

**Barriers and facilitators to screening, assessment and mental health care of
Looked After Children**

N. M. Parnell

A thesis submitted for the degree of Doctorate in Clinical Psychology

Department of Health and Social Care

University of Essex

Date of submission for examination: June 2020

Acknowledgements

With thanks to my partner for her patience, my supervisors for their guidance, the clinical recruitment service for their input, and most importantly the young people who lent their voices to make this project possible.

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Abstract

Background: Looked After Children (LAC) have significant needs and are at high risk of mental health difficulties. There is a predominance on views of carers and professionals to understand what helps or hinders LAC in accessing or engaging in mental health services. There is little understanding about the views of LAC themselves on this topic, despite calls for their voices to be heard.

Aim: Explore LAC perspectives on barriers or facilitators to mental health care in one UK LAC mental health service. Further explore clinical, social or personal factors that influence or contribute to this.

Method: A semi-structured topic guide was developed and employed. Opportunistic sampling was used to recruit young people from one UK LAC mental health service. Interviews were conducted face to face and audio recorded. The data was transcribed verbatim and analysed via thematic analysis.

Results: This study recruited five participants. Seven themes were related to barriers and facilitators for help-seeking and engagement - 1) Understanding mental health and emotional wellbeing 2) Perceptions of responsibility for help seeking and engagement 3) Help seeking from others or services 4) Engagement in services 5) Appreciating the parental qualities of the service 6) Developing reflective capacity in young people? and 7) Service development. Both personal and social factors were described within barriers and facilitators.

Discussion: Participants voiced complex barriers and facilitators for help seeking and engagement with services. Prominent personal and social factors included in these were stigma, understanding mental health and relationships. Clinical, organisational, policy and research implications of these findings are discussed.

Chapter 1: Introduction

Mental Health of Looked After Children

‘Mental health’ has generally been defined as a ‘state of wellbeing’ that can encompass ‘social, psychological and biological factors that determine the level of mental health’ (WHO, 2018). For young people in the UK, the term ‘mental health’ is integrated into services that support those having difficulties with this aspect of wellbeing, namely Child and Adolescent Mental Health Services (CAMHS). Terms such as ‘mental’ however has been reported to be stigmatising, associated with difficulties of this aspect of wellbeing, and hold negative connotations that hinder help seeking in young people due to such stigma (Rose et al, 2007). Rose et al (2007) found this was driven by a lack of education and understanding of mental health difficulties in young people. There have been instances where reviews (Bazalgette et al, 2015) and services (NELFT, 2020) have therefore preferred to emphasise or include other terms, such as ‘emotional wellbeing’ in their titles to disassociate from such language that may perpetuate stigma and hinder help seeking from young people. In this thesis, the terms mental health and emotional wellbeing are used to indicate the state of this aspect of wellbeing for young people, and those Looked After, in the introductory literature. Mental health and emotional wellbeing are also explored as concepts with participants in this study, but also explored in relation to having mental health or emotional wellbeing difficulties, as well as access and engagement to support and services for such difficulties.

The general mental health of young people in the UK continues to be of national concern (Committee of Public accounts, 2018). A recent national review of the mental health of young people in the UK show that one in eight young people (aged 5-19) have a diagnosable mental health disorder (NHS Digital, 2017). This is

up from one in ten from 2004 (NHS digital, 2005). The 2017 survey found that of those with a diagnosable mental health disorder, 25% of 11 to 16-year olds had self-harmed or attempted suicide. The state of young people's mental health in the UK seems to be deteriorating, yet the focus of research remains on the general population. This leaves questions about sub-populations, particularly vulnerable young people who may be more at risk of mental health difficulties.

Looked after Children (LAC) are a vulnerable group of young people that have been shown to have high rates of abuse, maltreatment and neglect (Oswald et al, 2010). These risk factors significantly increase the chance of mental health difficulties in this population (Murphy & Fonagy, 2012) either at the present time or in their future development (Richardson & Lelliot, 2003; York & Jones, 2017). As such, this population needs to be surrounded and able to access increased support when compared to other young people in the general population (Ford et al, 2007).

Despite the increased exposure to traumatic events and risk of emotional or mental health difficulties for LAC, the last national review of LAC mental health was in 2003 (Meltzer et al, 2003). This showed that 45% of LAC surveyed in the UK had a diagnosable mental health disorder. This translates to almost one in two LAC. The 32.5% difference in mental health difficulties between general young people and LAC is stark. Although there is a consultation to now conduct an updated review of UK LAC and the state of their mental health (NHS digital, 2019), LAC seem to have become a hidden demographic in the face of over a decade of deterioration in young person mental wellbeing.

