NHS
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Children in Care Evidence-Based Clinical Review & Practice Guide

Understanding and Supporting the Mental Health and Emotional Wellbeing Needs of Children and Young People in Care

NHS England and NHS Improvement

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Executive Summary

Everyone in the system around a child or young person in care has a role and responsibility in recognising, understanding and supporting their mental health and emotional wellbeing needs. Children and young people in care are at much higher risk of experiencing a range of mental health, emotional wellbeing, and neurodevelopmental difficulties than their counterparts who are not in care. However, these can often remain undetected, misunderstood, and insufficiently supported, which can have profound and long-lasting effects across all areas of the child or young person's life. Evidence shows that a range of support can be of considerable benefit. A substantial proportion of this support can be provided by those already known to the child or young person (their caregivers, significant others, and professionals in their wider system), or accessible in wider community settings. However, there may also be times that access to more specialist support is indicated, and equity of access to evidence-based approaches or treatment is critical.

This clinical review and practice guide draws on best available evidence, guidelines, and expert consensus, including the views and insight of care leavers and caregivers. The document begins by outlining core overarching principles in the approach to recognising, understanding and supporting the mental health and emotional wellbeing needs of children and young people in care. It then recommends key areas to consider, and cover, when trying to build an understanding of their mental health and emotional wellbeing needs. Tips are provided on how to approach and manage these conversations, and a range of measures and questionnaires that may support this process are outlined. The second section of the document focuses on providing and planning support for mental health and emotional wellbeing needs, including building wellbeing and resilience, facilitating healthy attachments, and targeted support for specific mental health and neurodevelopmental difficulties. This includes information on the types of approaches and treatments best supported by current evidence, consideration of when specialist support may be indicated, and tips on making referrals for specialist support.

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Introduction

This clinical review and practice guide has been designed in partnership with Anna Freud/CORC (Child Outcomes Research Consortium) colleagues as part of the South East Children in Care Mental Health Systems Change Programme[1]. It has been collated primarily to support Independent Reviewing Officers and Social Workers in how they gain an understanding of the mental health and emotional wellbeing needs of children and young people in care, respond to these needs, and collaboratively plan support as part of overall (ongoing) care planning and statutory looked after review processes. However, the contents are also of relevance to professionals across the children and young people's workforce who come into contact with children and young people in care, and have wider application beyond the statutory review process, as mental health and emotional wellbeing needs are cross-cutting, ongoing and change over time. It is hoped that the shared understanding from this clinical review and practice guide will help maximise multi-agency care planning and review processes for our Children in Care, as part of our shared Corporate Parent role.

Defining Evidence-Based Practice

Evidence-based practice may best be defined as a "three-legged stool", comprising best available research evidence, expert consensus, and the characteristics preferences and values of the person receiving support or care. In line with this definition the following clinical review and practice guide has been drawn from a range of national guidelines, national and international research, expert consensus statements/reports and consultation. Expert consensus statements include the expert perspectives of care leavers and their families and caregivers. A full list of references and source material can be found at the end of the report.

Core Overarching Principles

It is widely recommended that approaches to recognising, understanding and supporting the mental health and emotional wellbeing needs of a child or young person in care should follow these overarching principles:

- **Everyone's Responsibility**
- **Doing With, Not Doing To**
- **Acceptance, Curiosity and Empathy**
- **Inclusion**
- **Look Beyond Behaviour**
- **Integration and Joint Working**
- **No One-Size Fits All**
- **Timely Identification and Support**
- **Building Supportive Adults around Children & Young People**

1 https://www.southeastclinicalnetworks.nhs.uk/children-in-care/

1 EVERYONE'S RESPONSIBILITY

Identifying, understanding and supporting the mental health and emotional wellbeing needs of a child or young person in care is everyone's responsibility, and everyone around the child or young person has a role to play

2 DOING WITH, NOT DOING TO

Recognising needs, understanding needs, and planning of support should be transparent and undertaken in collaboration with the child or young person (and caregivers or significant others where appropriate), with ongoing informed choice and consent throughout

- Given the background experiences of many children and young people in care, consideration should be given to how best to engage them, present information in an accessible way, enable them to express their experiences and views, and ensure a genuine sense of choice/agency
- It is important to recognise the difference between compliance and consent, and to monitor both the verbal and non-verbal communication of the child or young person in relation to consent

3 ACCEPTANCE, CURIOSITY AND EMPATHY

Conversations to help recognise, understand and respond to mental health and emotional wellbeing needs should be relationship-based and characterised by a caring, non-judgemental, curious and empathic stance between everyone involved

4 LANGUAGE THAT CARES

Children and young people in care have given feedback on their preferences for the language that is used in conversations and communication around their needs and care. Every attempt should be made to adopt this preferred language and terminology https://www.tactcare.org.uk/news/language-that-cares/

5 INCLUSION

Approaches to understanding and supporting mental health and emotional wellbeing should promote inclusion and consider reasonable adjustments to facilitate equal access to evidence-based support. Examples include children and young people who are unaccompanied asylum seekers, for whom English is not their first language, with a learning disability, who have difficulties in forming healthy attachments, with behaviours that others find challenging, and those who are not in a stable placement

6 LOOK BEYOND BEHAVIOUR

Although it is important to find out about the child or young person's behaviour, and targeted behavioural support may be helpful, it is of greater importance to recognise that behaviour is often an expression of distress or need. Behaviour that is experienced as difficult to manage can be an outward expression of underlying emotional distress (low-mood, anxiety, trauma), social need (attachment, social skills, positive relationships), or neurodevelopmental difficulties (ADHD, autism, sensory sensitivities). It is therefore important to consider the context for behaviour, the potential causes and needs underlying it, and to respond and take action. Addressing emotional distress early will help to avert greater problems in later years, even where the distress may appear understandable given a child or young person's background and experiences.

7 INTEGRATION AND JOINT WORKING

It is important that the system around a child or young person in care can work together to understand and support their mental health and emotional wellbeing. Support should form part of an overall, integrated, and agreed cross-agency care plan. This should sit alongside regular monitoring and review of needs and progress/change.

