



Department
of Health



Department
for Education

Mental health and wellbeing of looked-after children: Government response to the Committee's Fourth Report of Session 2015-16



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Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

September 2016



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Introduction

The Government welcomes the Education Committee's report on the mental health and wellbeing of looked-after children.

Looked-after children are some of the most vulnerable children and young people in our society. As such, they need and deserve the best possible support from the services there to help them. Nowhere is this more important than in the services that give care and support to help meet their mental health needs. We know that timely, effective intervention can make the world of difference to any child or young person with mental health concerns, but for children who are particularly vulnerable it is absolutely critical to their health outcomes, their life opportunities and their happiness and wellbeing.

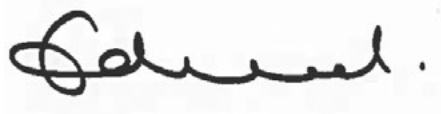
This Government is committed to improving mental health services for all children and young people, and we are investing £1.4 billion over the lifetime of this Parliament to drive that improvement. Specifically, this includes £1.4 million in 2016/17 followed by £2.8 million annually, for the following three years, targeted at improved mental health support for the most vulnerable looked-after children and young people, those who are looked-after in secure children's homes. In addition, the Children and Social Work Bill, introduced in the House of Lords on 19 May 2016, will require local authorities to have regard to a set of clear 'corporate parenting principles' including acting in the best interests of looked after children, and promoting their health and well-being. The Bill will also require each local authority to set out

its local offer to care leavers. We expect that this offer to care leavers will make clear how health and a range of other services will work together to promote wellbeing and a secure transition to adulthood.

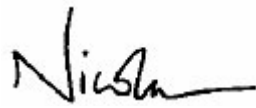
Our plans ensure we are holding local systems to account and we are asking local partners to assess and meet the needs of the young people in their areas. We are clear that without the active cooperation of all partners, we won't be able to deliver the services that are needed. As part of this we are supporting schools to build their capacity to promote good mental wellbeing, provide early support and to access specialist services. We have issued guidance on teaching and a blueprint for high quality school counselling. We have piloted better links with specialist mental health services and are looking at how to promote good peer support.

Looked-after children are increasingly being involved and engaged in their own care, and we strongly encourage that involvement. Children and young people, their families and their carers are the best people to tell commissioners and providers of services – and Government – what they need from us. The work that the Committee has done to bring together clinical experts, experts by experience, charities and others and the wealth of written evidence supplied will inform the next steps in designing and delivering better services that support looked-after children to achieve the best possible outcomes. The work of the Expert Working Group on the Mental Health of Looked-after

Children that we have set up will help us identify the most appropriate way of ensuring that looked-after children, as well as those who are adopted and care leavers, achieve the best possible outcomes.

A handwritten signature in black ink, appearing to read 'Ed Timpson'.

Edward Timpson MP
Minister of State for Vulnerable Children
and Families

A handwritten signature in black ink, appearing to read 'Nicola Blackwood'.

Nicola Blackwood MP
Parliamentary Secretary of State for Public
Health

RESPONSES TO THE EDUCATION COMMITTEE RECOMMENDATIONS

Assessments

[Responses to conclusion 1 and recommendation 6 are linked]

Conclusion 1: Current methods of assessing children and young people’s mental health and wellbeing as they enter care are inconsistent and often fail to identify those in need of specialist care and support. Initial assessments are rarely completed by qualified mental health professionals with an appreciation of the varied and complex issues with which looked-after children may present. (Paragraph 13)

Recommendation 6: In addition all looked-after children should have a full mental health assessment by a qualified mental health professional. Where required this should be followed by regular assessment of mental health and wellbeing as part of existing looked-after children reviews.

It is important that all children who need access to CAMHS health services get it in a timely manner. In recognition of the distinct challenges which looked-after children and young people face, we recommend that they should have priority access to mental health assessments by specialist practitioners but that subsequent treatment should be based on clinical need. (Paragraph 27)

1. We do not accept the Committee’s recommendation as it stands. However, we feel it is sensible to explore this issue further and it was partly to review the evidence and provide detailed guidance on this and other

complex issues about what is most likely to improve outcomes for these children and young people that we have announced work to develop care pathways and models of care for looked-after children. As announced in Ministers Timpson’s and Burt’s oral evidence to the Committee on 3 February 2016¹ we are establishing a new Expert Working Group for Looked-after Children² to consider how to improve the mental health and well-being of the following vulnerable groups:

- Looked-after children
- Children adopted from care
- Care leavers
- Children leaving care under a special Guardianship Order or Child Arrangements Order.

2. The first meeting of the Expert Working Group, which will work with NHS England, Health Education England, and sector partners took place on 11th July 2016. The group has been asked to explore the issue of specialist mental health assessment, taking evidence and forming views from the

1 Hansard: Education Committee oral evidence: mental health and wellbeing of looked-after children, HC481. Wednesday 3 February 2016: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/education-committee/mental-health-and-wellbeing-of-looked-after-children/oral/28408.html>

2 Announcement on the Expert Working Group for Looked-after Children, DH and DfE, 28 April 2016: <https://healthmedia.blog.gov.uk/2016/04/28/new-co-chairs-announced-for-expert-working-group-on-the-mental-health-of-looked-after-children/>

experiences of clinicians, experts on children in care, carers and children and young people themselves. The group will be asked to consider the current health assessment for looked after children, how mental health is taken into account as part of it, and how we avoid stigmatising looked after children through forms of 'automatic' mental health assessment while ensuring that they receive the right assessment at the right time.

3. The group will draw up care pathways and a quality standard and consider the most appropriate models of care for children and young people in these groups. They will set out what care children and young people can expect and how it might be provided to them; how children and young people along with their family or carers will be involved in decisions about their care; and how different professionals should work together. Children and young people who are or have been in care will be involved in their development.

4. The group will be co-chaired by Professor Peter Fonagy, Freud Memorial Professor of Psychoanalysis, University College London and Alison O'Sullivan, former president of the Association of Directors of Children's Services. The work is due to take approximately 18 months.

5. It is absolutely right that where those involved in the child's care, such as social workers, health professionals, carers or teachers are concerned that a looked-after child may have mental health difficulties, the child or young person should be identified as soon as possible and referred for further assessment without delay. That is vital to ensure that their mental health issues don't go undiagnosed and untreated, since this may lead to their condition and would impact on placement stability, educational progress and the ability to make good transitions to adulthood as well as their own happiness and wellbeing.

6. All looked-after children have an initial health assessment by a doctor, which should cover their emotional and mental health as well as their physical health needs. As with everyone receiving care from the NHS, it is critical that a child or young person's emotional and mental health needs be given parity of esteem with their physical health, in assessments and elsewhere.

7. *Future in mind*³ highlights that all looked-after children who need mental health support or treatment should be able to access the help that they need. Local partners across the health, social care and education systems have produced Local Transformation Plans (LTPs) which set out how identified local need will be met. Different parts of the country are meeting children and young people's mental health needs in different ways. There are several examples of good specialist mental health services for looked-after children such as the London Borough of Haringey's 'First Step' Service which is committed to addressing children's mental health needs. Every child who comes into care in Haringey is reviewed at a multi-agency, multidisciplinary meeting and appropriate support put in place. This allows a better and more tailored response to that individual child or young person's needs.