Health and social care contexts for helping LAC

This hidden demographic in mental health reviews continue to grow in numbers. Recent government statistics show that numbers of LAC in the UK have increased from 68,810 to 78,150 in the last 5 years alone (Department of Education, 2019). Extra measures are in place to consider their mental health needs, such as being monitored by the Strength and Difficulties Questionnaire (SDQ) by local authorities (Goodman & Goodman, 2012). There are also some National and Specialist (N&S) services for LAC specifically. Aside from this, LAC are predominantly subject to the same mental health services as young people in the general population.

Sadly, reports have portrayed Child and Adolescent Mental Health Services (CAMHS) as having little funding to meet current need for general young people, along with a significant imbalance of this funding within its services (Children's Commissioner, 2017; Kelly et al, 2018). Services have had to alter their 'threshold' for acceptance to CAMHS ever higher (Association of Child Psychotherapists, 2018). As such, young people who do not 'meet' this cut off point are subject to watchful waiting, either until things improve, or the severity of their difficulties meet this threshold (Parkin et al, 2017). Even then, they are subject to significant waiting times (NHS Digital, 2018). In addition to this, a separate review found that 28% of young people referred to child and adolescent mental health services (CAMHS) were not even allocated a service due to factors such as overstretch (Children's Commissioner, 2016). With such a bleak picture for young people in general in accessing services, this poses a worrying question about whether or how those with increased needs such as LAC are able to seek help.

Specifically for LAC, what little evidence and reports there are on funding (Kelly et al, 2018) suggest that spending has only just been allocated back toward

LAC after having been frozen for the previous ten years. Even then, the report outlines that this funding remains for ‘statutory and immediate needs’, whereas in real-terms, funding for early or preventative help has been cut by 60% between 2010-2017. Third sector organisations have therefore begun to collaborate with LAC and health care staff to reveal how imperative it is for the government to address, from a population perspective, this ‘silent crisis’ given the vulnerability of these young people (Oakley et al, 2018). This is also due to the current monitoring via the SDQ not being enough to capture the complexities of mental health within LAC (Milich et al, 2017). Further evidence for how service provisions at present are not meeting LAC needs are also coming from professionals working with LAC (Association of Child Psychotherapists, 2018), with such reports focusing on aforementioned thresholds remaining high for LAC to access CAMHS, and factors such as service underfunding and overstretch.

Socio-political contexts for LAC

Between 2017-2019, the socio-political conversation on the care and mental health of LAC across the media was one of government funding cuts or freezes. These cuts were being described as leading to subsequent pressures on legal, social and healthcare systems (Bartlett, 2017; Bulman, 2017; Press Association, 2018; Butler, 2018; Perraudin & McIntyre, 2019). This came at a time when the media was further portraying the government as neglecting children’s health through demoting the children’s minister in parliament (Feuchtwang, 2018) through to funding freezes being exposed as ‘inadequate’ to address the needs of young people in care (Savage, 2018).

Against this backdrop of rising numbers and system pressure, further narratives formed within the media on the implications of these pressures. This is not only for LAC, but also the consequences of the system attempting to survive itself. Stories of frequent placement moves for children and the impact – going from school to school - have been expressed as an attempt from the system to deal with rising numbers (Weale, 2018). This rhetoric has also been expressed within stories of children moving between residential homes. This is portrayed as an attempt to reduce costs charged to local authorities by private companies – who dominate the landscape of care – that are also increasingly winning expensive council contracts (Greenfield & Marsh, 2018; Oakley et al, 2018).

Parliamentary reports are echoing this rhetoric. One report (Education committee, 2016) highlighted how over half of young people in care had a diagnosable mental health disorder, and yet mental health and care provision for this population is poor in many areas of England. It also outlined how a lack of reliable statistics and data currently exist on LAC for their mental health needs. A more recent parliamentary report (Education Committee, 2018) outlined a narrative of ‘failing a generation’. This added to the above opinion from NHS, third sector organisations and public media that despite the high prevalence of mental health and needs of LAC, there is disappointment directly from government departments. It further shows that previous recommendations for priority access or understanding of mental health needs of LAC had still not been taken up between 2016-2018. The report also highlighted the above media narrative that these children moving in and out of, or between carers, may well exacerbate their mental health difficulties and create gaps in opportunities to help. Additionally, it highlighted there were no clear policy guidelines or recommendations for best support for these young people prior

to this report, and efforts to refocus help based on clinical need rather than 'thresholds' were not being reinforced.

These parliamentary reports made multiple suggestions to address the mental health needs of LAC. They recommended creating separate policies for how LAC access services and refocusing services on clinical need. They also emphasised one important voice to contribute to these recommendations, that of the LAC themselves (Education committee, 2016). These voices have been reiterated as important throughout other organisations working with LAC to understand how young people view or understand services, along with how they may want to access and engage in help (Bazalgette et al, 2015).