- Support planning and delivery is most likely to be effective when this includes an iterative conversation between IROs/social workers and specialist mental health or looked after children services. This might include a range of advice from specialist services, including how to navigate conversations with children and young people about their mental health and emotional wellbeing, interpreting and understanding information from initial conversations and questionnaires, how those already in the child or young person's life can best support them, and support plans that might be the most effective and best fit based on need and local resources. These conversations also provide opportunities for feedback between services to facilitate effective joint working

8 NO ONE-SIZE FITS ALL

There are no "one-size fits all" questionnaires or packages of mental health and emotional wellbeing support for children and young people in care. Support planning should be based on a shared understanding (formulation) of the individual child or young person's biological, psychological, social and environmental needs related to mental health and emotional wellbeing

- Support plans will often need to be multi-component, although consideration may need to be given to prioritising, pacing and sequencing
- Mental health and emotional wellbeing support plans may include both discrete short-term work and longer-term support
- Mental health and emotional wellbeing needs are often met by a range of support including school, community, voluntary services and/or specialist mental health support
- There is often a choice of different approaches, interventions or treatments that can be effective for the same type of mental health or emotional wellbeing need

9 TIMELY IDENTIFICATION AND SUPPORT

There is compelling evidence that timely identification of needs and access to support significantly improves outcomes for children and young people. Needs often change over time so monitoring and support planning around mental health and emotional wellbeing should be an ongoing process.

10 BUILDING SUPPORTIVE ADULTS AROUND CHILDREN AND YOUNG PEOPLE

The most effective interventions for the mental health and emotional wellbeing of children and young people in care are often those that support and equip the adults in their life to understand and contain their distress. Consultation, therapeutic advice, or direct work with the system around the child or young person (including caregivers and significant others) is therefore a valuable and effective intervention. This can be helpful to everyone who sees the child or young person. 1:1 therapeutic approaches with the child or young person are not always indicated and, where they are, may rely on first providing an understanding safe base from the adults in the child or young person's life to stabilise and support them.

Section 1: Identifying and Exploring Mental Health and Emotional Wellbeing Needs, and Monitoring Progress or Outcomes of Support

Wider Holistic Understanding of Strengths, Difficulties and Needs

Mental health and emotional wellbeing is the basis for stability, achievement and development for a child or young person, and is therefore also directly linked to placement stability, educational outcomes, personal and social development. Everyone in the system around a child or young person in care therefore has a shared responsibility and benefit to understanding the child or young person's strengths, difficulties and needs in relation to mental health and emotional wellbeing.

Initial exploration, and ongoing monitoring, of mental health and emotional wellbeing should form part of a wider holistic understanding or "formulation" of the child or young person's life, strengths and needs. This can provide valuable information about factors impacting on, and impacted by, mental health and emotional wellbeing. This wider holistic understanding already forms part of statutory health assessments, looked after reviews, and health action plans. It is recommended that the following areas are included in this wider holistic view, and considered in relation to mental health and emotional wellbeing:

- **Physical health**
- **Home life**
- **Relationships with adults and peers**
- **Identity**
- **School life**
- **Developmental milestones**
- **Self-care (including sleep, diet, exercise)**
- **Social life**
- **Personal values/ goals**

Starting Conversations about Mental Health and Emotional Wellbeing

Before starting any exploration of mental health and emotional wellbeing it is important to consider what information is already known (including any questionnaires or measures already used), how up to date this information is, and how this information has already been pieced together or understood jointly by those in the system and the child or young person themselves. This reduces the potential of the child or young person being repeatedly asked to recount information, which they may find distressing or frustrating. However, this also needs to be balanced against the child or young person consenting to personal information about their life being shared across those who come into contact with them.

Professionals who are not from a mental health background have sometimes expressed a lack of confidence, or fear, in talking to children and young people in care about their mental health. Concerns include knowing what to ask and how, inadvertently causing distress, and opening a "can of worms". Asking about mental health or emotional wellbeing does not cause problems that are not already there but rather prevents them from being neglected, and the associated long-term disruption and distress this can cause. Children and young people want their mental health and emotional wellbeing to be taken seriously and asked about. Evidence shows that when mental health and emotional wellbeing is explored in a transparent, non-judgemental, accepting, curious, empathic, collaborative way, and conversations are pitched at the right level, this can be of therapeutic benefit in its own right. The child or young person can feel heard and understood, and their experiences can be validated and normalised. This can increase the likelihood of them seeking or engaging with support and reduce the potential for problems to worsen and for the child or young person to adopt less helpful ways of coping.

The use of questionnaires such as those outlined below can help facilitate and guide conversations. Adopting predominantly open questions during conversations often helps the conversational flow and allows children or young people the opportunity to give the most detailed descriptions of their experiences (e.g. what, where, when, who things are worse/better around, how long things have been going on for, how often they happen etc.). It is useful to consider which adults in the child or young person's life they may feel most comfortable talking to about their mental health and emotional wellbeing, and to consider ways of supporting them to express their experiences and wishes (e.g. use of creative means for younger children, use of interpreters). However, it is also important to be clear with the child or young person that some mental health and emotional wellbeing needs can be supported by people who are already in their life but others may require the support of people with additional training and expertise.

Asking about Self-Harm and Suicide Risk

When conversations around risk are open, caring, non-judgemental, and empathic there is no evidence that they increase risk. The HARMLESS framework from Oxford Health NHS Foundation Trust provides a useful set of core questions and follow-up questions that can be used with children and young people who have indicated thoughts of self-harm (www.harmless.nhs.uk). The answers can be completed collaboratively online and the web-based app provides suggestions of next steps based on the answers. Any recommendations from the web-based app should be combined with professional judgment based on wider information known about the child or young person, and consultation with local specialist mental health services.

Combining Quantitative and Qualitative Methods

Developing a shared understanding of a child or young person's mental health and emotional wellbeing should combine both qualitative (e.g. conversations, observations) and quantitative (e.g. questionnaires, measures) information from a range of relevant sources. Utilising just one approach, qualitative or quantitative, risks missing significant information about a child or young person that is necessary for their best support and care. Similarly, taking information from a single source, whether a caregiver, professional or the child or young person themselves, risks excluding important perspectives that are crucial for understanding needs.

