www.dcsf.gov.uk/">www.dcsf.gov.uk/</a>
Department of Health	<a href="http://www.dh.gov.uk/en/index.htm">www.dh.gov.uk/en/index.htm</a>
Evidence Network	<a href="http://www.evidencenetwork.org/">www.evidencenetwork.org/</a>
Government Social Research	<a href="http://www.gsr.gov.uk/">www.gsr.gov.uk/</a>
Institute for Public Policy Research	<a href="http://www.ippr.org.uk/">www.ippr.org.uk/</a>
Intute	<a href="http://www.intute.ac.uk/">www.intute.ac.uk/</a>
INVOLVE	<a href="http://www.invo.org.uk/">www.invo.org.uk/</a>
Joseph Rowntree Foundation	<a href="http://www.jrf.org.uk/">www.jrf.org.uk/</a>
King's Fund	<a href="http://www.kingsfund.org.uk/">www.kingsfund.org.uk/</a>
Local Government Analysis and Research	<a href="http://www.local.gov.uk">www.local.gov.uk</a>

Mental Health Foundation	<a href="http://www.mentalhealth.org.uk/">www.mentalhealth.org.uk/</a>
NACRO	<a href="http://www.nacro.org.uk/">www.nacro.org.uk/</a>
NATCEN	<a href="http://www.natcen.ac.uk/">www.natcen.ac.uk/</a>
National Centre for Excellence in Residential Child Care	<a href="http://www.ncb.org.uk/Page.asp?sve=934">www.ncb.org.uk/Page.asp?sve=934</a>
National Children's Bureau	<a href="http://www.ncb.org.uk/Page.asp">www.ncb.org.uk/Page.asp</a>
National Foundation for Educational Research	<a href="http://www.nfer.ac.uk/index.cfm">www.nfer.ac.uk/index.cfm</a>
National Library for Health	<a href="http://www.library.nhs.uk/">www.library.nhs.uk/</a>
National Statistics	<a href="http://www.statistics.gov.uk/default.asp">www.statistics.gov.uk/default.asp</a>
NCVCCO (Children England)	<a href="http://www.ncvcco.org/">www.ncvcco.org/</a>
Northern Ireland Commissioner for Children and Young People	<a href="http://www.nickey.org/">www.nickey.org/</a>
Personal Social Services Research Unit	<a href="http://www.pssru.ac.uk/">www.pssru.ac.uk/</a>
Prison Reform Trust	<a href="http://www.prisonreformtrust.org.uk/">www.prisonreformtrust.org.uk/</a>
Promising Practices Network	<a href="http://www.promisingpractices.net/">www.promisingpractices.net/</a>
Research in Practice	<a href="http://www.rip.org.uk/">www.rip.org.uk/</a>
Restorative Justice Consortium	<a href="http://www.restorativejustice.org.uk/">www.restorativejustice.org.uk/</a>
Rethink	<a href="http://www.rethink.org/">www.rethink.org/</a>
The Howard League	<a href="http://www.howardleague.org/">www.howardleague.org/</a>
The National Youth Agency	<a href="http://www.nya.org.uk/">www.nya.org.uk/</a>
What Works for Children	<a href="http://www.whatworksforchildren.org.uk/">www.whatworksforchildren.org.uk/</a>
York Systematic Reviews in Social Policy and Social Care	<a href="http://www.york.ac.uk/inst/chp/srspsc/index.htm">www.york.ac.uk/inst/chp/srspsc/index.htm</a>
Young Minds	<a href="http://www.youngminds.org.uk/">www.youngminds.org.uk/</a>