8. If a child or young person's initial health assessment indicates a concern about their mental health, for example, by indicating a high score on the Strengths and Difficulties Questionnaire (SDQ)⁴ which should always be completed for looked-after children, we would

3 *Future in mind*, published March 2015, DH & NHS England: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

4 Strengths and difficulties questionnaire guidance, DfE, published December 2012: <https://www.gov.uk/government/publications/children-looked-after-return-2012-to-2013-strengths-and-difficulties-questionnaire-guide>

expect a multi-agency response to ensure that they get appropriate and high quality mental health support. Children and young people who need a more in-depth mental health assessment should be identified and referred at this stage, and those who might need some mental health support, for example to enable them to settle in their placement, can be helped quickly.

9. Access to NHS treatment should be determined on the basis of clinical need, not on the basis of personal circumstances or any other non-clinical criteria.

10. Local authorities as corporate parents may put in place additional services for their looked-after children's mental health. We have seen many good examples of where this is working well. We would like to see more local authorities and their partners considering how they might provide access to mental health care for their looked-after children. The Department for Education's 'Partners in Practice' programme and their regional Centres of Excellence in Adoption are available to local authorities to enable them to learn from and share practice with each other. We would expect local authorities and clinical commissioning groups, as they develop their Joint Health and Wellbeing Strategies, to use aggregated SDQ scores to help quantify the needs of their local looked-after children population.

Guidance

[Responses to recommendations 2, 17 & 20 are linked]

Recommendation 2: We recommend that the Government amends the statutory guidance to make clear that an SDQ should be completed for every child entering care as a starting point. In addition all looked-after children should have a full mental health assessment by a qualified mental health professional. Where required this should be followed by regular assessment of mental health and well-being as part of existing looked-after children reviews. (Paragraph 14)

11. The detail set out below responds to the committee's requests within recommendations 2, 17 & 20 to make the statutory guidance 'Promoting the health and well-being of looked-after children'⁵ clearer in a number of areas.

12. The Government accepts that looked-after children should undertake the SDQ as a starting point when they come into care, and then each year as part of compiling an accurate picture of their health needs. The Government does not accept that the SDQ should be followed automatically by a full mental health assessment by a qualified professional, unless the SDQ and/or the professionals working with the child indicate it is necessary.

5 Promoting the health and well-being of looked after children, DH & DfE, published 17 March 2015: <https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2>

13. The Government has found little evidence to support the claim that a full mental health assessment on or around the time of entry to care for all looked after children leads to improved health outcomes. We will look to the Expert Working Group in the early stages of their work to consider the evidence for and against full mental health assessments for all looked-after children.

Recommendation 17: We recommend that the statutory guidance on promoting the health and wellbeing of looked-after children be revised and strengthened to incorporate the recommendations made in The Children and Young People's Mental Health Taskforce report Future in Mind. (Paragraph 69)

14. The Government accepts in principle recommendation 17, subject to the findings of the Expert Working Group on Looked-after Children's Mental Health.

Recommendation 20: No looked-after child should face a delay in accessing services after moving local authority area. We recommend that the Government amend its joint statutory guidance to clarify the balance of responsibility between local authorities when looked-after children and young people are placed out of area. (Paragraph 84)

15. The Government accepts recommendation 20 and agrees that looked-after children should not face delays in accessing services after moving local authority area.

16. The Government believes that the guidance is already clear on the SDQ being used as a starting point, and the detail it includes about what should happen if a looked-after child moves local authority area.

17. Local authorities are responsible for making sure that a health assessment of physical, emotional and mental health needs is carried out in accordance with the 'Care Planning, Placement and Case Review (England) Regulations 2010'.⁶ The statutory guidance 'Promoting the health and wellbeing of looked-after children' emphasises the importance of the SDQ as a tool to gather information about the emotional health of looked-after children. Paragraph 14 states:

'Local authorities are required to use the Strengths and Difficulties Questionnaire (SDQ) to assess the emotional wellbeing of individual looked-after children'.⁷

18. Annex B within the guidance provides comprehensive information about the use of the SDQ, including that it can be completed at any point during the year and that helps social workers and health professionals decide whether the child's score should trigger further assessment. Whilst we understand the committee's desire for local areas to consider the SDQ as a 'starting point', we believe that skilled social workers and health professionals are already doing this, using their professional judgement about whether further assessment or exploration of mental health issues is required.

19. We have asked the Expert Working Group to consider the role of the SDQ as

part of their work to develop a care pathway for the mental health of looked-after children. They will be reviewing evidence about approaches to assessment that are achieving successful outcomes.

20. The Department for Education will write to local authorities to remind them of the importance of the SDQ, as both a screening tool for the child and as a mechanism to plan for the right level of services in order to meet the needs of their whole looked-after children population.

21. The Government agrees that children should not face delays in accessing services after moving local authority area. The statutory guidance is already clear about this. Paragraph 80 states:

'When a looked-after child or child leaving care is moved out of a CCG area, arrangements should be made through discussion between the "originating CCG", those currently providing healthcare and new providers to ensure continuity of healthcare. CCGs should ensure that any changes in the healthcare provider do not disrupt the objective of providing high quality, timely care. The needs of the child should be the first consideration'

22. 'The Care Planning, Placement and Case Review (England) Regulations 2010' require local authorities making distant placements to consult with children's services in the area of placement. They also require the Director of Children's Services of the responsible authority to approve these placements. The process for making distant placements and who should be consulted is described in 'Statutory Guidance on out of authority placements of looked-after children.'

23. The Government will consider further how the statutory guidance should be revised in light of the findings of the Expert Working Group on Looked-after Children's Mental Health.

6 Care Planning, Placement and Case Review (England) Regulations 2010, SI no.959: <http://www.legislation.gov.uk/ukxi/2010/959/contents/made>

7 Promoting the Health and Well-being of Looked-After Children, DfE & DH, published March 2015, page 10: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

Access to treatment for looked-after children

[Responses to conclusion 3 and recommendation 4 are linked]

Conclusion 3: Looked-after children who need access to mental health services often have numerous and complex issues that require specialist input across multiple agencies. We have heard evidence that CAMHS is often unable to provide this care due to high thresholds and a refusal to see children or young people without a stable placement. The inflexibility of CAMHS is failing looked-after children in too many areas and leaving vulnerable young people without support. (Paragraph 21)

Recommendation 4: CAMHS should not refuse to see children or young people without a stable placement or delay access to their services until a placement becomes permanent. (Paragraph 21)

24. We fully agree with the Committee that looked-after children should receive timely access to mental health services. Placement instability should not in itself preclude access to mental health services or specialist consultation and advice.

25. Any decision to delay an assessment or treatment should be made only after consideration of the needs of the child or young person, and these needs should be the deciding factor.