In terms of the quantitative approach to understanding a child or young person's mental health and emotional wellbeing needs there are some important considerations:

- **Collaboration** - questionnaires or measures should be used in a spirit of collaboration and therefore attention should be paid to how they are introduced and used with all parties (children, young people, caregivers, other professionals). For best results they should be used in a conversation, where the purpose and benefits of their use is discussed and any results are explored jointly
- **Exploration** - questionnaires or measures should be used to explore and investigate a child or young person's mental health and emotional wellbeing strengths, difficulties and needs
- **Interpretation** - the results from measures are not a diagnosis. Instead they should be checked out with the child, young person and caregiver to arrive at a shared interpretation. Any scores from completed measures should be treated as potential indicators of areas requiring further exploration, which may include consulting specialist mental health colleagues. Scores from completed measures should not be used to determine service or support access but should be considered in combination with other information
- **Timing** - the lives, thoughts and feelings of children and young people change over time and therefore it is helpful to re-use measures at different time points to see if anything has changed and to update a shared understanding accordingly. This should not be confined solely to statutory reviews. Typically measures are completed early on in a relationship with a child or young person, every 3-6 months thereafter (review) and whenever the child or young person, caregiver or professional thinks that things may have changed (this includes after an intervention or programme of support has been received by a child or young person)
- **Perspectives** - where possible use measures with a range of people from across the child or young person's network, including parents, caregivers, significant others teachers and other professionals working with the child or young person. As a minimum, self-reported measures should be used. Combining the findings from across multiple perspectives can be hugely informative

The Child Outcomes Research Consortium (CORC) provides free bite-sized videos that have been produced in collaboration with children and young people who have experienced using outcome measures in their care. Often these videos refer to MH professionals or such but in actual fact relate to any professional using measures in their work with children and young people.

The first video allows us to understand why and how they would like quantitative measures (questionnaires) used: https://www.corc.uk.net/for-young-people/

The second video is aimed at professionals working with children and young people to support them to use measures meaningfully, in a manner that supports children and young people and practice: https://youtu.be/bpdkiFyTih0#

Specific Areas to Include When Reviewing Mental Health and Emotional Wellbeing

It is suggested that the following areas are included in more focused mental health and emotional wellbeing reviews for children in care, taking a mixed approach incorporating measures/questionnaires, conversations, observations and information from across the child's network:

- The child or young person's functioning and behaviour; how they are getting along at home, in education and socially
- How the child or young person thinks and feels; identifying any low mood or anxiety
- The impact of trauma and/or adverse childhood experiences (ACEs); children in care are likely to have experienced significant trauma and be affected by this experience, including potential PTSD; experiences and memories around coming into care can be traumatic in their own right
- The child or young person's experience of support and care and their attachment relationship with adults
- Developmental difficulties; including ADHD, autism, learning disabilities and sensory difficulties (under-sensitivity or hyper-sensitivity)
- Risk (e.g. criminality, running away, radicalisation, experiencing or enacting thoughts of self-harm or suicide, physical/sexual/emotional harm to or from others, alcohol or substance use)
- The personal goals of the child or young person; significant for understanding strengths, difficulties and needs

It is also very useful to incorporate the caregivers' experience of caring too; carer stress, confidence/efficacy and relationship to the child or young person

Selecting Questionnaires and Measures to Help Identify Mental Health and Emotional Wellbeing Needs and Monitor Progress/Outcomes

There is no one-size fits all questionnaire or measure for exploring mental health and emotional wellbeing with children and young people in care. Each tool has merits and limitations and often a combination is most beneficial, balanced against overloading the child, young person, caregivers or professionals completing the measures. In selecting which tools to use it is important to consider the purpose, and what information and benefit it is hoped the tool may add to the planning or review process. Whilst not exhaustive, the tables on the following pages provide some questionnaires and measures that have been recommended and/or researched for children and young people in care. To find out more about these measures, understand their terms of use, and access all versions please refer to Appendix 1.

What We Need to Know	Suggested Measures	Suitability	Comments
Functioning How is the CYP coping at home, in education and socially?	Strengths and Difficulties Questionnaire (SDQ) (for self-reporting of younger or less able CYP consider Me & My Feelings)	2-17 (parent & teacher-report) 11-17 (self-report) 8-18 years	Overall screening questionnaire, covering externalising difficulties, internalising difficulties, social skills and social relationships. Has been translated into multiple languages
	(Child) Outcome Rating Scale (ORS/CORS)	CORS 6-12 years ORS 13+ years YPCORS for under 6 years	Translations available, widely used, short and simple
	Children's Global Assessment Scale (CGAS)	CGAS is a rating of functioning aimed at children and young people aged 6-17 years old	This is completed by a professional
General wellbeing What is the level of the CYP's general wellbeing?	Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWS)	15 -21 years (but has been used with 11 + years)	Translations available, 7 questions, no thresholds or norms available
	Students' Life Satisfaction Scale (SLSS)	8-18 years	A global measure of life satisfaction, 7 questions

Resilience What resilience factors does the child have or might need to develop?	Student Resilience Survey (SRS)	7+ years	47 questions, 12 subscales No known translations or normative data
	The Child and Youth Resilience Measure (CYRM-R)	CHILD – 5-9 years YOUTH – 10-23 years	Translations available, 12 and 26 item versions of both
Symptoms of MH distress How does the CYP think and feel, including mood, anxiety, stress	Revised Children's Anxiety and Depression Scale (RCADS)	8-18 years	Parent & self-report versions available, some translations, 6 subscales can be used independently
	Mood and Feelings Questionnaire (MFQ)	6 to 19 years	child self-report, parent-report and short versions available
Trauma What is the impact of trauma on the CYP?	Children's Revised Impact of Events Scale (CRIES-8)	8-18 years	Version with introductory wording adapted for CYP in care*, self-reported, translations available,
Attachment How does the CYP form relationships with adults and peers?	Brief Assessment Checklist (BAC-C/ BAC-A)	4-11 (BAC-C) 11-17 (BAC-A)	Completed by caregivers or parents, attachment and trauma questions, 20 questions
Personal goals What does the CYP want to change or achieve in terms of their mental health and emotional wellbeing?	Goals-Based Outcome Tool (GBO)	Any	Widely used, personalised, particularly useful for monitoring progress/outcomes and personalising support plans

* Adapted introductory wording to the CRIES-8 for children and young people in care:

