The Centre for Outcomes of Care

Putting outcomes at the centre of children's social care

A Brief Evidence Summary of the Mental Health Needs of Children Looked After & Care Leavers.

Produced for: Southwark Corporate Parenting Committee

Author: Dr Mark Kerr

Date: 28/01/20

The Centre for Outcomes of Care
4th Floor, 18 St. Cross Street
London, EC1N 8UN

0208 133 4320
hello@outcomesofcare.com
www.outcomesofcare.com

Company number:10996449

Introduction

This paper has been produced to be accessible to all members of the board and where possible scientific / medical terminology has been minimised. The research evidence drawn upon in this paper is referenced at the end of the paper, including the sources. If any committee members would like access to the source literature, I am happy to facilitate this on request.

Rather than producing a paper that is purely descriptive about mental health among CLA and Care Leavers, I have tried to pull together different areas of research. The sum of the evidence when combined provides a clear route to significantly improving life outcomes for CLA and Care Leavers, if the primary focus of services be on their emotional and psychological wellbeing.

Any criticism or findings of failure in regard to meeting mental health needs discussed in this paper are from various research studies and statistics. They should in no way be interpreted as reflecting the care provided by Southwark Borough Council or partner services.

Background

Children enter the care system for a variety of reasons, the most common of which is being - or at risk of being - maltreated in the home environment. The level and form of maltreatment CLA will have experienced varies from mild neglect through to extreme abuse - both physical and sexual - with inevitable long-term consequences. One of the most serious concerns for children that have experienced maltreatment is the impact it has on their emotional and mental health.

Historically, health and wellbeing has been a neglected area of policy, practice and research in the area of children in care[1] This point was made by the late Professor Howard Meltzer and colleagues who argued that "there have been few studies which have attempted to estimate the prevalence of mental disorder among CLA and those which have concentrated on a particular geographical area and have relatively small samples".[2] This observation was contained in the introduction to their own study, which is the largest and most robust research exercise investigating the mental and emotional health of CLA to date. Despite the limited research, significant mental health needs of the CLA population are well established; mental health screenings reveal that the majority of children in care suffer from chronic and often disabling mental health difficulties[3]

Mental Health Need in CLA population

Our understanding of mental health needs in the CLA population dramatically changed following Meltzer's 2004 landmark study. Commissioned by the Office for National Statistics (ONS) *'The Mental Health of Young People Looked after by Local Authorities in England'*[4] was the first national survey of adolescent CLA ever to be carried out in England. The primary purpose of the survey was to produce prevalence rates for three main categories of mental disorder: Conduct disorder, hyperactivity and emotional disorders (and their comorbidity).

The data collected are extremely important to our understanding of the emotional and mental health needs of CLA for two reasons: the first is the sample size with data collected on 1,039 participants; secondly the study included data from a control group collected from 10,500 non-looked after adolescents.

Need	*Odds ratio*[1]	*Prevalence (%)*	
	CLA	**Control**	**Gen pop**
SEN	23	4.5	2.9
Neurodevelopmental disorder	12.8	4.5	3.3
1+ psychiatric diagnosis (ICD 10)	**4.92**	**46.4**	**14.6**	**8.5**
Any anxiety disorder	2.09	11.1	5.5	3.6
Depression	2.28	3.4	1.2	0.9
Hyperkinesia	3.9	8.7	1.3	1.1
Any behavioural disorder	7.53	38.9	9.7	4.3

Table 1

The findings from the study are as startling as they are valuable; as can be seen in Table 1 there is a four to five fold increase in mental disorder for looked after children with conduct disorder contributing most of the difference in childhood psychopathology.

Most of the disorders are behavioural in nature, with that category suggesting that CLA are 7.5 times more likely to have a need that meets diagnostic criteria. The authors suggest that this is largely due to adverse factors impacting on children prior to entry into care rather than the care experience itself. They also identified significantly higher rates of developmental disorders, such as Autism and Attention Deficit Hyperactivity Disorder (AHDH), which may have gone previously undiagnosed. Other studies further indicate that behaviour and mental health problems in

[1] An odds ratio is the multiplyer for how many times more likely an individual is to have the need e.g. CLA are 4.92 times more likely to have at least 1 psychiatric diagnosis

children, along with a number of other factors in the child and carer, are linked to increased risk of placement breakdown and a continuous threat to establishing secure attachments with carers.