Help-seeking

Young people in general can face significant barriers in accessing mental health care. These include stigma, embarrassment, and poor mental literacy such as recognising symptoms of mental health difficulties (Gulliver et al, 2010). Along with Gulliver et al (2010), other reviews (McDonald et al, 2011) have reported that facilitators enabling young people to access mental health care were under-researched, with the only factors identified being previous positive experience with services, and encouragement from others. A more recent review of young people perspectives on mental health has shown similar barriers and facilitators (Plaistow et al, 2013).

For LAC, having their voice heard to explain why they do or don't access services can be difficult whilst navigating a maze of care and health pathways. There is a large portion of research therefore from foster carer or social work voices explaining how LAC may be able to access mental health care. Such studies on

mental health care access for LAC explore aspects such as varying mental health literacy in foster carers and the impact this has on help-seeking (Bonfield et al, 2010; Mount et al, 2004). Further barriers from carers included waiting times, not being listened to, and the importance of a support structure (York & Jones, 2017). Those focusing on social workers or residential staff found that factors influencing LAC accessing mental health care were: instability in placements creating instability for LAC; stigma at being 'looked after' and having mental health difficulties; waiting lists for those that are stable enough to identify need; and a lack of early help or preventative measures (Callaghan et al, 2003).

As such, current evidence suggests that LAC not only have to contend with the barriers that other young people face but added systemic factors (underfunding and overstretched services, waiting times, constant moves) and double stigma that hinder their ability to reach out for help.

What research has been done in the past with LAC has highlighted an imbalance of LAC voices. Davies & Wright (2008) is one of the few reviews of studies looking at LAC views of mental health services. At that point, they did not find any research that exclusively explored LAC views specifically for mental health access and engagement, instead including studies involving both young people and LAC together along with carers. Positively, not only do they highlight the main focus of parent, guardian or professional views in the research at the time, but importantly emphasise LAC's ability to provide such views despite being deemed a vulnerable population. They go on to outline how young people in their included studies expressed very different points on help-seeking and engagement to the adults in the care system. Specific individuals being consistent and able to be trusted were important to these young people, along with the use of non-verbal interventions to

facilitate expression. The physical environment was important in being friendly and comforting. Inclusion was key in both the therapy process and service development. Importantly, young people in the review (Davies & Wright, 2008) studies acknowledged social context as a double-edged sword; one of shared experiences, but that of social stigma. Davies & Wright (2008) also highlighted the role of media stories in perpetuating this stigma, particularly for vulnerable young people such as LAC. The authors did extrapolate some findings specific for ‘vulnerable children’, which unfortunately again focused more on barriers than facilitators. These included; wariness of professionals, ambivalence toward talking and the value of non-verbal communication in therapy.

The views gathered in the last LAC mental health survey in the UK (Meltzer et al, 2003) also gathered brief data from text boxes. These included highlighting sex differences in help seeking (girls more so than boys), parents or the ‘mother’ being the primary person when seeking help, children with a diagnosable mental health problem being less likely to seek help due to mistrust, along with a mix of practical advice and talking being what was wanted if LAC were to seek help.

Addressing the LAC perspective

The choice to seek help is the foundational step prior to accessing whatever support is available to young people. The voice of those seeking help is important to understand how they then engage with what support is offered. It is important to understand how and why these steps are undertaken. Having a voice, or having it heard, is therefore one important factor in understanding how and why young people such as LAC do or do not/cannot access and engage in help.

There is existing literature and insights into broader LAC views on their care. Studies such as Fargas-Malet et al (2014) have focused on the perspective of LAC on entering care and returning to birth parents. Others such as Schofield (2005) have focused on a connecting issue of placement decisions. This paper (2005) reviewed Schofield's and others' previous studies (for example Schofield, 2003; Schofield & Thoburn, 1996) on LAC and care leavers experiences of family placement decisions, and the importance of considering and including their views and development as young people. There are other areas of study that focus on LAC views of being in care and experiences of the social system (for example Ward et al, 2005; Selwyn et al, 2008), their views of education progression (Harker et al, 2002), and perspectives of LAC on domains for evaluating their wellbeing within care and health systems (Selwyn et al, 2017; Selwyn & Wood, 2017).