"Thinking back over your life, there might have been something really upsetting that happened before you came into care, after you came into care, or you might have found coming into care really upsetting and stressful. Below is a list of comments made by people after upsetting or stressful life events. Please put an X for each item showing how frequently these comments were true for you during the past seven days. If they did not occur during that time please put an X in the 'not at all' box" (Morris, Salkovskis, Adams, Lister & Meiser-Stedman, 2015)

Carer Questionnaires (all age)			
What We Need to Know	**Suggested Measures**	**Suitability**	**Comments**
Coping How is the carer coping with the caring responsibilities?	The Parental Stress Scale (PSS)	Parents or carers of children 0-18 years	Translated into 26 languages, wide application within research encompasses different populations, including first-time parents, parents of children with chronic somatic health conditions and ASD, and a mix of clinical and non-clinical samples, 16 questions
	Brief Parenting Self-Efficacy Scale	Parents or carers of children 0-18 years	Short (5 questions), easy to complete
Relationship (including attachment) What is the relationship between CYP and carer like?	Brief Assessment Checklist (BAC-C/BAC-A)	4-11 (BAC-C) 11-17 (BAC-A	Brief Assessment Checklist (BAC-C/BAC-A)
	Child-Parent Relationship Scale	children ages 3-12 years	15 questions, corresponding to conflict and closeness subscales
	Thinking About My Child or 'The Carer Questionnaire'	For children and young people of all ages	12 questions and up to 3 'concerns' or goals, This is not a validated measure but it is used by services

Questionnaires for CYP Under 5 Years			
What We Need to Know	**Suggested Measures**	**Suitability**	**Comments**
	Mothers Object Relations Scale (MORS) MORS-SF My Baby MORS-My Child	 0-2 years 2-4 years	A measure of the attachment relationship between mother/carer and child
	Ages and Stages Questionnaire (ASQ-SE) Social and Emotional Subscale	6 to 60 months (5 years)	questionnaire about children's social-emotional development completed by parent/carer, an initial cost to access the questionnaires and guidance
	Strengths and Difficulties Questionnaire (SDQ)	Versions for 2-4 years and 4+ years	Completed by carer/parent
	Attachment and Bonding Checklist ABC	0-5 years	Completed by professional based upon observation of mother/carer and child and conversation with carer/parent
Please also see Carer Questionnaires Table			

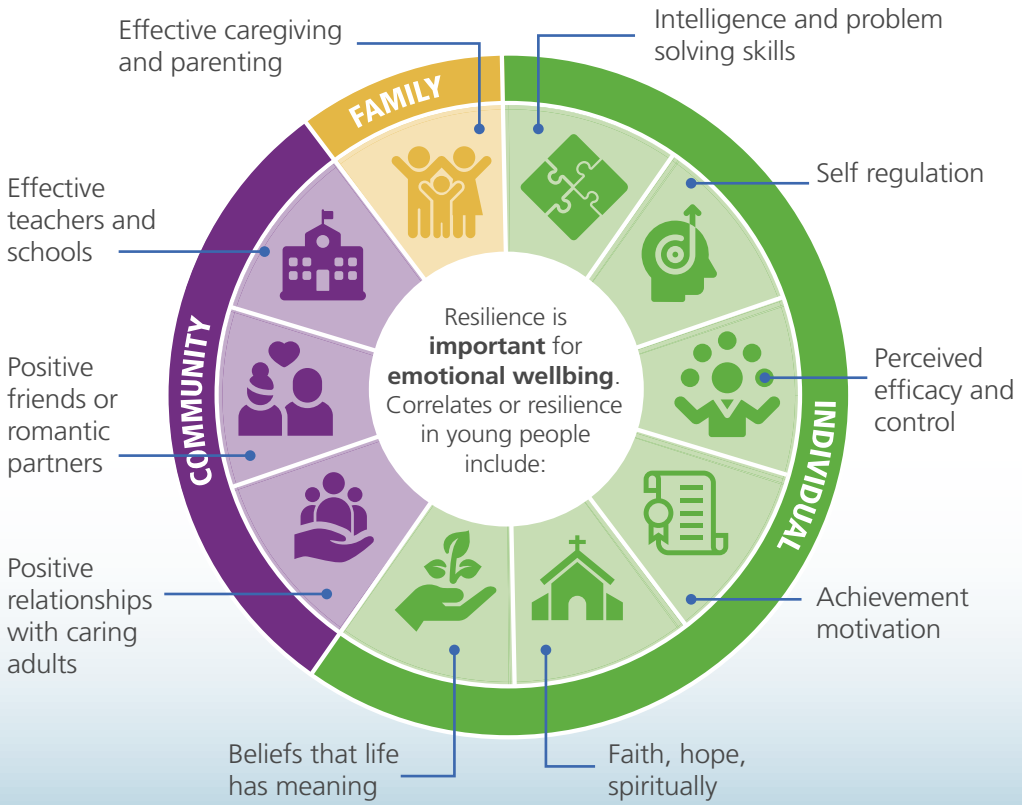
Section 2: Planning Support for the Mental Health and Emotional Wellbeing of Children and Young People in Care

Building Wellbeing and Resilience

Wellbeing and resilience underpin positive mental health for everyone. Evidence suggests that activities and interventions positively promoting health and wellbeing are the most engaging and successful for children and young people in care, and can significantly impact on placement stability. These approaches can be a precursor to, or negate the need for, specialised mental health support. They can also compliment such support and reduce the risk of future recurrence of mental health difficulties. The Public Health England (2016) diagram below shows a number of key areas that can promote wellbeing and resilience. Whilst some of these areas are likely to require more specialised support for children and young people in care, **others may usefully and effectively be provided by existing adults in the child or young person's life (professionals, caregivers, significant others) and/or those accessible through community and voluntary services rather than specialist mental health provision**. These activities, including hobbies, sports and pets, are part of many children and young people's ordinary family life but can be disrupted or overlooked for children in care.