## Appendix 3: Parameters document

### 1. C4EO Theme 3 Vulnerable Children

#### 2. Priority

3.2. Improving the emotional and behavioural health of looked after children and young people (LACYP).

#### 3. Context for this priority

Improving the emotional and behavioural health of LACYP is a Department for Children, Schools and Families (DCSF) strategic delivery objective. Using DCSF data, the National Indicator Set will create a baseline in 2008/09. We have not identified any trend data for looked after children, but one Office for National Statistics (ONS) survey showed that mental health problems among LACYP is four times that for all children, with conduct disorder the most prevalent diagnosis (Meltzer *et al* 2003). Emotional health is a keystone building block needed to achieve other outcomes throughout the child's life and challenging behaviour is one of the main factors in placement breakdown for looked after children. Problematic emotional health and behaviour are likely to be a consequence of pre-care experiences and can be exacerbated by instability of placements. LACYP mention low self-esteem and self-concept as barriers to educational and other outcomes and emphasise promoting resilience as well as targeted interventions as an important means to improve emotional health (Bostock 2004; A National Voice 2007; Who Cares? Trust 2008). This means that interventions to assess and improve emotional and behavioural health are likely to entail systems-level change as they concern interfaces between children's health, schools, social care and housing. DCSF and the Department of Health (DH) are issuing revised statutory guidance on promoting the health of LACYP. The National Institute for Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) will be producing joint guidelines on improving the physical and emotional health of LACYP.

#### 4. Main review questions to be addressed in the scoping study (no more than five; preferably fewer)

What do we know about how to improve the emotional and behavioural health of LACYP?

##### Sub-questions<sup>11</sup>:

What are LACYP's views on what constitutes emotional and behavioural health and do they compare with policy-makers, children's services personnel and independent sector providers?

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<sup>11</sup> Review sub-questions were changed during the review process, following completion of the scoping study.

What do we know about the accessibility, acceptability and effectiveness of policies, services and interventions to improve emotional and behavioural health initiated by central, regional and local government and the independent sector for LACYP?

What do we know about the contribution made to improved emotional and behavioural health of LACYP by the attitudes, skills and abilities of foster, residential and kinship carers and birth families and interventions to support this contribution?

**5. Which cross-cutting issues should be included (child poverty; safeguarding; equality and diversity; disability; workforce development; change management; leadership; learning organisations)?**

Child poverty

Safeguarding

Equality and diversity

**6. Definitions for any terms used in the review questions**

*Population of children:*

looked after children and young people in medium- and long-term care (more than six months) – wherever they are looked after (e.g. residential care, foster care, young offenders' institution) – up to age 25, and their families

children and young people who have several short-term (up to six months) periods in local authority care (either under a Care Order, or on a voluntary basis)

children and young people preparing to leave medium-term or long-term local authority care.

*Definition of health:*

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity ([www.who.int/about/definition/en/print.html](http://www.who.int/about/definition/en/print.html)).

*DH's definition of wellbeing:*

'Wellbeing is a general term encompassing the total universe of human life domains including physical, mental and social aspects, that make up what can be called a "good life". Health domains are a subset of domains that make up the total universe of human life.'

*Outcomes:*

ECM Outcomes:

Be healthy.

Stay safe.  
Enjoy and achieve.  
Make a positive contribution.  
Achieve economic wellbeing.

National indicator 58: Emotional and behavioural health of looked after children.  
Specific LACYP-defined outcomes to be identified during the scope.

## **7. What will be the likely geographical scope of the searches?**

(Work conducted in/including the following countries)

**England only**

**UK only**

**Europe only**

**Europe and other countries (English language)**

NB: UK, USA, Canada, Australia and New Zealand.

## **8. Age range for CYP:**

Up to 25.

## **9. Literature search dates**

Start year 2000.

## **10. Suggestions for key words to be used for searching the literature**

See scoping summary document for complete list of search terms.

## **11. Suggestions for websites, databases, networks and experts to be searched or included as key sources**

A National Voice ([anationalvoice.org](http://anationalvoice.org))

BAAF

CAMHS ([www.camhs.org.uk/](http://www.camhs.org.uk/))

Children's Rights Directors ([www.rights4me.org/reports.cfm](http://www.rights4me.org/reports.cfm))

Fostering Network

Healthy Care, NCB resources ([www.ncb.org.uk/](http://www.ncb.org.uk/))

National Asylum Support Service (NASS)  
([www.asylumsupport.info/specialfeatures/children.htm](http://www.asylumsupport.info/specialfeatures/children.htm))