26. The looked-after children's health guidance states that:

*"When looked-after children move placement or move into another CCG area and are currently receiving, or on a waiting list for, health services, their treatment continues uninterrupted. Looked-after children should be seen without delay or wait no longer than a child in a local area with an equivalent need who requires an equivalent service. The length of a placement should not affect a child's access to services."*⁸

27. This guidance therefore makes clear that looked-after children should be able to access mental health services just as other children and young people do and that the length of placement or the fact that they are in a temporary placement (i.e. their placement stability) should not affect their access to services.

28. Dedicated mental health teams offer consultation and liaison support for looked-after children, including those who do not currently have a stable placement or are moving between placements. They support both the young person and their carers – whether foster carers or children's home staff – and provides therapeutic intervention when

8 Promoting the Health of Looked-after Children, DH & DfE, published March 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

required in the context of the looked-after child's needs and the needs of their carers.

29. Looked-after children can have particular vulnerabilities, but there is also a broader recognition of the need to improve mental health services for all children and young people. It is in recognition of this that additional funding has been allocated to enable capacity to increase at local level.

30. We also agree with the Committee's conclusions elsewhere in their report that a multi-agency approach is required and that those with emerging mental health problems might require a response from a number of agencies, including Children and Adolescent Mental Health Services (CAMHS) and other local partners. The issue of access will be addressed by the Expert Working Group who will identify how current arrangements can be improved. There are already some excellent local services in place including some specialist services for looked after children with mental health needs, many of which are provided jointly or collaboratively between the local authority and the NHS. It is this kind of joint working that will deliver the high quality services that we all want to see.

CAMHS as a multi-agency team

Recommendation 5: We recognise CAMHS is not the only, or in many cases the most suitable, source of support for looked-after children. We recommend that where possible CAMHS should form a part of a multi-agency team in which education, health and social care work in partnership. Looked-after children and young people are best supported when professionals collaborate and services are tailored to the needs of the individual. (Paragraph 23)

31. We agree with the Committee that a multi-agency team is best-placed to offer support to looked-after children and young people. The statutory guidance on *Promoting the health and well-being of looked-after children*⁹ sets out how local authorities and health commissioners should work together with other partners to commission health services for all looked-after children and young people in their area.

32. The statutory guidance is supported by public health guidance from the National Institute for Health and Care Excellence (NICE) on *Promoting the quality of life of looked-after children and young people* (2010).¹⁰ This focuses on how organisations,

professionals and carers can work together to help looked-after children and young people reach their full potential and enjoy the same opportunities in life as their peers.

33. The joint health and social care *Quality standard for the health and wellbeing of looked-after children and young people* (NICE, 2013)¹¹ expects looked-after children and young people to receive care from services and professionals that work collaboratively.

34. With regard to mental health services, the statutory guidance is clear that:

“CCGs, local authorities and NHS England should ensure that CAMHS and other services provide targeted and dedicated support to looked-after children according to need. This could include a dedicated team or seconding a CAMHS professional into a looked-after children multi-agency team. Professionals need to work together with the child to assess and meet their mental health needs in a tailored way.”¹²

35. The Government has made very clear that supporting the mental health of children

9 Promoting the Health of Looked After Children, DH and DfE, published March 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

10 Promoting the quality of life of looked-after children and young people (2010), NICE: <https://www.nice.org.uk/guidance/ph28>

11 Quality standard for the 'health and wellbeing of looked-after children and young people (2013), NICE: <https://www.nice.org.uk/guidance/qs31>

12 Promoting the Health of Looked After Children, DH and DfE, published March 2015, page 10: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

and young people is the responsibility of all those involved with them: parents, carers, teachers, healthcare professionals, social workers, care workers and others. MindEd,¹³ a free educational resource on children and young people's mental health, provides resources to enable these groups to do this.

36. *Future in mind* suggested that there should be a more cohesive way to plan locally, of which LTPs would be a critical part. LTPs cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

37. In response to the guidance issued in August 2015, 123 plans covering all areas in England for 2015/16 were submitted, assured and published locally. LTPs are intended as living documents and during 2016, CCGs are required to revise and refresh their LTPs as part of the wider Sustainability and Transparency Planning (STP) process.

38. In her evidence to the Committee on 13 January, Claire Bethel (Deputy Director, Children and Young People's Mental Health and Wellbeing, Department of Health) stated that "*It is not just a CAMHS response that is needed*",¹⁴ and her views were echoed by foster carers and those they care for when they gave evidence that what was needed was mental health support from education and social workers as well as from CAMHS practitioners.¹⁵ We believe that delivery of the multi-agency response that is needed

will be best achieved by local partners working together to take an active role in the STP process.

39. One area where mental health staff are preparing for a new way of working with social care and education staff is within secure children's homes. NHS England and the Department for Education are working jointly with the Secure Children's Homes Sector to develop a new framework for integrated care – where care staff and mental health staff will work side by side on shifts, discussing and agreeing interventions as a team, and undertaking joint and individual supervision and training and development.

[Response to recommendation 6 is linked with conclusion 1 and can be found on page 3.]

13 MindEd: <https://www.minded.org.uk/>

14 Education Committee Oral Evidence: Mental health and well-being of looked after children, HC 481, 13 January 2016.

15 Education Committee Oral Evidence: Mental health and well-being of looked after children, HC 481, 13 January 2016.

Continuity of care

[Responses to conclusions 7 and 8 are linked]

Conclusion 7: Continuity of care in an environment where children and young people are able to form strong, enduring relationships should be at the heart of the care system. We are pleased to see an increase in funding for 'Staying Put' and expect to see evidence that this additional investment leads to more young people remaining in secure placements for longer. (Paragraph 32)

Conclusion 8: Leaving the care system can be a time of significant upheaval and disruption. This is likely to be more acute for care leavers with mental health concerns. Current support for these vulnerable young people is inadequate and based too heavily on inflexible age restrictions. (Paragraph 39)

40. We welcome the Committee's endorsement of 'Staying Put', which allows for a more gradual transition to adulthood and independence. The duty allowing young people in Foster Care to 'Stay Put' began in May 2014. We are pleased that in the first year (up to March 2015), almost half (48%) of those who were eligible to Stay Put chose to do so. We will publish data for the year ending March 2016, in September this year.

41. However, we want all care leavers to have a safe and affordable place to live, with appropriate support, for example in semi-independent accommodation or supported lodgings. We are working with Department

for Communities and Local Government to identify the actions we need to take to achieve this and will be setting out our plans in a new cross-Government care leaver strategy later this year.

42. Making the transition from being in care to living independently at a young age can be very challenging for care leavers. For those young people receiving mental health care, it can also coincide with a transition from CAMHS to adult mental health services or elsewhere, which can make the move to independence even harder. This will be something that the Expert Working Group responsible for developing the care pathway for children in care and care leavers will be considering. We are aware that some areas are already reconfiguring their services. In Sheffield for example, a community psychiatric nurse is available to care leavers for consultation within the care leaver team to help them gain access to adult mental health services if this is needed, as well as providing one-to-one support.