In terms of prevalence of mental disorder, these findings established that CLA are the most in-need child population in society. The findings are also in line with the previous studies[5] and, taken in combination, produce a robust evidence base of the extreme mental health need amongst the CLA population. For those living in residential care, 72 per cent were assessed as having a mental disorder, compared with approximately 40 per cent living in foster care

Overall, the literature provides compelling evidence of the significant over-representation of the poor mental health and wellbeing of CLA and young people that is often unmet. Research exercises have consistently highlighted the scale of the problem – these include large scale samples that the Government has acknowledged. Therefore, early assessment and screening is critical for care planning. However, despite continuous guidance from health bodies [6] [7] [8] and the introduction of the Health and Social Care Act (2012), routine data on the prevalence of emotional and mental health difficulties are still not available.

Unmet Need

In line with their aims, the ONS research team also investigated level of service use among the sample (in essence, evaluating if these needs were being met). Worryingly, the research found that only 44 per cent of children with a mental disorder were in contact with child mental health specialists. This meant that over half of the sample with a mental health disorder had unmet needs. Sizable proportions of children residing in care are "undetected clinical cases" - that is, they have clinical-level mental health difficulties that have not been identified through screening or formal assessment[9].

A further study conducted by Phillips[10] focused on social worker views of the mental health of CLA placed in foster care. Phillips asked social workers to rate, inter alia, the level of perceived symptomatology of these children using questions based on the Maudsley Item Sheet.[11] Out of the 44 children only five (14 per cent) were asymptomatic (no mental health need) with the most frequently reported symptom groups identified as anxiety, conduct disorder and depression; 55 per cent had anxiety that was expressed as a fear that something bad was going to happen to them or their foster families; most had social anxiety and were anxious about visitors to the foster home; 46 per cent had conduct disorders with behaviours including fighting with siblings, stealing, truancy and being generally destructive. Social workers stated that they believed 80 per cent of all the assessed children should be receiving therapy of some sort from a mental health professional but only 27 per cent had received any.

Care Leavers' Mental Health

Research on the mental health needs of care leavers is fairly sparse, with only a few significant studies prior to the 1990s and a growing but still limited body of research emerging over the past three decades. Jo Dixon[12] provides one of the only extensive examinations of mental health outcomes for care leavers. The study analysed factors affecting adult mental health rather than simply documenting disorder and problem rates. Dixon surveyed 106 young people approximately one year after leaving care, obtaining several measures of mental health and behavioural functioning - including the General Health Questionnaire screen, the Lancashire Quality of Life Profile, and the Cantril's Ladder subjective assessment of general wellbeing - along with a wealth of data regarding subjects' support networks, service provision and general outcomes.

The findings suggested that the initial year out of care might prove particularly difficult for care leavers, with mental health issues often intensifying rather than decreasing over time. Twelve per cent of the sample reported some kind of significant mental health issue at baseline, shortly after leaving care; this number increased to 24 per cent one year later, with 44 per cent of the total sample indicating some general increase of mental health problems. Disturbingly, four per cent of the sample attempted suicide during this initial transition year.

A key finding from Dixon's work is the interconnectedness of care leaver outcomes across all areas of life. Multivariate analysis of key outcome measures suggested that mental health issues at baseline not only predicted poor wellbeing and elevated anxiety at one year follow up, but also poor housing and career outcomes. Positive accommodation and home-making experiences during the first year out of care were protective factors for individuals with mental health problems, as was a lack of substance abuse after leaving care.

A second example is my own research (Kerr, 2017) where I found high levels of mental health needs and a clear relationship with placements and care journeys (see table 2). Over half of the sample of 167 Care Leavers had a mental health need and those in residential care this rose to 60%. By far the care journey associated with the highest prevalence of mental health problems was where a CLA experienced a succession of foster placements before being placed in residential are. This care journey was associated with a cluster of negative outcomes including offending, sexual exploitation and homelessness.