There are some studies that more specifically focus on the mental health of LAC. Longitudinal studies such as 'Mind your Health' (McSherry et al, 2015) have set out to profile the health of LAC in Northern Ireland. This study has components that gain perspectives of LAC on their mental health and help-seeking behaviours (Fargas-Malet & McSherry, 2018). Within this multifaceted exploration with professionals, carers and young people in care (Fargas-Malet & McSherry, 2018), there were findings such as high rates of mental health difficulties in young people in the care system. Young people in care also expressed systemic barriers – waiting times and lack of access echoed in other studies (York & Jones, 2017) - along with indications that LAC would more likely seek help from family rather than services. Specifically for the interviews conducted with LAC in this study, there were reports of stigma, embarrassment and fear of opening up due to not knowing what would happen if they sought help. Further, similarly to studies in Davies & Wright (2008),

a lack of strong relationships or time to get to know professionals were key in hindering help seeking. Improvements from young people were discussed as more outreach and communication between services to not have to repeat their stories. Other points of interest are the recommendations that more still needs to be done to explore what engages young people with mental health services, and the importance of listening to young people in care on these issues given the inherent power imbalances between them and professionals. The above findings have been reiterated in other multifaceted studies (Bazalegette et al, 2015) with LAC and care leavers, where they reiterated stigma, relationship to foster carers, and systemic factors as barriers to help, such as waiting times and ‘thresholds’. Further factors included the importance of exploring the perspectives of LAC on access and engagement to mental health services.

Based on the above studies, it is clearly important to continue to hear LAC voices not only on their care, but also increase the focus on their views specifically of mental health care access and engagement. Developing understanding of this could help in the development and existence of services. However, despite efforts and relative to others’ perspectives, there is currently less of an understanding from the perspective of LAC about how and why they seek help for their mental health as opposed to other aspects of their care. Political, social and organisational voices have been heard, whilst professional bodies (Care Quality Commission, 2012) and academics call for LAC to be able to express themselves more.

There are however potential barriers even within mental health services that hinder LAC continuing to being heard. Whilst ‘capable children’ have their right to be heard as outlined in a United Nations bill of rights (United Nations, 1989), Davies & Wright (2008) note that due to the complexity of LAC histories and

subsequent attachment difficulties impacting on trust, this may engender clinicians to be reluctant to engage LAC in reflective discussions about mental health services. They go on to describe how professionals ‘guard against an all or nothing’ – taking full responsibility to express themselves vs protecting them from having to do so - approach for obtaining LAC views. This approach is gleaned from Golding et al (2006) who, alongside the British Psychological Society (Rhodes, 2015) note that there is a tension between the rights of the children to have their views heard against the need to protect them, particularly those in social care contexts (McNeish, 1999).

In the research context, the lesser heard LAC voice could have manifested as clinicians or those in health services leaning toward this ‘nothing’ position through protecting this vulnerable group of young people. This point is not to diminish the care or duty from professionals – at times this is necessary to safeguard these children at sensitive times in their life, development or pathway in the care or health system. However, at present, it seems this protective position could also be one factor contributing to an imbalance of research with LAC and their views on mental health care access and engagement. Davies & Wright (2008) therefore call for a balanced approach in involving LAC in research through considering their complex situation and capacity to take part. They note that navigating these issues ethically can result in LAC being able to have their voice heard.

Within a research context, although LAC are being heard in a broad sense, there is still a specific gap in current understanding of LAC views of accessing, and particularly engaging in UK mental health care. This lack of specific understanding on mental health services is in significant contrast to historically known mental health needs of LAC, the changing NHS and care landscapes, along with complex and additional barriers to accessing help, of which a large portion is voiced by those

caring for LAC. A review of the literature on LAC perspectives in the UK needs to be sought to monitor if LAC voices are continuing to contribute to this specific but important perspective of service access and engagement.

Systematic Meta-Synthesis

Aim

To review the existing qualitative research on LAC perspectives of mental health care access and engagement, particularly in relation to barriers and facilitators to accessing help and engagement.

Method

Search strategy

A search was conducted multiple databases: Web of science; PubMed; and EBSCO host – PsycINFO, PsychARTICLES, MedLine, CINAHL, E-journals and MEDLINE (all searched between January 1950- February 2019). The following search terms are examples of those used: (Looked after child* OR Looked after young pe*) AND (mental health) AND (care OR utili*) AND (interview*) AND (barriers OR facilitat*) AND qualitative*. See appendix 1 for full search terms and strategy. This was constructed with SPIDER guidelines around question, search terms and strategy setting (Cooke et al, 2012). Further grey literature was searched using included article reference sections and Google Scholar after the above search strategy was completed. Organisational software (Endnote web and desktop V9) was utilised for reference management. Date of last search was 16/02/2020. Given the lack of research found in the systematic search, sample age range was lifted beyond 18 years providing these studies were exploring current or retrospective accounts of

being a LAC and mental health care experiences. Further, the search was broadened to include all other countries for not only richer data in anticipation of a lack of UK studies, but to provide a broader perspective on where the UK stands on its evaluation of the needs and voices of LAC and their mental health care experiences. Given previous literature reviews focused on the UK had other ‘similar’ populations to LAC (Davies & Wright, 2008), it was felt appropriate to do this here.