43. The legislative proposals relating to care leavers that are in the 'Children and Social Work Bill'¹⁶ show that the Government is determined to improve the life chances for some of the most disadvantaged and vulnerable members of society. We want to provide the level of support that they need to help them make a successful transition to adulthood. This includes providing consistent

¹⁶ Children and Social Work Bill, [HL] 2016-17, published 19 May 2016.

and supportive relationships as part of a wider pro-social network.

44. We are planning to introduce through the new legislation:

- A new set of principles to which local authorities should have regard when carrying out their responsibilities in respect of children in care and care leavers.
- A new requirement on local authorities to consult on and publish a 'local offer' setting out the local support available for care leavers.
- Allowing all care leavers to have support from a Personal Adviser up to the age of 25 if they need it (currently it is only those in education and training who have access to this support after age 21).

45. We are also proposing to create a new 'care leaver covenant', which organisations in the public, private and voluntary sectors could sign up to – setting out how they will fulfil their responsibility as members of civil society to work to improve the lives and life chances of care leavers.

CAMHS for looked-after children up to age 25

Recommendation 9: CAMHS should be made available for all looked-after young people up to the age of 25 in recognition of the distinct issues which this vulnerable group of young people face as they leave the care system. Access to services beyond the age of 18 should be offered where appropriate but not made mandatory where an individual would be better suited to moving onto adult mental health services. (Paragraph 40)

46. We do not agree with this recommendation. Mental health support should be available for those that need it regardless of age and the government does not therefore mandate an age range for statutory mental health services for children or adults. The configuration of local mental health services is a matter for commissioners, based on the needs of their local population.

47. The Government is clear that whatever the point of transition is from a particular service, this should be carefully planned and implemented, involving the individual, and where appropriate their families or carers.

48. Transition is a consideration across a range of services, not just children and young people's mental health. But, as the Government acknowledged in *Future in mind* and elsewhere, practice on transition needs to improve and we have taken steps to support this. NHS England has produced non-mandatory service specifications for commissioners about transition from child

to adult mental health or elsewhere¹⁷ that deliberately do not specify an age at which transition must take place. Instead, the specifications make clear this should be a decision based on the needs, wishes and feelings of the young person concerned, where appropriate involving their family.

49. As noted in paragraph 42, there are a number of local approaches to supporting transition across the country, for example, some areas have commissioned 0-25 services or transition support team workers. Clinical networks provide the opportunity to share emerging practice at a regional and national level, and there is an active network for children and young people's mental health in place supported by dedicated posts in regions.

50. The Youth Select Committee Report, published in November 2015,¹⁸ endorsed flexibility around transition and was clear that 'what works for one area will not necessarily work for another.'

51. The legislative proposals to extend support to care leavers up to age 25 will help promote and navigate access to services, including transition to adult health services. In addition, the Government's refreshed care

17 'Model Specification for Transitions from Child and Adolescent Mental Health Services, NHS England, published 2015: <https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-transt-camhs-spec.pdf>

18 Young People's Mental Health: British Youth Council, Youth Select Committee 2015: <http://www.parliament.uk/youthselectcommittee-2015>

leaver strategy, to be published later this year, will consider how the health and wellbeing of care leavers can best be promoted.

Data

[Responses to conclusion 10 and recommendation 11 are linked]

Conclusion 10: There is an urgent need for comprehensive and up to date data on the mental health and well-being of looked-after children and care leavers. We are disappointed that a new ONS survey will not report until 2018. (Paragraph 45)

Recommendation 11: We strongly urge the Government to return to funding ONS prevalence surveys on a five-yearly basis. We also recommend that they invest in outcomes monitoring to better understand the challenges that young people face whilst in and when leaving the care system. (Paragraph 46)

52. We fully agree with the Committee that up-to-date information on the mental health of all children and young people, including those who are the most vulnerable, is essential. Having this information helps local commissioners and providers work together to commission and deliver the right services to meet local demand both now and in the future.

53. It is clear that there is no shortcut to collecting valid information to guide service development. It takes time to run, analyse and then properly report on a national survey of this nature and scale. Fieldwork on a general mental health prevalence survey of children and young people is due to begin later in 2016 and will continue until the middle of 2017. A national report of the survey

findings will then be published in 2018 once detailed analysis is complete.

54. We know that because children and young people who are, or have been either looked-after or voluntarily in care make up such a small proportion of the whole population of children and young people in England, a general survey cannot in itself give us robust, quantitative, information about their needs. We are therefore considering ways to improve the evidence base for these groups, and this includes commissioning a piece of work to explore the feasibility of a further similar survey focusing specifically on them.

55. Subject to decisions taken by future governments, we support in principle the *Future in mind* proposal and the similar proposal in the recent Taskforce report¹⁹ for a prevalence survey of children and young people's mental health to be repeated regularly.

56. Prevalence surveys are only one element of the Government's approach to improving data and information on mental health. The new Mental Health Services Dataset²⁰ is beginning to collect for the first time ever a comprehensive range of patient level data about children and young people's access to, and outcomes from, mental

19 The Five Year Forward View for Mental Health: Mental Health Taskforce, NHS England, published February 2016: <https://www.england.nhs.uk/mentalhealth/taskforce/>

20 Mental Health Dataset: Health & Social Care Information Centre: <http://www.hscic.gov.uk/mhsds>

health services, and this includes access and outcomes for children who are looked-after. Reporting from the dataset is currently limited by the relatively small amount of data available. As the amount of data improves, the dataset will provide an increasingly important evidence base for service improvement.

57. The Government shares the Committee's view that routine monitoring of outcomes that are relevant to the needs of children and young people is essential in providing effective support and services. The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme trains staff working in CAMHS in the use of Routine Outcomes Monitoring, along with promoting evidence based interventions and greater participation of children, young people and families and carers. The programme is being extended to work with children and young people's mental health services that cover 100% of the 0-19 population of England by 2018. Looked after children are part of the population accessing services that are participating in the CYP IAPT programme.

58. We have asked the Expert Working Group to explore improving the use of information on outcomes for looked-after children.

59. The Department for Education's annual data collection (known as the SSDA903)²¹ currently provides information on 19 to 21-year-old care leavers' engagement in training, employment and education, and also information on their accommodation arrangements. For the first time, the Department for Education has extended the coverage of this collection also to

include 17- and 18-year-old care leavers. National level findings will be published in September 2016 and local authority level statistics in December 2016. While this collection provides valuable information, the Department for Education recognises that data collected by other Departments offer the potential to gain a fuller understanding of the outcomes achieved by care leavers. A one-off data sharing agreement is in place with the Ministry of Justice to link pupil level data to prison, probation and police data. A separate agreement is in place with Her Majesty's Revenue and Customs, the Department for Work and Pensions and the Department for Business, Innovation and Skills to explore the link between educational achievement and labour market outcomes. Conditional on the quality of the data match achieved, the Department for Education's aim is to move to a more regular sharing of data and the Department for Education will also consider how best to disseminate the findings.