Cohort	Placement	No. (%) respondents	No. (%) GHQ >=4	Mean (sd) GHQ score
	Residential	10	6 (60)	4.7 (1.27)
	Foster	36	15 (23)	3.19 (0.54)
1	last Residential	16	10 (63)	5.38 (0.74)
	last Foster	10	7 (70)	5.3 (0.93)
	Total	72	38 (53)	4.18 (0.39)
	Residential	36	15 (42)	3.58 (0.66)
	Foster	18	6 (33)	3.44 (0.8)
2	last Residential	22	11 (50)	4.27 (0.81)
	last Foster	21	9 (43)	3.76 (0.86)
	Total	97	41 (42)	3.75 (0.38)

Table 2

Overall it is clear that there is an acute mental health need among the CLA population, and a significant number of these young people are not having this need met. This may be due to a variety of factors, not least the fact that we do not routinely undertake full psychological assessments.

Whose problem? Whose budget?

At the risk of adding complexity to this paper, to understand the policy dimension to the problem, a brief overview of the macro / national policy context must be engaged with. The decentralising of the delivery of services, significant over the last 25 years, has created a situation where local authorities are responsible for delivering an increasing number of Government funded public services. The devolution of budgets to frontline agencies and decision-making bodies such as hospital, primary care and children's trusts provided an incentive to summon and use sound evidence in resource allocation and service development. But targets set by central Government created an environment where most of the resources were aimed at satisfying performance criteria. This was exemplified under New Labour with measurable outcome targets for local

authorities having an overarching focus on education in the belief this will improve outcomes for CLA. However, as already discussed, this does not address the main need of CLA: emotional and mental health problems, often a consequence of ACEs, with subsequent outcomes of concern particularly including health harming behaviours. An explanation for the misalignment of policy responses to the needs of CLA may be found in the way the hierarchical structure for the delivery of services between departments has developed.

'Who pays' seems to dominate support and intervention provision - a factor not lost on the Children and Young People's Mental Health and Wellbeing Taskforce (2015). During their discussion and report they recommended adopting a joint commissioning approach. Adopting a joint commissioning approach would address concerns raised by one of the Social Workers contributing to the report, who argued that "Serious consideration should be given to joint commissioning arrangements between social care and health… to promote better understanding, better allocation of resource and reduce the futile arguments about "is it social care or mental health?" - which is really about who will pay and rarely about the needs of the child."

As discussed in preceding sections, the evidence is clear that CLA are at risk of developing a number of behavioural or health related issues[13] [14] [15] [16] [17]- a number of which are suitable for and require intervention at the earliest opportunity. If the needs and risk factors are not addressed, CLA are likely to become a cost to society as a whole. Insufficient qualifications are a barrier to entering the labour market, lead to welfare dependency and an increased risk of offending behaviour, drug and alcohol addictions, and overall, (the Government would argue), contribute to the cycle of deprivation.[18]

The costs of these negative outcomes to the Treasury when all departmental spends are combined, along with the loss in revenue due to not being active in the labour market, has been modelled by the Audit Commission to cost over £2 million for a single care leaver.[19] This significant cost is spread across a number of national Government departments and accrued across the life-course. Thus, when one takes a life-course view in terms of cost benefit, the incentive to invest to try to divert negative trajectories for care leavers is stark. However, the Government departments who are exposed to this large financial risk are not responsible for the delivery of services e.g. for adolescents and care leavers who are expected to prevent negative outcomes.

CAMHS

The service expected to address the needs associated with mental health problems is the Child and Adolescent Mental Health Service (CAMHS), part of the NHS. Generally CAMHS are only available up until a child's 18th birthday so not accessible for Care Leavers. As a service it has been

plagued with criticism for a number of years. As discussed earlier in the review, a significant amount of unmet need exists within the care population, with CAMHS being uncoordinated and leaving a worrying gap in mental health provision.[20] As with many public services there is considerable variation in the availability and provision of CAMHS to meet the needs of children and young people both looked after and not.[21]

In the 'State of the Nation' research report[22] it was argued that at present, CAMHS are turning away nearly a quarter (23 per cent) of children referred to them for treatment by concerned parents, GPs, teachers and others. This was often because their condition was not considered serious enough, or not considered suitable for specialist mental health treatment and that the average waiting time from referral to first appointment was 6 months, whilst the duration between referral and first treatment or intervention to commence was 10 months.