Inclusion and Exclusion criteria

Inclusion: Research included were qualitative (or mixed method focusing on qualitative results) studies focusing on barriers and/or facilitators of mental healthcare screening, assessment and access (either initial or continual engagement access) in LAC. These studies were published in English. Studies were taken from available research across the globe, specifically the USA and Canada, due to lack of UK research found in systematic search. The age range of a LAC was defined by country definition. Research focusing specifically on retrospective accounts of mental health services from care leavers were also included.

Exclusion: Studies were excluded based on non-peer reviewed journal articles, such as: Dissertations; conference abstracts; case studies; dissertations or commentaries. Quantitative research, systematic reviews, meta-analyses and meta-syntheses were also excluded. Non-English language studies were also omitted.

Sensitivity Analysis and Quality Assessment Framework

The Critical Appraisal Skills Programme (CASP) tool for qualitative research (CASP, 2014) was used to assess methodological quality of each included research

paper. Each of the ten items on this tool are considered below individually (also see appendix 2) due to no scoring algorithm being needed for appraisal.

A sensitivity analysis (Thomas & Harden, 2008) is usually recommended to be carried out to assess if inclusion or exclusion of included papers within the final thematic synthesis has any bearing on the outcome. However, given this area of child health may well be under researched, the value of including all research identified as appropriate in this review outweighs the benefits of isolating and excluding studies that may be assumed to not contribute ‘significantly’. This assumption of excluding qualitative research based on ‘value of contribution’ is also in itself problematic (Thomas & Harden, 2008) given the principles of this methodology. As such, all papers are included, however the quality of each individual paper in relation to its contribution to the final synthesis is outlined below for clarity on the state of the included research.

Data Extraction

The following data was extracted from the final included papers: Population; country of origin; sample size; sampling method; age; language; objective of study; study type; qualitative method of data collection; themes identified; implications. These aspects were collected based on being present across included studies and aimed to be in line with research and thesis relevance.

Data Synthesis

Thematic synthesis was conducted across final included papers. This method aims to gather themes than span across research from implicit and explicit data. These themes are subsequently pooled to generate further interpretations that transcend the

descriptive and explicit results generated in each paper included. The three stages (Thomas & Harden, 2008) of this adhered to in this literature review included:

- 1) Line by line coding of text
- 2) Developing descriptive themes
- 3) Generating analytical themes

In accordance with guidelines (Thomas & Harden, 2008) all data explicitly marked as ‘results’ or ‘findings’ was exported verbatim to Nvivo (V12) for line by line coding and subsequent synthesis steps. In the case of multistage studies involving carer or stakeholders, only data pertaining to young people were included within this synthesis. Given some papers also included multiple topics, some of which were outside of the research question here, all *relevant* data (that of which was deemed by the author to be in line with the research question) was read multiple times for data familiarisation and identification to include in the coding steps. Line by line coding included, at times, attributing more than one code to a particular piece of text.

Results

Study Characteristics

A total of nine studies (Fleming et al, 2009; Heath & Priest, 2009; Jee et al, 2014; Johnson & Menna, 2017; Beck, 2006; Lee et al, 2006; Stanley et al, 2007; Tatlow-Golden & McElvaney, 2015; Blower et al, 2004) with a combined sample size of 601 young people were included in this review. See figure 1 for search process and results. This sample size is significantly increased by Beck (2006) (N=109) and Lee et al (2006) (N=389) due to two reasons; 1) having to widen the search to include Lee et al (2006) from the USA for sufficient sensitivity in the synthesis, and 2) both studies implemented qualitative analysis to open-ended written questionnaires which

captured a large range of young people. These papers were found in the original search on 14/02/2019. An update search from 14/02/2019 to 16/02/2020 consisted of the same search methods and databases above. This yielded 62 new titles, with 12 duplicates being removed. Of the remaining 50 titles, one abstract was screened and deemed outside of the inclusion criteria. No new papers were therefore included in this meta-synthesis from this update search.

Three included studies were conducted outside of the UK – two in the USA (Jee et al, 2014; Lee et al, 2006) and one in Canada (Johnson & Menna, 2017). The reasons for including these were three fold; 1) Given the dearth of research on perceptions and experiences of mental health care of LAC themselves, this focus was thought to override the variation in social care system construction, 2) It was thought be appropriate to broaden the scope of the search and include these studies for a wider oversight of the research area, and 3) These papers contributed significantly to the specific synthesis topic alongside UK based studies.