21 Children looked after return 2014 to 2015 guide: DfE, published November 2015: <https://www.gov.uk/government/publications/children-looked-after-return-2014-to-2015-guide>

Training for those in care roles

[Responses to conclusion 12 and recommendation 13 are linked]

Conclusion 12: Training and support for foster and residential carers is highly variable and in many local authorities fails to equip carers with the knowledge and skills needed to support looked-after children with mental health difficulties. Foster and residential carers are professionals who need comprehensive and regular training in how to properly support children and young people in their care. (Paragraph 52)

Recommendation 13: The current Training, Support and Development standards should be supplemented with specific modules which focus on mental health and emotional wellbeing. The Department for Education and the Department of Health should fund and develop these learning modules, building on best practice and those existing programmes with clear evidence of success. We recommend that the Government creates a curriculum development committee to oversee the formation of these modules. (Paragraph 53)

60. The Government agrees on the need for basic training for foster carers in recognising mental health issues. However, it does not agree with recommendation 13 in respect of immediately developing specific mental health modules for the Training,

Support and Development Standards²² and forming a curriculum development committee to oversee development of new mental health modules for the Training, Support and Development Standards. In the context of its ongoing children's social care reform agenda, the Department for Education is considering how to improve the experience and life chances of looked-after children and care leavers. In looking at the people and leadership needed for success, we will consider carefully whether the Training, Support and Development standards continue to provide the right framework within which foster carers' skills are developed and maintained.

61. Foster carers are key members of the social care workforce and make a hugely valuable contribution to the lives of many children who cannot live with their own parents. The Fostering Services (England) Regulation 2011,²³ and the National Minimum Standards for Fostering Services,²⁴ clearly set out the expectation that support and training

22 TSD standards workbook for foster carers, DfE, published November 2012: <https://www.gov.uk/government/publications/training-support-and-development-standards-for-foster-care-evidence-workbook>

23 Children and Young Persons, England: The Fostering Services (England) Regulation 2011: SI 2011, no.581: http://www.legislation.gov.uk/uksi/2011/581/pdfs/uksi_20110581_en.pdf

24 Fostering Services: National Minimum Standards, DfE: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192705/NMS_Fostering_Services.pdf

is made available to foster carers to assist them in meeting the specific needs of the children they are caring for or are expected to care for. This would include ensuring that foster carers have the knowledge and skills required to support looked-after children with mental health difficulties.

62. The National Minimum Standards set out that foster carers must be able to evidence the Training, Support and Development Standards – which include the need to develop skills and knowledge to support children’s health needs, including mental health – within 12 months of approval (18 months for family and friends foster carers). The Government is committed to ensure that foster carers receive the training, development and resources they need.

63. The Department for Education has invested £100 million in the Children’s Social Care Innovation Programme which includes fostering projects focussed on therapeutic services to improve outcomes for young people. The National Implementation Service has been testing and building the sustainability of evidence-based therapeutic interventions for children in care and their carers in the UK. Four sites have been specially funded to implement KEEP Safe, a training and support programme for foster carers who look after teenagers. Sites are also testing Treatment Foster Care Oregon (TFCO), formerly known as Multi-Dimensional Treatment Foster Care (MTFC), an intensive treatment intervention for children between 3-17yrs. Foster carers receive intensive support and training to enable children and young people to build on their strengths and address the difficulties in every area of their lives.

64. It is with these promising evidence-based programmes in mind that the Government, along with the fostering providers who support foster carers, will,

over the coming months, consider the most effective ways to ensure foster carers receive the appropriate training and support necessary to meet the emotional health and well-being needs of those they care for.

65. On residential care, the Government has already amended The Children’s Homes Regulations (England) 2015²⁵ in response to calls for staff to be better trained, supervised and supported. The 2015 regulations clearly set out the expectations on residential care staff in terms of the skills they need, and the way in which they are expected to develop positive relationships with the children that they care for, including supporting the child with their health and wellbeing. New mandatory qualifications for children’s homes staff were introduced in January 2015, providing a curriculum that requires the residential care worker to demonstrate their skills and ability to support children in their care. These qualifications include a mandatory unit on children’s health and wellbeing, including mental health. Ofsted inspect to ensure that staff hold the appropriate skills and that practice within the home meets the appropriate standards. The Government will also take into account recommendations about the children’s homes workforce from Sir Martin Narey’s review of residential care, published in July 2016.

25 The Children’s Homes Regulations (England) 2015: <http://www.legislation.gov.uk/uksi/2015/541/contents/made>

Training for those in school based roles

Conclusion 14: We support the recent recommendation made by the Youth Select Committee on the inclusion of mental health training in the core content of initial teacher training. We see this as a minimum requirement. Training on emotional well-being and mental health should also be included in continuous professional development for current teachers. (Paragraph 57)

66. The Government does not prescribe the content of Initial Teacher Training (ITT). However, we commissioned an independent group of experts chaired by Stephen Munday CBE to build a better shared understanding of what elements good ITT courses include and to develop a framework of core ITT content. The report and the Government's response was published in July 2016.

Conclusion 15: School based counsellors should be available to identify early potential problems and signpost children and young people with more acute mental health difficulties to specialist care. Schools have a clear role in teaching about mental health and well-being, and should work with partners in health and local authorities to direct students to further support. (Paragraph 63)

67. The Government agrees that school-based counselling can be an important part of a whole-school approach to mental health and wellbeing, although research evidence shows it is appropriate for mild to moderate depression and is not appropriate for many

other problems. It is right that schools should decide themselves what support to provide for their pupils. The Department for Education has recently updated its guidance to schools on school-based counselling, which was drawn up in conjunction with experts in the area. This sets out the Government ambition that over time all schools should offer access to counselling, and advice on how to offer effective, high quality, counselling as part of a whole-school approach.

68. Young people can also support each other to build good mental wellbeing and work through issues linked to their mental health. Earlier in the year we set up an expert steering group and issued a call for evidence on how to encourage good practice in peer support in schools, community groups and online. This included consultation on how to support a range of vulnerable groups, including looked-after children. We will be using this to inform projects supported with £1.5m to develop and share practice.

69. To support schools in teaching about mental health, the Department for Education funded the PSHE Association to provide mental health guidance and age-appropriate lesson plans on teaching about mental health in PSHE, which were published last year. The Government have also funded the development of MindEd, a free online portal, which allows teachers and other school staff to access information to learn more about mental health issues and how best to support their pupils.

Recommendation 16: The interface between schools and health services needs to be strengthened to ensure that teachers and schools are better equipped to identify, assess and support children and young people with mental health difficulties. However, schools must not be relied on to provide specialist care and treatment. We recommend that, if successful, the current schools link pilot be extended across all clinical commissioning groups with funding for all schools to train a mental health coordinator. (Paragraph 64)

70. The Government agrees that the interface between schools and mental health services can be strengthened. The outcomes from the pilot of single points of contact are being independently evaluated and a final report will be produced by the end of this year. Initial outcomes were shared at two national events in April and May and all local areas can choose to use funding to put single points of contact in place. DfE and NHS England will consider what further action to take in the light of the evaluation. In the meantime, the Government is looking at what additional activity they can support to inform implementation – including testing how the pilot approaches can be scaled up within existing pilot areas to reach more schools.