A further study[23] - 'a teenager's pathway through the mental health system' - found waiting times of between 13 and 140 days and 15% of referrals denied access without further action; equivalent to 30,000 children overall. Indicators reported by the Children's Commissioner (2016) agree with this estimation overall, noting that on average 28% of referrals were declined; however within this, one CAMHS confirmed that 75% were not allocated a service, whilst in the South East and West Midlands this was 18%.

The delay of provision is also noted by Armiger (2017) who ascertains "Within every provision I have worked in, we have many children with very complex mental health issues. Many have gone untreated for a very long time and had no access to support, or have been on waiting lists for over 12 months". This means that when the report is published by the Care Quality Commission, little will change in real terms for those currently waiting, and for those being refused; many of whom will be LAC. Furthermore, during the time the report takes to be published, many LAC who are waiting for appointments or treatment may need to move placement out of the catchment area for that CAMHS provision, therefore any outstanding referral may become void requiring a new referral to be made thus extending the duration of delay.

The Children's Commissioner (2016) found that of the 3,000 referrals made to CAMHS for concerns around life threatening conditions (such as suicide, self-harm, psychosis and anorexia nervosa), 14% receive no support and 51% were placed on a waiting list (which as previously discussed could be for several months); some of whom would be in corporate care provision. In addition, whilst it is known that many LAC (along with their peers) may decide not to attend their appointment, this in itself can prevent them from accessing services as 28% of CAMHS providers indicate they would stop any further access, and 35% indicated they would place restrictions on access

Returning to the potential causes of the mental health problems CLA experience, as previously highlighted, many will have experienced numerous traumatic events including abuse, neglect, exposure to domestic violence, alcohol and drugs leading to long-term consequences for future wellbeing. These experiences are referred to in the literature using a variety of terms including abuse, neglect, harm, violence, maltreatment and trauma often leading to confusion and a lack of specificity. However, a further development in knowledge helps us reduce this complexity with the concept of Adverse Childhood Experiences (ACEs).

Introduction to ACEs

There have been significant improvements in our understanding of trauma that health and social care bodies should be using to inform service design. In the area of trauma, highly relevant is the ACEs research that originated at the Centre for Disease Control (CDC) in the United States and has now become a worldwide collaboration. The concept of ACEs emerged in the early 1990s in the work of experts Anda and Felitti who conducted a large empirical study exploring the relationship between ACEs and physical and mental health and behaviours. The research developed ACE Scores, based on the number of 'yes' responses to questions from ten ACE categories (not incidents) that included: 'emotional, physical, and sexual abuse, emotional and physical neglect, witnessing domestic violence, growing up with mentally ill or substance abusing household members, loss of a parent, or having a household member incarcerated'[24].

Child abuse and neglect are the most common reasons for children entering care. These children have often experienced the 'toxic trio' of parental domestic violence, substance misuse and mental illness; inevitably this will mean that they have high ACEs scores.

The study found strong relationships between ACE scores and a number of health and social problems throughout the life-course. Moreover, ACEs were found to be common, highly interrelated, and exerted a powerful cumulative impact on human development and supported the view that 'childhood stressors, such as abuse, affect the structure and function of the brain' (Ibid). The health problems were physical as well as mental and the research team discovered that ACEs are related to prevalent diseases (heart disease, cancer, lung disease...), health risk factors (smoking, alcohol abuse, promiscuity...), mental health (depressive disorders, anxiety, hallucinations...) and general health and social problems[25].

The findings of this ground-breaking study have been repeated in the UK and in 2017 a systematic review of the current research published in the Lancet Public Health showed that most studies were from high-income countries, nine samples from middle income countries and none from low-income countries. 57% of participants across all studies report at least one ACE and 13% report at least four. Individuals with 4 or more ACEs are at significantly greater risk of many adult

diseases or health-related problems. So, the evidence for an association between ACEs and a wide range of adult outcomes is reliable. This is supported by a number of prospective observational studies over many years and in different countries.