One study included physical health into their exploration (Fleming et al, 2009). Mental health was segregated into separate themes by this paper which enabled it to be included within this review. Three studies (of which two were UK based) also reported focusing on (Tatlow-Golden & McElvaney, 2015) or including care leavers over 18 alongside LAC under 18 in their samples (Johnson & Menna, 2017; Stanley et al, 2007). One study with LAC also combined young people who were homeless and living with biological parents (Health & Priest, 2009). As has been done in previous literature reviews on LAC perspectives to mental health care (Davies & Wright, 2008), it was thought best to include the views of such young people that had experience of various health and social care systems, difficult experiences, and

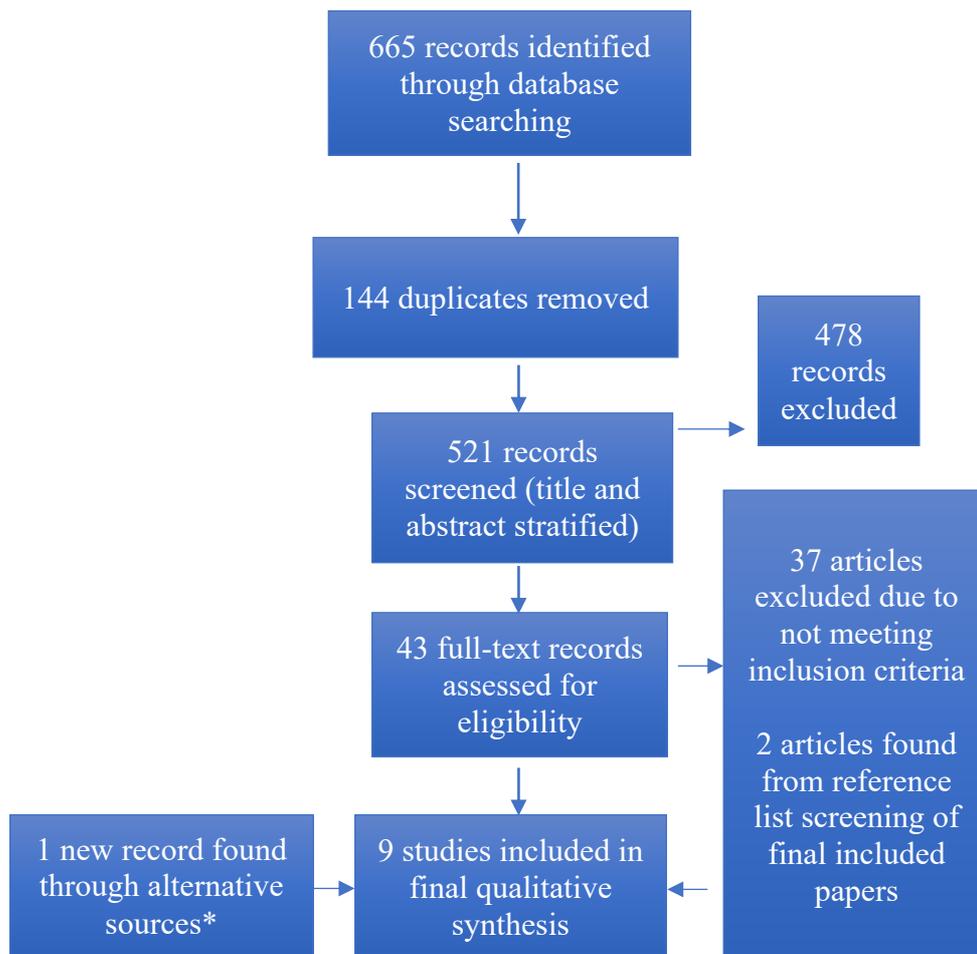


Figure 1. Study screening process (Diagram format has reference to Preferred Reporting Items for Systematic Reviews and Meta-Analyses – PRISMA – guidelines; Moher et al, 2009). * Google scholar

studies that focused on retrospective accounts of being looked after and mental health care or experiences. It is hoped by including these studies, it would shed further or unknown information on this research area of barriers, facilitators and experiences of mental health care from a LAC perspective. See table 1 for study characteristics.

Authors (year)	Populations	Countries of Origin	**Sample size	§Study type	Sampling method	Age (range)	§Qualitative method	Analysis type
^Fleming et al. (2009)	^^LAC (residential and foster care)	Northern Ireland	8	Qualitative	Not stated	Unknown (most over 14)	Semi-structured interviews	Content analysis
Heath & Priest (2009)	LAC, homeless and in parental care (under *YOT)	England	4	Qualitative	Purposive	14-17	Semi-structured interviews	Thematic analysis
^Jee et al. (2014)	LAC (foster care)	USA	14	Qualitative	Purposive	11-17	Semi-structured interviews	Deductive Thematic analysis
Johnson & Menna (2017)	LAC (foster care - 1 exited foster system and one currently transitioning)	Canada	7	Qualitative	Opportunistic	16-20	Semi-structured interviews	Grounded theory
^Beck (2006)	LAC (foster care)	England	109	Qualitative	Opportunistic	11-18	Postal questionnaire	Common theme consensus
Lee et al. (2006)	LAC (foster care)	USA	389	Mixed method	Not stated	17	Open-ended interview	Thematic analysis
^Stanley et al. (2007)	LAC (residential and foster care - 2 were care leavers)	England	14	Qualitative	Not stated	12-19	Focus groups	Reported 'standard approach'
^Tatlow-Golden et al. (2015)	Care leavers (retrospective study on experiences)	Northern Ireland	8	Qualitative	Purposive	18-27	Semi-structured interviews	+CQR - Thematic analysis
Blower et al. (2004)	LAC (foster care, child home and residential school)	Scotland	48	Mixed method	Opportunistic	Unknown for qualitative section	Semi-structured interviews	Framework analysis