[Response to recommendation 17 is linked with recommendations 2 and 20 and can be found on page 7.]

Local transformation plans

Conclusion 18: Since the publication of the Children and Young People's Mental Health Taskforce report last year, and the more recent independent Mental Health Taskforce report, the Government has committed to both a qualitative analysis of Local Transformation Plans and the creation of an expert working group on the mental health needs of looked-after children. We look forward to seeing both pieces of work. (Paragraph 77)

Recommendation 19: Looked-after children will only benefit from Local Transformation Plans if their needs are addressed and funding allocated for their care. We recommend that all plans state the services they provide specifically for looked-after children and the funding assigned for them. (Paragraph 78)

71. In October 2015, local areas in England developed Local Transformation Plans (LTPs) for child and adolescent mental health. These plans demonstrate how contributors will deliver the vision set out in *Future in mind*, working together to improve the emotional health and well-being of children and young people in their area, and support those with mental health problems, across the whole care pathway.

72. LTPs are the richest source of information available to date on the state of Children and Young People's mental health services across England. NHS England commissioned analysis of the plans, looking at specific themes – including approaches to support the mental health of vulnerable

groups. A quantitative analysis of the 2015-16 LTPs by NHS England is available on the NHS England website²⁶. NHS England also commissioned a thematic review of the information provided in LTPs. This report summarises the information provided using six themes; participation, vulnerable groups, whole systems, outcomes, eating disorders, and prevention²⁷. It reflects self-reported information including key facts and case studies.

73. Funding for local areas was released after the LTPs were assured, following the process set out in the LTP guidance document published in August 2015. The priorities within in each plan were for local determination. However, some 85% of plans included specific activity or plans for looked after children and/or care leavers. The analysis shows the level of detail in plans and the local approaches varies between areas.

74. The Expert Working Group established jointly by the Department of Health and Department for Education will work closely with NHS England, Health Education England, and sector partners to develop care pathways that will support an integrated approach to meeting the needs of looked-after children with mental health difficulties. The minutes of the meetings will be published on the website of the Social Care Institute

26 www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/08/nhse-camhs-baselining-summary1.pdf

27 www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/08/cyp-mh-ltp.pdf

for Excellence, who are providing secretariat support to the group. The Government will report back to the Committee on the group's conclusions.

75. We do not accept this recommendation, as it was for local areas to identify the local priorities for action within LTPs, including how they will meet the needs of vulnerable groups. LTPs are intended as living documents and during 2016, CCGs are required to revise and refresh their LTPs as part of the wider Strategic Transformation Plan process.

[Response to recommendation 20 is linked with recommendations 2 and 17 and can be found on page 7.]

Designated mental health professional

Recommendation 21: Integration of education, social care and health services should be driven by strong local leadership. The Health and Well-being Board should have ownership of this agenda and strategic oversight of the commissioning of services for children and young people in their care. We recommend that each local area employ a senior, designated mental health professional with expertise in the diagnosis and treatment of mental illness and awareness of the broader risk factors common in looked-after children. (Paragraph 91)

76. On an individual basis, a nominated person locally may be one way to improve the focus on the needs of individual children and young people, enabling children and young people to reach the most appropriate service quickly, and supporting other professionals in the team to work with the child or young person. Similarly, embedded professionals such as social workers in CAMHS teams help mental health professionals to refer appropriately and swiftly to social care. While there is no statutory requirement for areas to do this, we encourage this response if it is the best way to meet identified local needs.

77. The joint health and social care *Quality standard for the health and wellbeing of looked-after children and young people* (NICE, 2013)²⁸ expects looked-after children

and young people to receive care from services and professionals that work collaboratively.

78. With regard to mental health services, the statutory guidance is clear that:

“CCGs, local authorities and NHS England should ensure that CAMHS and other services provide targeted and dedicated support to looked-after children according to need. This could include a dedicated team or seconding a CAMHS professional into a looked-after children multi-agency team. Professionals need to work together with the child to assess and meet their mental health needs in a tailored way.”²⁹

79. In addition to these arrangements already in place in many parts of the country, we would encourage local partners to explore other potential models for a role as envisaged by the Committee in this recommendation. This includes looking at the existing roles of senior leaders such as virtual school heads, embedded professionals, designated or lead professionals and others giving similar support and leadership to assess whether there is a need for a new designated role of this type to meet the needs of children and young people in their area.

28 Quality Standard for the health and wellbeing of looked-after children, NICE, published 2013: <https://www.nice.org.uk/guidance/qs31>

29 Guidance on Promoting the health and well-being of looked after children, published 2015, page 19: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

Looked-after children – involvement in decision making

Conclusion 22: All looked-after children should play a meaningful part in the decisions made about their mental health care. They should also be empowered to have a more active role in decisions about their placements to increase the likelihood that they will be stable and successful. (Paragraph 98)

80. Like the Committee, the Government is firmly committed to the principle that the ‘voice of the child’ should be at the heart of the care system. Every looked-after child should have a care plan which identifies what they need in relation to their health, education, family and social relationships and how these needs will be met.

81. Local authorities are required to listen to the wishes and feelings of a child they look after. Section 22(4) of the Children Act 1989³⁰ requires them, before making a decision about a child they look after, so far as is reasonably practicable, to ascertain the child’s wishes and feelings. That includes his or her wishes and feelings about placement decisions and decisions about their social and health care. This requirement is reflected in the new Corporate Parenting Principles, contained in the Children and Social Work Bill that is currently before Parliament.

82. When placing a child, the local authority must ensure that the placement is the most

appropriate way to safeguard and promote the child’s welfare and that the placement is able to meet the child’s needs as a whole and is consistent with their wishes and feelings. We agree that by involving children in decisions about their placements, they are much more likely to be stable and fulfilling.

83. There are a number of safeguards in the system to ensure that the child’s wishes and feelings are taken into account when decisions are taken about their care. In particular, each child must have a “named” Independent Reviewing Officer (IRO) who listens to the child and advocates the child’s views on their behalf. IROs chair the annual care planning meeting and advise on, or challenge, care plans. In addition, there are duties on local authorities to promote and provide advocacy services for looked-after children and children in need.

30 The Children Act 1989 Guidance and Regulation: Vol.2, care, planning, placement and review, DfE, published 2015: Section 22(4) of the Children Act 1989.

Appendix A: Roles and responsibilities of the Expert Working Group on the Mental Health of looked-after children

1. The Expert Group co-chairs

1.1 The co-chairs ensure that the Expert Group takes full account of the evidence in developing recommendations and considers the analysis and interpretation of the evidence prepared by the evidence review team.

1.2 To facilitate the effective working of the Expert Group, the co-chairs:

- Ensure that all members have their voices heard and their experience and expertise respected
- Encourage constructive debate without forcing consensus
- Steer the discussions according to the agenda, ensuring progress is made
- Keep the group discussions unified and discourage disruption or dominance by any members
- Summarise the main points and key discussions from the debate
- Ensure that Expert Group members declare any new conflicts of interest that have arisen and handle any conflicts as they arise
- Sign off meeting minutes once approved by the Expert Group
- Together with SCIE ensure effective agenda planning to maintain momentum of the work within agreed timescales

1.3 The co-chairs also offers members, on an annual basis, feedback and comment on

their contribution for revalidation purposes or personal development.