Why are ACEs so important?

The evidence base linking ACEs and trauma to poor health and social outcomes in adulthood has become increasingly robust in recent years. At an emotional and behavioural level the consequences of childhood trauma are far reaching and include conduct problems, difficulties in forming relationships, inappropriate sexual behaviour, anxiety, depression and poor concentration.[26 27 28 29 30] Of more serious consequence are diagnosable emotional and mental disorders including anxiety, depression, conduct disorders, hyperkinetic disorders and pervasive developmental disorders. [31 32 33 34 35 36 37]

The importance of addressing this need among CLA cannot be overstated due to the well documented consequences if we fail to do so. Numerous studies have now established that exposure to ACEs may lead to profound consequences in adulthood including mental ill health, substance abuse, offending and unemployment.[38 39 40 41 42 43 44 45] Further, exposure to multiple ACEs (a regular finding with CLA) has a cumulative effect increasing the severity of poor outcomes. [46 47 48]. Considering CLA and Care Leavers, as a sub population, they have the greatest exposure to ACEs.

Impact on children's social care services

The high mental health need in the population and current service structures for CLA exist in significant tension. With access to specialist mental health services being difficult to secure and often taking a significant amount of time, non-clinical professionals (including social workers, foster carers and residential care workers) have to try to meet the needs of the children. Many are unequipped or lack training to deal with such high levels of mental health need - creating additional pressure. Where services are commissioned this often comes at a high cost for a placement with specialist clinical staff to meet the needs.

A key problem in services for CLA is that when a child is placed in a foster placement or children's home, often the provider (inhouse or commissioned) has no choice but to address the unmet mental health need. Further, this is often part of the service commissioned so children's social care is forced to meet the cost of a service that should be within health. The buck stops with children's social care, which to some extent accounts for the expensive placements many children are in. A placement officer or social worker cannot turn a child away or put them on a waiting list.

Previous projects undertaken for local authorities by The Centre for Outcomes of Care continuously find unmet mental health need as being the catalyst for a chaotic and often costly care journey with appalling life outcomes. There are a large number of cases that ultimately cost the public purse over £5 million each (often £2 million to the local authority), a cost that could have been prevented if mental health needs had been identified and met. To be clear: the collective failure to meet the mental health needs of CLA and Care leavers creates a multi-billion pound problem every year.

In April 2016, the Education Select Committee published a report on the mental health and well-being of looked-after children. The report recommended that CLA are given priority access to mental health assessments by specialist practitioners, with subsequent treatment based on clinical need. However, they forget to send a cheque, so this cannot be a reality on the frontline.

Conclusion

The evidence for an association between adverse childhood experiences (ACEs) on adult health and wellbeing is strong. In terms of mental health for CLA at a policy level, the last decade has seen a considerable amount of rhetoric but this has arguably failed to translate into improvements at delivery level.

Advances in neuroscience and genetics are rapidly adding to our understanding of the impact of ACEs and trauma on child development, creating a neurobiologically-informed developmental narrative. With such an improved understanding of the seriousness and high prevalence of emotional and mental ill health across the looked after population one would expect policy and practice improvements. However, except for the introduction of a mandatory duty to annually administer the SDQ, very little is being done to improve our knowledge of prevalence across the looked after population, or measure progress in improving mental health outcomes. It should be noted that the SDQ is woefully inadequate for assessing CLA.

High incidences of ACEs will mean that CLA are highly likely to demonstrate worrying behaviours that are difficult to manage and remedy when in care. However, the evidence indicates that the behaviours are the symptoms not the causes. Whilst conduct or hyperkinetic disorders and health harming behaviours may be the externalised behaviours acknowledged in practice, these are highly likely to be driven by internalised trauma from the pre-care experience of this vulnerable population.