National Centre for Excellence in Residential Child Care  
([www.ncb.org.uk/page.asp?sve=934](http://www.ncb.org.uk/page.asp?sve=934))

References from NICE/SCIE scope on physical and emotional health and wellbeing of LACYP

Scottish Institute for Residential Child Care ([www.sircc.org.uk/](http://www.sircc.org.uk/))

Teaching and Learning Scotland  
([www.ltscotland.org.uk/lookedafterchildren/index.asp](http://www.ltscotland.org.uk/lookedafterchildren/index.asp))

Therapeutic Communities ([www.therapeuticcommunities.org/](http://www.therapeuticcommunities.org/))

Voice ([www.voiceyp.org/ngen\\_public/default.asp](http://www.voiceyp.org/ngen_public/default.asp))

Voices from Care Cymru ([www.voicesfromcarecymru.org.uk/main.htm](http://www.voicesfromcarecymru.org.uk/main.htm))

Young Minds ([www.youngminds.org.uk/](http://www.youngminds.org.uk/))

## 12. Any key texts/books/seminal works that you wish to see included?

SCIE's review on challenging behaviours

SCIE/NICE guidance on conduct disorders

DH (2002) *Promoting the health of looked after children*

Action for Children (2007) *A review of the promotion of children's emotional wellbeing by Action for Children services* (available at [www.actionforchildren.org.uk/uploads/media/29/331.pdf](http://www.actionforchildren.org.uk/uploads/media/29/331.pdf))

Margo and Sodha (2007) *Get happy: children and young people's emotional wellbeing* (available at [www.actionforchildren.org.uk/uploads/media/36/1581.pdf](http://www.actionforchildren.org.uk/uploads/media/36/1581.pdf))

Rainer Policy Briefing: Mental health and care leavers (available at [www.leavingcare.org/data/tmp/3191-6781.pdf](http://www.leavingcare.org/data/tmp/3191-6781.pdf))

Who Cares? Trust (2008) *Who cares? About feeling good?*

Cafcass Health and Wellbeing review: the experiences of young people in care

Mental Health Foundation (1999) *Bright futures: promoting children and young people's mental health*

Young Minds, Looked after children and mental health

Pughe and Philpot (2006) *Living alongside a child's recovery*

Ward (2003) *Therapeutic approaches in work with traumatised children and young people*

*Child*, adolescent mental health magazine

Davies and Wright (2008) 'Children's voices: a review of the literature pertinent to looked after children's views of mental health services'

Wade and Dixon (2006) 'Making a home, finding a job: investigating early housing and employment outcomes for young people leaving care'

Scott and Hill (2006) *The health needs of looked after and accommodated children and young people in Scotland: messages from research* (available at [www.swia.gov.uk/swia/files/Health%20of%20Looked%20After%20and%20Accommodated%20Children%20in%20Scotland.pdf](http://www.swia.gov.uk/swia/files/Health%20of%20Looked%20After%20and%20Accommodated%20Children%20in%20Scotland.pdf))

What makes the difference? Project (WMTD) Peer research project, leavingcare.org

### **13. Anything else that should be included or taken into account?**

concept of resilience

relationships and attachment

importance of housing to wellbeing (Wade and Dixon 2006)

mental health of children in secure settings, 300 held for welfare reasons – HM Government (2007) *Promoting mental health for children held in secure settings: a framework for commissioning services*, London: Department of Health (available at [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_073414](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073414)).