Building resilience

(the ability to cope with adversity and adpat to change)



Evidence-Based Approaches to Supporting Wellbeing and Resilience

National guidelines and expert consensus statements on children and young people in care have highlighted that the following key health and wellbeing areas should be considered when planning mental health and emotional wellbeing support:

- Support around diet, exercise and sleep
- Ensuring the child or young person feels physically and psychologically safe (e.g. at home, at school)
- Promoting and supporting personal identity and self-esteem, including cultural and religious beliefs, sexuality, and gender identity
- Promoting opportunities for children and young people to have agency and self-efficacy across all areas of their life, through fully engaging them, respecting their views and wishes, and providing as much choice as possible. The use of advocates or interpreters may be of particular importance for some children and young people to maximise their capacity to express themselves and to have their voice heard
- Life-story work (with someone specifically trained and supervised in this approach)
- Promoting and supporting a sense of belonging and achievement:
    - Participation in a wider network of peer, school and community activities (including sports and hobbies)
    - Stable experience of education
    - Peer group support, and engagement with religious/community groups - this may be particularly important for unaccompanied asylum-seeking children and young people
- Promoting and supporting relationships with others:
    - Positive and attuned relationships with school staff
    - Consider assertiveness and social skills training for all children and young people in care, adjusted to age, to promote self-esteem and safety, developing and maintaining positive peer relationships, combat bullying, and enhance wellbeing (ideally delivered by trained mentors)
    - Help for relationships with peers, caregivers, significant others and siblings - sometimes this may require more specialised parenting or attachment work (see following sections)
    - Caregivers and significant others in the child or young person's life may require, and benefit from, wellbeing and mental health support in their own right

Wellbeing and Resilience Outcome Measurement

There are a number of useful measures or questionnaires that can be used to understand a child or young person's sense of emotional wellbeing and resilience (including self-esteem and relationships with others), and to review the impact of any of the above support. For information on suitable measures, please see table of questionnaires on page 12. It is helpful to use such measures over time, every six months for instance, to see whether wellbeing or resilience is improving or not for the child or young person.

Support in Developing Healthy Attachments

Although it is important not to assume attachment difficulties will be present for all children and young people in care, developmental trauma, loss and transition almost always impact on the development of secure attachment relationships between the child or young person and the adults around them. Upon exploring mental health and emotional wellbeing needs, attachment-focused support may be considered part of the child or young person's wider mental health and emotional wellbeing needs.

Research shows that children and young people have the capacity to form new trusting relationships despite early abuse, although this process may be longer and require more support for older and more traumatised young people. Through the development of positive attachment relationships children and young people can be supported themselves to manage difficult feelings and to develop responses to these feelings, and to other people in their life, that can have a beneficial impact on their wider mental health, emotional wellbeing and resilience. **However, the provision of attachment-focused support should not preclude children or young people and their caregivers from receiving targeted, evidence-based, interventions for specific mental health or neurodevelopmental difficulties where they have been identified, as there is evidence that some of these difficulties are unlikely to improve without this.** The relative merits and timing of attachment-focused support, targeted support for specific mental health or neurodevelopmental difficulties, or a combination of both, should be considered and discussed as part of support planning.

When Might Attachment-Focused Support Be Useful?

Where the experiences of children or young people in care leave a legacy of difficulties forming secure attachments this can take various forms, including anxious, avoidant, indiscriminate or disorganised attachments. Signs that may indicate such difficulties include:

- Difficulties accepting or sticking to boundaries
- Behaviour others find disruptive (e.g. in the classroom)
- Difficulties forming or maintaining relationships with caregivers, significant others, teachers or positive peers
- Not seeking or accepting comfort
- Vigorous independence (which may include high levels of risk-taking)
- Indiscriminate friendliness or approach to strangers
- Continuous need to be close to teachers, caregivers or significant others, and significant difficulties separating or being apart from them

Children and young people showing some of the above difficulties may have a greater need for support at points of life transition (e.g. moving placement or school).

For information on suitable measures that may be used to screen for potential attachment difficulties, please see table of questionnaires on page 12. Some social care teams may have practitioners trained in more specialised attachment assessments where this is warranted. The NICE guidelines on children's attachment (2015) provide recommendations on specific formal attachment assessments that are supported by research evidence, including analysis of cost-effectiveness (see https://www.nice.org.uk/guidance/ng26/ - recommendation 1.3.4).

Evidence-Based Attachment-Focused Support

Attachment-focused support aims to strengthen relationships between the caregiver(s) and the child or young person, primarily through promoting and supporting sensitive caregiving and management of emotions and behaviour. This is predominantly through direct work or consultation with caregivers (or significant others), or joint work with them and the child or young person, both of which are supported by available research evidence. This work should be delivered by practitioners trained, competent, and supervised in the specific approach or programme being used.

Based on best available evidence regarding approaches that can strengthen attachment security, guidelines and expert consensus reports recommend the following approaches (see https://www.nice.org.uk/guidance/ng26/ for further detail):

- Standard parenting programmes such as Incredible Years or Triple-P, which have been shown to increase sensitive parenting. However, parenting programmes specifically for foster carers and based on evidence-based principles may be available. These are likely to be more preferable and sensitive to need as they have a greater focus on attachment, maintaining stability at home, and how to support children and young people through life transitions. Parenting programmes may be delivered in groups or individually
- Video feedback approaches, particularly for pre-school aged children
- Carer sensitivity and behaviour training, including sessions with the caregiver and child together. This includes carer-child (or dyadic) psychotherapy, which might be play-based for younger children, and mentalising approaches

There is some suggestion that combining the above approaches with group therapeutic play sessions (for pre-school children) or group training in social skills and maintaining positive peer relationships (for older primary/early secondary age) can be beneficial, alongside intensive training for caregivers in advance of the placement.

For children or young people in residential care it may be possible to identify a key attachment figure (significant other) from the staff group who the above approaches can be delivered with (adapted to the role of professional caregivers), alongside wider staff group consultation and support in sensitive and attuned responding (e.g. trauma or attachment-informed care; mentalising programmes).

The above approaches may not be possible for unaccompanied asylum seeking children and young people, or care leavers. However, other approaches such as Trauma-Focused Cognitive Behaviour Therapy (TF-CBT), Interpersonal Therapy (IPT-A), Dialectical Behaviour Therapy (DBT), or Cognitive Analytic Therapy (CAT) may help to support any needs arising from adverse attachment experiences for these children and young people.