^Multistage study with stakeholders, carers and professionals ^^ Looked After Children * Youth Offending Team **Qualitative sample used in study §Type for young people only +Consensual Qualitative Research

Table 1. Study characteristics focusing on Looked After Children participation and design factors only.

Quality Assessment

Please see appendix 2 for an overview of quality assessment of included papers.

This was conducted using the Critical Appraisal Skills Program checklist for appraising qualitative research (CASP, 2014), based on a ‘yes’, ‘no’ or ‘can’t tell’ rating system. This is split into three sections; 1) Validity 2) Results, and 3) Will the results help locally. It was felt important to separately address the quality and sensitivity of these papers here to make clear the findings of this appraisal in the context of; 1) the lack of research found on LAC perspectives of mental health care, and 2) research being included from various methodologies, countries and social care systems.

All papers were evaluated as ‘valid’ through being adequate or appropriate in the following categories: clear statement aims and appropriate methodology. All included studies portrayed the value of their research to ‘helping locally’ in clinical and academic applications. For ‘results’, based on the checklist, it was felt that all studies further met the criteria of appropriate research design to meet their aims and stated their findings clearly. Only two papers (Health & Priest, 2009; Tatlow-Golden & McElvaney, 2015) met ‘yes’ criteria for all criteria on the CASP checklist.

The following five CASP criteria include each paper which did not meet ‘yes’ rating, of which all are based on the results section of the CASP checklist. All papers in the review are explored within the criteria of ‘relationship’ for clarity on how the complexity of this was managed in each paper.

Was the recruitment strategy appropriate to the aims of the research?

Four papers were unclear as to how the qualitative sub-sample were recruited from larger samples (Lee et al, 2006; Blower et al, 2004; Fleming et al, 2009; Stanley et

al, 2007). The remaining papers were thought to be *sufficient* to meet ‘yes’ criteria in justifying their design to meet with aims. Little was seen through all papers on refusal reasons however.

Was the data collected in a way that addressed the research issue?

All but one paper (Lee et al, 2006) were considered to use an appropriate data collection method that addressed the research question. This was due to the paper reporting a multi-stage data collection (face to face and telephone interviews) procedure in a way that confounded understanding of where the data was derived. They further reported in their limitations that ‘embedding open-ended questions in a long survey does not engender in-depth responses’, and ‘purely qualitative interviews might uncover more about...salient themes’.

Has the relationship between researcher and participants been adequately considered?

Only three papers were felt to *adequately* address researcher and participant relationships, however even these were specific in their approach, only focusing on research design (Fleming et al, 2009), engagement, researcher and setting influence on interview data and interpretation (Heath & Priest, 2009), and professional role on data interpretation (Tatlow-Golden & McElvaney, 2015). None encompassed an overall approach throughout their research. The latter two papers were the only studies to allude to a reflexive account on their role and influence within or on the actual interview process and data derived from this. Two papers were rated as ‘can’t tell’ (Beck, 2006; Johnson & Menna, 2017). One paper (Beck, 2006) used postal questionnaires, however did consider the influence of young people’s answers on

these questionnaires - including comments on their social worker and professionals – when they were sent back to the work address of these professionals. The other (Johnson & Menna, 2017) alluded to managing researcher influence through ‘rapport, adherence to interview guide and careful keeping of memos...’, however no other information was provided on this. Four papers were felt to not adequately consider this factor (Lee et al, 2006; Blower et al, 2004; Jee et al, 2014; Stanley et al, 2017), with little or no mention of relationship on the outcome of the research. One paper (Blower et al, 2004) did look at interpreting data, however this focused on rationalising problems within the study through a psychological model medium.

Have ethical issues been taken into consideration?