The consequence of failing to identify and meet emotional and mental health needs has a substantial impact on that individual throughout their life-course, however this has also been evidenced to carry a high financial cost. To not assess and meet the needs of CLA is a failure in

both moral and statutory duties as well as being myopic when considering cost to the public purse.

Potential questions and discussion points for the committee:

- **How many full clinical assessments did CAMHS carry out on CLA and Care Leavers in the last year?**
- **Should ACE scores form part of an early warning function for services?**
- **Should the CLA team have a full-time clinical psychologist in the service funded by the NHS?**

Author's question:

Just over a year ago there was a commitment from Southwark as the Corporate Parent that every single child with a mental health condition will get the treatment they need before 2020 is out. The pledge – made jointly by the council, healthcare providers, and commissioners – makes it the only local authority in the country to say it will treat 100 per cent of children with a diagnosed mental health condition, outstripping a 'shameful' national target of just 35 per cent.

With the evidence overwhelmingly indicating that at least half of CLA in Southwark will have a mental health condition that needs meeting, surely we must assess them all to identify those who require treatment?

Sources:

[1] Stein, M. and Wade, J. (2000). Helping Care Leavers: Problems and Strategic Responses. London: Department of Health.
[2] Meltzer, H., Corbin, T., Gatward, R., Goodman, R. and Ford, T. (2003). The Mental Health of Young People Looked After by Local Authorities in England. London: Office of National Statistics.
[3] (e.g., Blower 2004; C4EO, 2009b; Ford et al., 2007; Meltzer 2003).
[4] Meltzer, H., Corbin, T., Gatward, R., Goodman, R. and Ford, T. (2003). The Mental Health of Young People Looked After by Local Authorities in England. London: Office of National Statistics.
[5] McCann et al.,[5] and Dimigen et al.,[5]
[6] Department of Health (2002). Promoting the health of looked after children. London: DoH.
[7] DCSF / DOH, 2009. Statutory guidance on promoting the health and well-being of looked after children. London: DCSF.
[8] NICE / SCIE (2010). NICE guidelines: Looked after children and young people. London: NICE.
[9] Romanelli et al., 2009
[10] Phillips, J. (1997). Meeting the psychiatric needs of children in foster care.
[11] Goodman, R. and Simonoff, E. (1991). Reliability of Clinical Ratings by Trainee Child Psychiatrists: A Research Note. Journal of Child Psychology and Psychiatry., 32(3), pp. 551-555.
[12] Dixon, J. (2008). Young People Leaving Care: Health, Well being and Outcomes. Child & Family Social Work., 13(2), pp. 207-217.
[13] Hobbs et al. (1999)
[14] Dimigen, G., Priore C., Butler, S., Evans, S., Ferguson, L. and Swan, M. (1999). The Need for a Mental Health Service for Children at Commencement of Being Looked After and Accommodated by the Local Authority: Questionnaire Survey. British Medical Journal., 319, pp. 675.
[15] McCann, J.B., James, A. and Wilson, S. (1996). Prevalence of Psychiatric Disorders in Young People in the Care System. British Medical Journal, (313), pp. 1529-1530.
[16] Meltzer et al. (2002)
[17] Meltzer et al. (2004)
[18] DWP (2011)
[19] Coles et al. (2010)
[20] Dimigen, G., Priore, C., Butler, S., Evans, S., Ferguson, L. and Swan, M. (1999). The Need for a Mental Health Service for Children at Commencement of Being Looked After and Accommodated by the Local Authority: Questionnaire Survey. British Medical Journal., 319, pp. 675.
[21] Vostanis, P., Bassi, G., Meltzer, H., Ford, T., & Goodman, R. (2008). Service use by looked after children with behavioural problems: Findings from the England survey. *Adoption & Fostering*, *32*(3), 23-32.
[22] Firth (2016 p.5)
[23] Abdinasir and Pona (2015)
[24] Larkin et al 2012: 264
[25] Anda et al 2006
[26] Jackson, S. and Thomas, N. (1999). On the Move Again? Barnardo's, Ilford.
[27] Skuse, T. and Ward, H. (2003). Outcomes for looked-after children: Children's views of care and accommodation. An interim draft report for the Department of Health. Loughborough: Loughborough University, Centre for Child and Family Research.
[28] Ward, H., Holmes, L., Soper, J. and Olsen, R. (2008). Costs and Consequences of Placing Children in Care. London: Jessica Kingsley.
[29] Quinton, D. and Murray, C. (2002). Assessing Emotional and Behavioural Development in Children Looked After Away From Home. In: H. Ward & W. Rose, eds, Approaches to Needs Assessment in Children's Services. London: Jessica Kingsley Publishers, pp. 277-308.
[30] Meltzer, H., Corbin, T., Gatward, R., Goodman, R. and Ford, T. (2003). The Mental Health of Young People Looked After by Local Authorities in England. London: Office of National Statistics.
[31] McCann, J.B., James, A. and Wilson, S. (1996). Prevalence of Psychiatric Disorders in Young People in the Care System. British Medical Journal, (313), pp. 1529-1530.
[32] Bamford, F. and Wolkind, S.N. (1988_. The Physical and Mental Health of Children in Care: Research Needs. London: Economic and Research Council.