There is often an intuitive and well-intentioned wish to alleviate distress by providing individual therapy or support for the child or young person. However, research suggests individual psychotherapy (including individual creative or non-directive therapies) is of uncertain value in strengthening attachment security. **Therapies involving restraint or enforced "holding", coercion, lying on therapists, or "rebirth" do not have an evidence-base and have been associated with harm so should be viewed as malpractice and not considered under any circumstances.**

There is some evidence that short-term respite as part of an overall parenting support package can be effective when considered absolutely necessary and managed sensitively. This can provide caregivers with time and space to rejuvenate, leading to greater sensitivity in their caregiving, and increased placement stability.

Measuring Outcomes of Attachment-Focused Support

Measures that directly explore attachment security, caregiver-child relationships, caregiver confidence or stress, and those exploring wider social relationships may all be useful in reviewing progress and outcomes of attachment-focused support. For information on suitable measures, please see the table of questionnaires on page 12. It is helpful to use such measures over time, every six months for instance, to see whether wellbeing or resilience is improving or not for the child or young person. Where attachment-based therapies are being undertaken, more specialist attachment tools (including observational measures) may also be used.

Support for Specific Mental Health Difficulties, Neurodevelopmental Difficulties and Risk to Self or Others

There is substantial evidence that children or young people in care, with or without attachment difficulties, are at a much higher risk of experiencing a range of mental health difficulties and/or neurodevelopmental difficulties for which evidence-based treatments exist. Mental health or neurodevelopmental difficulties can often appear a natural and understandable response to the child or young person's current and past experiences but this does not negate the need for targeted support. It should not be assumed that evidence-based treatments will be ineffective due to current or past circumstances, current attachment patterns, or complexity. Left unrecognised and without targeted support or intervention, mental health and neurodevelopmental difficulties often worsen and lead to a range of negative outcomes for the child or young person. It is therefore important to offer children and young people in care the same interventions and support as their counterparts who are not in care, where indicated. Consideration should be given to any adjustments necessary for the circumstances and characteristics of the child or young person, and specific therapies or treatments should be incorporated into a wider multi-component package of support that is based on a holistic and shared understanding (formulation) of need which is regularly reviewed.

Effective support for mental health or neurodevelopmental difficulties often improves quality of life, a sense of psychological safety, wider engagement and achievement, and may help caregivers and significant others be more sensitive and responsive, in turn promoting attachment and placement security. However, **the provision of targeted, evidence-based, support for specific mental health or neurodevelopmental difficulties should not preclude a child or young person and their caregivers from receiving attachment-focused support where this is indicated.** As noted above, the relative merits and timing of attachment-focused support, targeted support for specific mental health or neurodevelopmental difficulties, or a combination of both, should be considered and discussed as part of support planning.

When Might Specialist Support for Mental Health or Neurodevelopmental Difficulties Be Useful?

The concept of "clinically significant symptoms" may be useful in determining when further specialist assessment or support would be useful for any mental health or neurodevelopmental difficulties. This refers to a combination of "symptoms" (thoughts/memories; physical sensations; emotions/mood; behaviours) that may not meet the threshold for a formal diagnosis but are causing significant levels of distress, disruption to daily life and functioning, and may be associated with significant risks.

As noted in above sections, there is often an intuitive and well-intentioned wish to alleviate distress by providing individual therapy or support for children and young people in care but it is important to be clear what specific difficulties or symptoms help is being sought for, what might be giving rise to these, and how referral for additional assessment or support is aligned with the child or young person's goals and wishes.

What is a Psychological Formulation, What is Diagnosis, and How Can They Help?

Psychological formulation refers to the application of theory and research evidence to help develop an individualised understanding of a specific difficulty or difficulties, particularly factors leading to these, what keeps them going, and things that make them better or worse. This may include consideration of biological, developmental, psychological and social factors, alongside environmental influences, the impact of the network around the child or young person, and any strengths or protective factors. When a child or young person is experiencing mental health or neurodevelopmental difficulties an individualised formulation can be critical to supporting the child or young person and those around them to better understand the difficulties, respond to them, and plan support.

Diagnosis refers to the use of a specific term or name used to describe a difficulty (e.g. depression, ADHD) when a core set of features are present. As noted above, aspects of how a child or young person in care presents may appear natural or understandable given their current and past circumstances but this does not negate the presence of specific (diagnosable) mental health or neurodevelopmental difficulties nor the need for a diagnosis. Diagnostic assessments usually take into account relevant relational and social factors, and alternative explanations for any key features the child or young person is showing. Use of diagnosis alone often poorly captures the complexity of needs that many children and young people in care experience however, and where diagnosis is sought or given this should always sit alongside wider holistic assessment and individualised psychological formulation of the difficulties.

Where possible, diagnosis should not be used as a threshold for access to specialist support, as symptoms can significantly impact on daily life and functioning even if they do not reach threshold for a diagnosis. However, there may be times when referral for a diagnostic assessment is both necessary and helpful to the child or young person and those around them in best understanding their needs and accessing specific therapies, treatments and provision. Although some children or young people may find diagnosis stigmatising and unhelpful, others find it helpful in making sense of the difficulties they experience, knowing they are not alone in experiencing those difficulties, and feeling hopeful that there are specific approaches or support that can be effective in helping them. The relative merits and drawbacks of referral for diagnostic assessment should therefore be discussed and agreed collaboratively with the child or young person, their caregivers or significant others, and local services.

Evidence-Based Support for Mental Health and Neurodevelopmental Difficulties

Therapies or approaches outlined below should always be provided by someone with sufficient formal training, competency, accreditation (where this exists) and ongoing supervision in that approach. For the vast majority of approaches outlined below it is useful to have some element of caregiver involvement, particularly when working with children or young people in care. This can lead to a greater understanding of the child or young person and how best to support them, increased caregiver sensitivity, and enable caregivers to promote the use of any new strategies between sessions.

Anxiety-based difficulties - For anxiety-based difficulties such as social anxiety, phobias and obsessive-compulsive difficulties, cognitive behavioural therapy (CBT) approaches are often most effective. For specific types of anxiety difficulties, younger children, or those with learning needs, behavioural elements are emphasised. CBT can be delivered in an individualised way and use creative methods to facilitate understanding, engagement and capacity of the child or young person to express their thoughts and feelings. CBT may be delivered through guided self-help, group or 1:1 sessions, or via parent/carer-led approaches.