2. All Expert Group members

2.1 Expert Group members are expected to:

- Review and abide by the Terms of Reference and standing orders set out in this document.
- Contribute constructively to meetings and have good communication and team- working skills; this should include a commitment to considering the needs of people using services, family members and carers.
- Use their background knowledge and experience of the topic to advise SCIE on the best available evidence
- Read all relevant documentation and make constructive comments and proposals at (and between) Expert Group meetings.
- Work with other members of the Expert Group to develop the products based on the best available
- Help ensure that the products as a whole, are worded sensitively (for example, that people using services or population groups are treated as people, not as objects of assessments or interventions).
- Advise SCIE on how to identify best practice in areas for which research evidence is absent, weak or equivocal.

- Consider, with other members of the Expert Group, the feasibility of the recommendations and highlight any potential implementation issues.
- Agree, with other members of the Expert Group, the minutes of Expert Group meetings.

2.2 Committee members are not routinely expected to:

- Review the evidence
- Search the literature
- Write the pathways, models of care and accompanying guidance.

Appendix B: Standing Orders

1. General

1.1 These Standing Orders describe the procedural rules for managing the work of the Expert Group. The Expert Group will act as an advisory body to SCIE.

1.2 Members of the Expert Group shall be bound by these Standing Orders and will be expected to abide by the 7 principles for the conduct of public life as recommended by the Nolan Committee, which are:

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership.

1.3 Behaviour by Expert Group members and attendees at Expert Group meetings such as bullying, harassment and victimisation is unacceptable to SCIE. SCIE is committed to taking the necessary action to ensure that such behaviour does not occur, and to taking the appropriate action in the event that it does occur.

1.4 All reasonable facilities shall be provided for members to ensure that they have the opportunity to participate fully and equitably in the business of the Expert Group.

1.5 Statements of Expert Group members made at meetings shall be relevant to the matter under discussion at the time and the

decision of the co-chairs on questions of order, relevancy and interpretation (including conflicts of interest) shall be final.

1.6 The quorum is set at 50% of the full membership of the Expert Group

1.7 All members of the Expert Group shall abide by the principle of collective responsibility, stand by the recommendations of the Expert Group and not speak against them in public.

1.8 Members of the Expert Group are not permitted to submit comments as stakeholders during the consultation on any draft products and guidance. If an Expert Group member is involved with a registered stakeholder organisation, they should not submit comments during the consultation on behalf of that organisation – someone else in the organisation should draft and submit the comments.

2. Confidentiality

2.1 On appointment, Expert Group members will be required to sign a confidentiality agreement with SCIE relating to any information designated confidential by SCIE such as academic or commercial-in-confidence material or sensitive personal data.

2.2 Confidential papers and confidential information disclosed in Expert Group deliberations should not be discussed with colleagues who are not members of the Expert Group, with other organisations, the media, or members of the Expert Group who

are excluded from discussions because of a conflict of interest.

2.3 If Expert Group members are asked by external parties – including stakeholders or their professional organisation – to provide information about the work of the Expert Group, they should discuss the request with the SCIE. They should also declare this at the next Expert Group meeting. Any enquiries from the media should be directed to SCIE's Project Manager.

3. Arrangements for the meetings

3.1 SCIE will ensure that Expert Group meetings take place in venues that are accessible to, and have facilities for, disabled people.

3.2 Meetings of the Expert Group shall be held at such times and places as are deemed necessary to facilitate the conduct of its business.

3.3 EG members may also be required to attend a working group that may be associated with the Expert Group and will be expected to contribute to virtual discussions and occasional teleconferences as appropriate.

3.4 SCIE shall determine which aspects shall appear on every agenda in advance of each meeting.

3.5 Any other business shall be discussed at the discretion of the co-chairs. Meetings will normally begin at 10:00 am and finish no later than 4:30 pm unless otherwise advised.

3.6 Expert Group members will be expected to attend for the full day unless agreed in advance with the co-chairs or unless they have declared a conflict of interest to 1 or more discussions.

3.7 SCIE will make all reasonable attempts to agree each meeting date in advance and

Expert Group members are expected to keep these dates free until they are released.

4. Minutes

4.1 The draft minutes of the Expert Group meetings shall be drawn up and submitted to the next meeting for approval.

4.2 The approved minutes will be published on SCIE's project website subject to the redaction of any confidential or otherwise exempt material within 20 working days of approval.

5. Declarations of interest

5.1 All Committee members must make an annual declaration of interests.

5.2 All members must make a declaration of any potential conflicts of interest that may require their withdrawal in advance of each meeting. This declaration will be reaffirmed again at the start of each meeting. Declarations of interest will be recorded in the minutes and published on SCIE's project website.

5.3 During the course of the meeting, if a conflict of interest arises with matters under consideration, the member concerned must withdraw from the meeting, or part thereof, as appropriate.

5.4 Experts invited to provide expert testimony, and co-opted members will make a declaration of interest before Expert Group meetings. This declaration will be reaffirmed again at the start of each meeting. These will be recorded in the minutes and published on the SCIE's project team website.

6. Recording of meetings

6.1 The recording of proceedings or the taking of pictures at Expert Group meetings by public attendees is not allowed.

6.2 The recording of meetings is permitted by SCIE where agreed by the Expert Group,

and for the purposes of facilitating guideline development or promoting transparency. Recordings will be deleted on approval of the meeting minutes.

7. Record of attendance

7.1 A record will be kept of EG members' attendance at EG meetings via the minutes.

7.2 Members are expected: to attend at least 75% of meetings during a 12-month period not to miss more than 2 consecutive meetings.

7.3 If an EG member is unable to fulfil their duties (for example, because of illness), another recruitment process may be considered to replace that person.

Annex A:

TERMS OF REFERENCE

1. Overview of the project

1.1 The overall aim of the project is to ensure that the emotional and mental health needs of children and young people in care, adopted from care, and care leavers are better met. The aspiration is that in the future looked after children will have access to high quality services, based on a clear assessment of need, from a range of professionals working across agencies.

1.2 The project will involve developing:

- Care pathways – focussing on the journey that a child or young person in need of support might make
- Models of care – the organisation and configuration of services to ensure the provision of appropriate evidence-based interventions
- Quality principles – clear statements and measures that set out an achievable marker of high-quality and effective care.
- Implementation plans and products to support the use of the care pathways, models of care and quality principles.

1.3 The project outputs will be delivered by October 2017.

2. The Expert Group – overview

2.1 The Expert Group's role is advisory. Throughout the project, the Expert Group will:

- Consider the best available evidence to assist in developing the care pathways, models of care and quality principles
- Make recommendations, identify priorities, and advise on the assumptions being made in the development of the products
- Advise on how to identify best practice in areas where evidence is absent or weak
- Advise on any opportunities and challenges in implementing the product to ensure that they are as useful and as relevant as possible to end users – and in particular, children and young people
- Review drafts and agree the final products.