[33] Wolkind, S. and Rushton, A. (1994). Residential and Foster Family Care. In: M. Rutter, E. Taylor and L. Hersov, eds, Child and Adolescent Psychiatry: Modern Approaches. 3rd edn. Oxford: Blackwell, pp. 252-255.
[34] Quinton, D., Rushton, A., Dance, C. and Mayes, D. (1998). Joining New Families: A Study of Adoption and Fostering in Middle Childhood.
[35] Dimigen, G., Priore, C., Butler, S., Evans, S., Ferguson, L. and Swan, M. (1999). The Need for a Mental Health Service for Children at Commencement of Being Looked After and Accommodated by the Local Authority: Questionnaire Survey. British Medical Journal., 319, pp. 675.
[36] Minnis, H. and Devine, C. (2001). The Effect of Foster Carer Training on the Emotional and Behavioural Functioning of Looked After Children. Adoption and Fostering., 25(1), pp. 44-54.
[37] Meltzer, H., Corbin, T., Gatward, R., Goodman, R. and Ford, T. (2003). The Mental Health of Young People Looked After by Local Authorities in England. London: Office of National Statistics.
[38] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, J.S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine., 14(4), pp. 245-258.
[39] Mair, C., Cunradi, C.B. and Todd, M. (2012). Adverse Childhood Experiences and Intimate Partner Violence: Testing Psychosocial Mediational Pathways among Couples. Annals Of Epidemiology., 22(12), pp. 832-839.
[40] Akister, J., Owens, M. and Goodyer, I.M. (2010). Leaving Care and Mental Health: Outcomes for Children in Out-of-Home Care During the Transition to Adulthood. Health Research Policy and Systems, 8(10), pp. 8-10.
[41] Skuse, T. and Ward, H. (2001). Performance Targets and Stability of Placements for Children Long Looked After Away From Home. Children & Society., 15(5), pp. 333-346.
[42] Saunders, L. and Broad, B. (1997). The Health Needs of Young People Living in Care. Leicester: De Montfort University.
[43] Viner, R.M. and Taylor, B. (2005). Adult Health and Social Outcomes of Children Who Have Been in Public Care: Population-Based Study. Pediatrics., 115(4),
[44] Buchanan, A. (1999). Are care leavers significantly dissatisfied and depressed in adult life? Adoption and Fostering, 23(4), pp. 35-40.
[45] Pritchard, C. and Cox, M. (1998). The Criminality of Former “Special Educational Provision” Permanently “Excluded From School” Adolescents as Young Adults (16–23): Costs and Practical Implications. Journal of Adolescence., 21(5), pp. 609-620.
[46] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, J.S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine., 14(4), pp. 245-258.
[47] Chartier, M.J., Walker, J.R. and Naimark, B. (2010). Separate and Cumulative Effects of Adverse Childhood Experiences in Predicting Adult Health and Health Care Utilization. Child Abuse & Neglect., 34(6), pp. 454-464.
[48] Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H. and Anda, R.F. (2003). Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study. Pediatrics., 111(3),