Low-mood - For difficulties related to low-mood a range of approaches may be useful, including CBT, interpersonal therapy (IPT - individual or family), behavioural activation or family therapy. These would typically be the first-choice approaches, and each has components that lend themselves to addressing specific issues that may underlie or maintain low-mood for children and young people in care. Psychodynamic psychotherapy may also be considered for more significant low-mood or when alternative approaches above have been tried without success.

Trauma - Evidence suggests that post-traumatic stress disorder (PTSD) or complex PTSD is substantially higher in children and young people in care, and unlikely to improve without specific PTSD-focused therapy. Intrusive trauma memories (e.g. nightmares, flashbacks, re-enacting in play) are one of the defining features of PTSD that set it apart from other attachment or mental health difficulties. Trauma-focused CBT (TF-CBT) is often the approach of choice, either 1:1 or with a caregiver, and can be delivered in highly flexible and creative ways. TF-CBT often includes broader emotion regulation, social skills and positive parenting components, which can be particularly useful for children and young people in care and those experiencing complex trauma (where additional symptoms include difficulties regulating emotions, difficulties in personal relationships and a negative self-perception).
A flexible, phased-based, approach incorporating skills teaching is especially advocated for unaccompanied asylum seeking children or young people.
Eye Movement Desensitisation Reprocessing (EMDR) is an alternative evidence-based approach for PTSD that may be considered.

Behaviour - When a child or young person in care is presenting behaviours that others find difficult to manage (e.g. response to authority or boundaries, aggression, disruptive), consideration should always be given to any underlying difficulties with attachment, mood, anxiety, trauma, neurodevelopmental difficulties or substance misuse, and support should be targeted at these underlying difficulties where present. Specific evidence-based approaches for behaviour difficulties may be helpful for some, and these approaches often include parent training, or group social skills/problem solving training for the child or young person.

Where children or young people present with sexualised behaviours or behaviours that are harmful towards others these should be approached following the same principles as other behaviours that challenge, i.e. through professional curiosity, reserving judgement, understanding the underlying causality and what maintains the behaviour, then identifying an appropriate action plan to address this (including risk management and wider support). Behavioural support as outlined above may be useful. In young people where behaviours are more severe, enduring or escalating, completion of a SAVRY (structured assessment of violent risk in youth) and consultation with local forensic CYP mental health services may be beneficial.

Restrictive eating or bingeing - If a child or young person in care is showing any combination of: restricting their food intake; bingeing; purging; exercising excessively; reporting body image concerns; stating an ideal weight or shape; they should be referred to specialist mental health services. If they are showing signs of physical compromise (weight loss, weakness/fatigue, feinting/light-headed, struggling to keep warm, changes in menstrual patterns) referral for a physical health screen should be prioritised. It is important to give consideration to whether the child or young person may be experiencing wider mental health difficulties (low mood, anxiety, trauma), thoughts or actions of self-harm or suicide, and/or alcohol or substance use.

Losing touch with reality as other people see it - Consultation and advice from early intervention in psychosis services is recommended if a child or young person in care describes: hearing, seeing, feeling, smelling or tasting things that do not exist outside their mind but feel very real to them; a sense of disconnection from reality; fixed false beliefs about reality (e.g. extreme paranoia). It is also important to establish if the child or young person is currently, or has previously, used drugs or alcohol.

Neurodevelopmental difficulties (e.g. ADHD & Autism) - If a child or young person is showing hyperactivity, difficulty focusing or sustaining their attention, and high levels of impulsivity, this should be discussed with local specialist services with respect to whether further assessment would be beneficial.

Similarly, if a child or young person is showing long-standing difficulties in their social communication and interactions, capacity to build and sustain relationships, and fixed patterns of behaviour or interest, this should also be discussed with local specialist services. Children and young people in care experience higher rates of autism and this can be a significant feature in some of our most complex and vulnerable children and young people in care, whose autism status is not recognised or responded to. Autism can often be under-reported, under-diagnosed or conflated with attachment difficulties in the looked after population. Frameworks exist to support MH specialists in distinguishing if a child may have autism in addition to, or rather than, attachment difficulties.

Support around potential or diagnosed Attention Deficit Hyperactivity Disorder (ADHD) or Autism often includes carer support and education, and environmental adaptation.

As with autism, learning disabilities and developmental language disorders can often be overlooked in children and young people in care. If there are significant signs of developmental delays and/or difficulties in understanding and using language, this should be discussed with local paediatric and/or educational psychology services.

Self-harm or suicidality - Where a child or young person is expressing or enacting thoughts of self-harm or suicide, consideration should always be given to potential underlying mental health difficulties as listed above, and specific support should be identified for these where present. A shared understanding of the risks, and factors increasing and decreasing risk, should be developed between the child or young person and the caring adults around them. This should be used as the basis for a plan of how risk will be monitored and managed by the child or young person, and the adults in their life. The HARMLESS framework may be useful in informing the best course of action, as may consultation with specialist children and young people's mental health services. Long-term planning decisions should not be made in the middle of a crisis. Multi-disciplinary planning in advance of escalation and at the point of deescalation is critical.

Specific support around emotion regulation, or a short number of sessions with cognitive-behavioural, psychodynamic or problem solving elements specifically targeting self-harm and its drivers may be useful. For more long-standing self-harm, support such as Dialectical Behaviour Therapy (DBT) is extremely beneficial where available.

Alcohol or drug use - As with self-harm, consideration should be given to underlying mental health or developmental difficulties, and support provided for these were present. However, specialist support from substance misuse services is also recommended.

The Role of Medication

As with diagnosis, professionals can have reservations over the use of medication with children and young people in care. Medication is not a recognised treatment for attachment difficulties. However, medication should be offered to children or young people in care as part of the wider treatment of their specific mental health difficulties in the same way that other children and young people would be offered such treatment (e.g. for depression; ADHD). This offer should be made in the context of the overarching psychological understanding of their difficulties, and their wishes and needs. Medication would be a consideration where psychological approaches in the table above have not had a significant impact, and/or where symptoms are severe. It would usually be recommended that medication is used alongside and not instead of ongoing psychological approaches. Where medication supports the management of more severe symptoms this may have an indirect impact on the relationship between the child and carer, and on subsequent placement stability.