2.2 SCIE is the secretariat for the Expert Group. This means that SCIE's project team locate and provide evidence on current research and practice for the EG's deliberation, as well as organising the practicalities around each meeting.

2.3 SCIE is responsible for producing the final care pathways, models of care and quality principles, but the Expert Group will be collectively responsible for its recommendations.

3. Expert Group – membership

3.1 The Expert Group is co-chaired by Peter Fonagy and Alison O'Sullivan.

3.2 The Expert Group consists of around 30 members including:

- 20 representatives from across the health, social care, education and voluntary and community sector;
- Four young people with experience of being in care;
- Six frontline professionals.

3.3 The Expert Group comprises nominated representatives from key stakeholder organisations identified by the Department of Health and frontline practitioners and young people recruited by SCIE.

3.4 The members of the Expert Group have experience and knowledge of services and issues relating to the support of children and young people in care, adopted from care and care leavers with mental health and wellbeing needs. Appropriate support will be provided to support young people on the Expert Group to participate, and in case of any concerns arising from discussing sensitive issues.

3.5 Expert Group members add value to the group because of their individual skills, experience and knowledge. Members are not expected to represent their specific organisation's or sector's perspective.

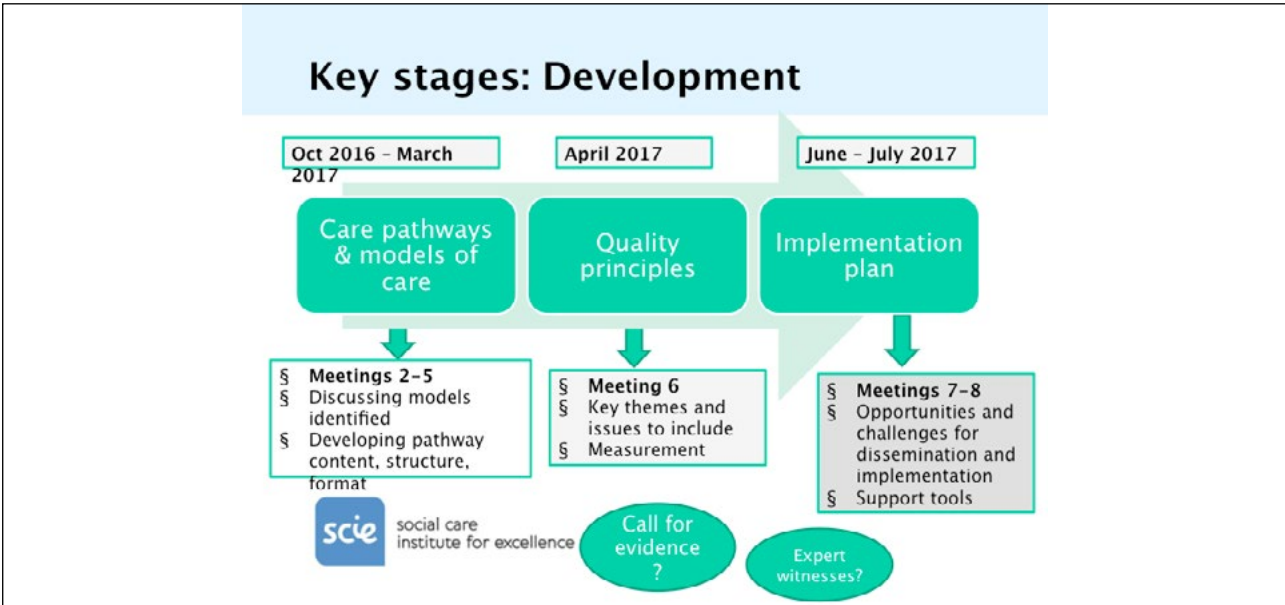
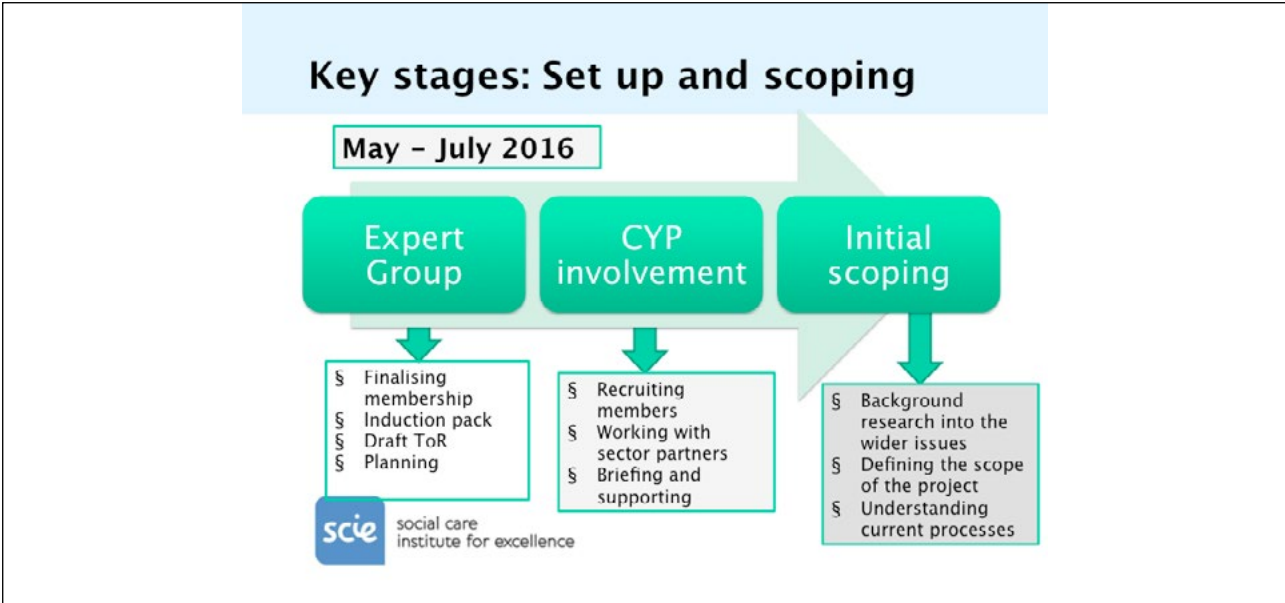
3.6 Expert witnesses may be invited to the Expert Group meetings on specific topics and can be drawn from a wide range of areas as appropriate. They are invited to present their evidence in the form of expert testimony and are asked to provide a written paper or summary of their evidence. They also help the Expert Group to consider and interpret the evidence.

4. Supporting documents

4.1 More information on the expectations of the co-chairs and members, and Standing Orders can be found in the appendix.

4.2 More information on the scope of the Expert Group can be found in the project scope document which has been developed by SCIE and will be discussed and agreed at the first Expert Group meeting.

Expert Working Group on improving mental health and wellbeing support for children and young people in care Outline Work Programme



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