## Appendix 4: Relevant national indicators and data sources

National indicator (NI) number	National indicator (NI) detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
<b>Be healthy</b>							

National indicator (NI) number	National indicator (NI) detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
I58	Emotional and behavioural health of looked after children	Melzer, H., Corbin, T., Gatward, R., Goodman, R. and Ford, T. (2003) <i>The mental health of young people looked after by local authorities in England</i> , London: The Stationery Office, ISBN=0116 216514, Online edition, and hardcopy publication	National (UK and country level)	<i>Ad hoc</i>	2001/02	2001/02	<a href="http://www.statistics.gov.uk/statbase/Product.asp?vlnk=10432">www.statistics.gov.uk/statbase/Product.asp?vlnk=10432</a>  <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019442">www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019442</a>

National indicator (NI) number	National indicator (NI) detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
NI58	Emotional and behavioural health of looked after children	Department for Children, Schools and Families (2009a) <i>DCSF: children looked after in England (including adoption and care leavers) year ending 31 March 2009</i> (statistical first release 25/2009), London: DCSF.	National, regional and local authority	Annual	2009	2009	<a href="http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000878/index.shtml">www.dcsf.gov.uk/rsgateway/DB/SFR/s000878/index.shtml</a>

National indicator (NI) number	National indicator (NI) detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
NI115	Reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances	Department for Children, Schools and Families (2010) <i>DCSF: statistical first release (sfr) on outcome indicators for children looked after, twelve months to 30 September 2009 – England</i> (statistical first release 08/2010), London: DCSF	National, regional and local authority	Annual	2009	Trend data available since 2005	<a href="http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000930/index.shtml">www.dcsf.gov.uk/rsgateway/DB/SFR/s000930/index.shtml</a>

National indicator (NI) number	National indicator (NI) detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
<b>Stay safe</b>							
NI111	Reduce the number of first-time entrants to the criminal justice system aged 10–17	Department for Children, Schools and Families (2010) <i>DCSF: statistical first release (sfr) on outcome indicators for children looked after, twelve months to 30 September 2009 – England</i> (statistical first release 08/2010), London: DCSF	National, regional and local authority	Annual	2009	Trend data available since 2005	<a href="http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000930/index.shtml">www.dcsf.gov.uk/rsgateway/DB/SFR/s000930/index.shtml</a>

National indicator (NI) number	National indicator (NI) detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
<b>Demographics</b>							
Additional indicators	Characteristics of looked after children	Department for Children, Schools and Families (2009a) <i>DCSF: children looked after in England (including adoption and care leavers) year ending 31 March 2009</i> (statistical first release 25/2009), London: DCSF	National, regional and local authority	Annual	2009	Trend data available since 1998	<a href="http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000878/index.shtml">www.dcsf.gov.uk/rsgateway/DB/SFR/s000878/index.shtml</a>

## Appendix 5: Validated local practice process and assessment criteria

### What is validated local practice?

Validated local practice examples describe how local authorities and their partners have successfully tackled key challenges and improved outcomes for children and young people. Their success in achieving improved outcomes has been assessed as being sufficiently well evidenced to merit inclusion within the review.

### Collection methods

C4EO collected practice examples by sending invitations to local authorities and trusts to submit promising or proven practice examples to C4EO relevant to each theme after the knowledge workshops. The call for local practice examples was also advertised at the Vulnerable Children knowledge workshops and was placed on the C4EO website and publicised through various publications. Members of the Theme Advisory Group were also asked to use their own contacts and networks to publicise the call for practice examples. Respondents submitted examples in hard copy or via email.

### Validation process

Local authorities and their partners were asked to submit their practice examples in a form that was designed to encourage them to fully describe their practice and to provide evidence of how it had improved outcomes. The forms were then assessed by a validation panel made up of a small group of sector specialists, professionals drawn from across the children's sector who have an expertise and a track record of achievement in vulnerable (looked after) children. Two sector specialists assessed each example against the following validation criteria:

**Adequacy of the information supplied.** Is there enough to apply the validation process?

**Strength of the rationale.** Was the intervention/practice fit for purpose and based on a clear and sound rationale? Was it based on prior and good-quality evidence of need and what works in similar contexts?

**Sufficiency of impact and outcome evidence.** Is there sufficient external and/or internal evaluation evidence that the practice/intervention has made a difference and led to improved outcomes? Are there good practitioner, service user and other stakeholder views? Do others implementing the same or similar practice or strategy changes or interventions report similar findings?

**Evidence of what has/has not worked and why.** Is there some good guidance here which will be useful to others? What are the golden threads for what works? What barriers and ways of overcoming these have been documented?