Making Referrals to Specialist Mental Health Services

Many specialist mental health and looked after children services offer telephone consultation for professionals. Where referral to one of these services is being considered it is advisable to make use of the opportunity for telephone consultation, as this may provide useful advice to those already working with the child or young person on how best they can to continue to support them, alongside identifying any additional or alternative support options. Consultation will clarify referral criteria, relevant information to include in any referral to these services, and the support options (including those that may be helpful in the interim).

When screening referrals, many mainstream specialist mental health teams will be particularly interested in information regarding:

- The specific difficulty/difficulties they are being asked to offer further assessment or support for (referrals that are focused predominantly on behaviour rather than thoughts and emotions may be less likely to be taken up)
- Any information regarding the severity of these difficulties
- How long the difficulties have been going on for and/or when they worsened
- The child or young person's perspective on the difficulties and any goals they would have from support
- The impact the difficulties are having on everyday life and functioning
- Any risks, particularly those associated with the difficulty
- What support has been offered for the difficulties to date and how effective this has been

This is likely to include qualitative and quantitative information as outlined earlier in this guide. Inclusion of scores from questionnaires and measures can be useful to include in referrals but is often not the sole deciding factor in whether referrals are accepted.

Referrals should be undertaken with the full knowledge and input of the child or young person, their caregivers and significant others, and there should be agreement on the information being shared with other services unless there are clear justifications on why this would be harmful to the child or young person. The child, young person and/or their caregivers and significant others may wish to co-construct the referral (many services now accept self-referrals) and receive a copy for their own records.

Some areas have dedicated looked after children teams specialising in mental health support for children and young people in care, and the systems around them. These teams can vary in terms of staff composition and numbers, who they see, what they can offer, and thresholds/criteria. It is therefore important to understand local provision and referral pathways/criteria where these services exist, as this may differ from that outlined above.

Specialist child and young people's mental health services will often begin the process of transition planning to adult mental health services, where needed, up to six months prior to a young person reaching their 18th birthday. Local policies and pathways are often in place to guide this process and it can be helpful to be sighted on these. A Phase 2 Care Leaver redesign is currently underway across the South East.

Understanding the Impact of Evidence-Based Support for Specific Mental Health and Neurodevelopmental Needs

Many specialist mental health practitioners use routine outcome measurement and goals monitoring as part of their work with children and young people, their caregivers, significant others, and professionals who work with them. With the permission of the child or young person it is useful to share scores from these measures between professionals involved in their wider care and support. Again a combination of quantitative (goals progress, responses and scores on questionnaires/measures) and qualitative information is useful when reviewing progress and impact of interventions. When interpreting the scores on any questionnaires or measures it is most helpful to compare any scores against the baseline scores for that child or young person, rather than comparing against population norms. It is useful to share perspectives across professionals, caregivers, significant others, and the child or young person. Wider conversations are important to help establish if things have got better, worse or stayed the same, rather than relying on specific scores or categories that scores fall in on measures. As noted above, evidence-based approaches from mental health specialists may often be insufficient in isolation and are likely to require the ongoing support and care of those around the child or young person to maximise, maintain, or further any gains.

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Appendix 1: Links to Key Questionnaires and Measures to Help Identify Mental Health and Emotional Wellbeing Needs and Monitor Progress/Outcomes

Please follow the links here to find out about the measure, understand its terms of use and to access all versions

Type	Measure:	Link
Functioning	Strengths and Difficulties Questionnaire (SDQ)	https://www.sdqinfo.org/
	Me & My Feelings	https://www.corc.uk.net/outcome-experience-measures/me-and-my-feelings/
	(Child) Outcome Rating Scale (ORS/CORS)	https://www.corc.uk.net/outcome-experience-measures/outcome-rating-scale/
	Children's Global Assessment Scale (CGAS)	https://www.corc.uk.net/outcome-experience-measures/childrens-global-assessment-scale/
General wellbeing	Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWS)	https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs
	Students' Life Satisfaction Scale (SLSS)	https://www.corc.uk.net/outcome-experience-measures/students-life-satisfaction-scale-slss/
Resilience	Student Resilience Survey (SRS)	https://www.corc.uk.net/outcome-experience-measures/student-resilience-survey/
	The Child and Youth Resilience Measure (CYRM-R)	https://cyrm.resilienceresearch.org/

Symptoms	Revised Children's Anxiety and Depression Scale (RCADS)	https://www.corc.uk.net/outcome-experience-measures/revised-childrens-anxiety-and-depression-scale-and-subscales/
	Mood and Feelings Questionnaire (MFQ)	https://devepi.duhs.duke.edu/measures/the-mood-and-feelings-questionnaire-mfq/
Trauma	Children's Revised Impact of Events Scale (CRIES-8)	https://www.childrenandwar.org/projectsresources/measures/
Attachment	Brief Assessment Checklist (BAC-C/BAC-A)	http://www.childpsych.org.uk/BACinfo.html
Goals	Goals-Based Outcome Tool (GBO)	https://goals-in-therapy.com/goals-and-goals-based-outcomes-gbos/

Caregiver questionnaires		
Type	**Measure:**	**Link**
Coping	The Parental Stress Scale (PSS)	http://www.personal.utulsa.edu/~judy-berry/parent.htm
	Brief Parenting Self-Efficacy Scale	https://www.corc.uk.net/media/1279/brief-parental-self-efficacy-scale.pdf
Relationship (including attachment)	Brief Assessment Checklist (BAC-C/BAC-A)	http://www.childpsych.org.uk/BACinfo.html
	Child-Parent Relationships Scale	https://www.annenberginstitute.org/instruments/child-parent-relationship-scale-cprs
	Thinking About My Child or 'The Carer Questionnaire'	https://ddpnetwork.org/library/thinking-child-questionnaire-scoring/

Questionnaires to use for children under 5 years of age		
Type	**Measure:**	**Link**
	Mothers Object Relations Scale (MORS) MORS-SF My Baby MORS-My Child	https://www.morscales.org/
	Ages and Stages Questionnaire (ASQ-SE) Social and Emotional Subscale	https://agesandstages.com/products-pricing/asqse-2/
	Strengths and Difficulties Questionnaire (SDQ)	https://www.sdqinfo.org/
	Attachment and Bonding Checklist ABC	http://www.socialworkerstoolbox.com/observations-checklist-look-assessing-attachment-bonding-tool/