**Actual or potential for replication or transfer** to other contexts and settings. What evidence is there that the practice has already been successfully transferred to different settings, or has the potential for replication? Which elements are especially transferable? What elements are non-negotiable, and which are open to adaptation to suit other contexts? What do people need to put in place to transfer the practice, without substantial loss of effect?

Where two sector specialists assessed an example as being strongly supported by practice experience and evidence or as describing promising practice along with a good rationale for the intervention and some evidence of success and potential to be replicated, the Theme Lead reviewed the assessment. Only examples that were endorsed by the Theme Lead were validated.

This review has drawn on four validated practice examples.

All the practice examples featured within the review, and those submitted and validated since the review was written, are available at *[SCIE to insert url]*.

## Appendix 6: Stakeholder data

The views of parents, young people and service providers were sought in four ways.

### Parents and carers panel

First, the executive summary of the research review on 'improving the emotional and behavioural health of looked after children and young people' was sent to the parents and carers panel, organised by C4EO. Their views were sought on the following questions:

- What are your views on the main findings of the report? (Seven parents, all mothers, responded to this question.)
- As a parent or carer, are you being supported to address any emotional and behavioural health needs of your children? If yes, in what ways? (Seven parents – six mothers and one father who was also a foster carer responded to this question.)
- How can parents and carers be helped to support the emotional and behavioural health of looked after children better? (Ten parents – nine mothers and one father who was also a foster carer and one care leaver responded to this question.)

### Consultation with birth parents

Second, C4EO also organised a consultation event with a group of four birth parents who have or have had children in care. The group comprised of two mothers and two fathers, including: a single father whose daughter had returned home from foster care; a mother whose five children had been in care since 2003, and whose 18-year-old son had recently left care; a father whose children had been placed for adoption; and a mother whose son accessed respite care, and whose son-in-law was a care leaver.

The group met several times a year to advise their local authority on issues relating to children in care. In respect of improving the emotional and behavioural health of looked after children and young people, the group's views were sought on improving the emotional and behavioural health of looked after children and young people.

### Young people's podcasting workshop

Third, a group of nine young people who were involved with two Action for Children's looked after care projects spent two days together exploring issues raised by the C4EO research reviews, including *Improving the emotional and behavioural health of looked after children and young people*.

The young people were aged between 16 and 23 and had experience of being looked after in foster care, supported accommodation and a residential school. Their views were contained within a podcast.

They identified the skills, experiences and competences of their 'ideal carer'. Their views were also sought on the following questions in respect of emotional and behavioural health:

- How are you emotionally supported by your carer?
- How do you feel about being in care?
- What do you understand about the reasons why you were put in care?
- Why do you think people in care get stereotyped? What would make a difference?

## **C4EO service provider workshops**

Evidence was also gathered from service providers during discussion groups held at C4EO knowledge workshops. Six events were held at which the authors presented the findings from the Vulnerable Children reviews. These were attended by senior managers and practitioners from statutory and voluntary agencies. One hundred and nine delegates attended discussion groups on improving the emotional and behavioural health of looked after children and young people. The 'local challenges' discussed in the groups included:

- Identifying protocol, models, and barriers between health and other bodies. How to achieve joint ownership and understanding.
- Building capacity of all professionals and carers and strengthening the resilience of the systems they use to enable them to meet the long-term social, emotional and behavioural needs of looked after children. (Support early assessment and intervention.)
- Transition from child to adult mental health services and from universal to specialist services.
- What constitutes best practice in terms of early identification and assessment of the mental health needs of looked after children?
- How can we be creative in supporting young people to access appropriate interventions to promote their emotional health and wellbeing?
- How can the 'professional network' be supported in managing the emotional and behavioural needs of looked after children?

## Improving the emotional and behavioural health of looked after children and young people

This knowledge review aims to tell us what works in improving the emotional and behavioural health of looked after children and young people, on the basis of a rapid and systematic review of research literature and analysis of key data. As recommended in the scoping study on which this review builds, we focus on the interventions for which the evidence base is most developed and relevant to the review subject.

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