Five papers (Fleming et al, 2009; Jee et al, 2014; Johnson & Menna, 2017; Lee et al, 2006; Blower et al, 2004) were rated as ‘can’t tell’ in *sufficiently* reporting to take into consideration ethical issues. One paper (Blower et al 2004) reported no ethical approval from a governing body. The remaining four papers reported ethical clearance, however did not report other important aspects such as explaining the research to young people and safeguarding or risk procedures. In the context of LAC and the complexities of discussing mental health, this would be needed. Further, one paper (Johnson & Menna, 2017) piloted sensitive interview questions around negative life experiences with only graduate students prior to using these with LAC.

Was the data analysis sufficiently rigorous?

Three studies (Beck, 2006; Fleming et al, 2009; Blower et al, 2004) were rated as ‘can’t tell’ in reporting *sufficiently* rigorous analysis. Little contradictory data or insight was reported within these studies. Beck et al (2006) reported a process rather

than specific analysis, however did report second rater and theme agreement processes. Fleming et al (2009) was detailed in their process, however provided little analysed themes in comparison to other populations within the study. Blower et al (2004) provided little clarity on their 'framework' procedures. One study (Stanley et al. 2007) was felt to not report sufficiently their analysis – this paper reported a 'standard approach' to analysis which referenced grounded theory, however in text outlined thematic procedures, which made this unclear and difficult to disentangle.

Sensitivity analysis

The studies that contributed significantly to the synthesis are those that not only had the most relevance to barriers, facilitators and mental health care engagement, but also the experiences of LAC specifically (Stanley et al, 2007; Tatlow-Golden & McElvaney, 2015; Blower et al, 2004; Jee et al, 2014). All but one (Jee et al, 2014) were conducted within UK care systems, enabling some insight into the UK specifically.

Despite this, several factors reduced the sensitivity of obtaining UK LAC views on mental health care and access. This subsequently influenced the synthesised themes below. The most prominent studies to contribute above were also found to be in the majority of those that were 'lesser' quality on the CASP tool (Stanley et al, 2007; Blower et al, 2004; Jee et al, 2014). Three studies were from the USA (Jee et al, 2014; Lee et al, 2006) and Canada (Johnson & Menna, 2017), representing various care systems that differ from the UK. Varying methods of data collection (see appendix 2) ranging from interviews, focus groups and open-ended postal questionnaires further confounded consistency in methodology. In addition, despite focusing on the views of LAC in their mental health services and help-

seeking (Blower et al, 2004; Johnson & Menna, 2017; Beck, 2006; Lee et al, 2006; Tatlow-Golden & McElvaney, 2015) there are differences in the focus of studies, such as understanding carer and LAC views (Jee et al, 2014; Stanley, 2007), youth offenders (Heath & Priest, 2015) and physical and mental health (Fleming et al, 2005). This therefore dilutes or potentially reduces the sensitivity to LAC voices on their help-seeking.

Overall, although some specificity to the review aim was obtained in included studies, the sensitivity to hearing LAC voices on their access to and opinions of mental health services in the UK is reduced due to the confounding factors above.

Thematic Synthesis

Only data relating to LAC and similar populations stated above were included. Given variation in study populations outside of LAC and included experiences of initial and continual engagement of mental health care, step three of thematic synthesis was difficult to achieve without risk of overinterpretation. As such, descriptive thematic synthesis has predominately been conducted within this review, as is noted to be acceptable (Thomas & Harden, 2008).

Across the nine papers, five themes with 23 sub-themes were derived; 1) Understanding of and factors in mental health 2) Relationship to help 3) Barriers 4) Facilitators 5) Service development. All studies looked directly at barriers or facilitators to mental health care access or engagement, or factors and experiences that contribute to these issues within LAC. In accordance with the reported analysis plan, descriptive themes were grouped, re-grouped and revised into themes that were thought acceptable for interpretation and reporting.

Understanding of and factors in mental health

Several papers explained LAC's perspectives on mental health difficulties. Some papers explained LAC attributed their mental health difficulties to a large variation of factors, including adverse experiences (Blower et al, 2004) along with family, school, transitions in placements and not fitting in anywhere due to this (Fleming et al, 2009; Johnson & Menna, 2017; Beck, 2006). In response to these factors, across four papers (Bower et al, 2004; Heath & Priest, 2009; Tatlow-Golden & McElvaney, 2015), LAC reported attempting to cope through self-harm, drinking alcohol, substance use, and stealing. Some LAC also showed other coping mechanisms, including self-care (Tatlow-Golden & McElvaney, 2015), distraction (Johnson & Menna, 2017), exercise (Heath & Priest, 2009; Fleming et al, 2009; Tatlow-Golden & McElvaney, 2015) and music and writing (Tatlow-Golden & McElvaney, 2015). There seemed to be an emphasis from LAC in findings on practical/physical self-support or problem solving to address difficulties (Heath & Priest, 2009; Fleming et al, 2009; Tatlow-Golden & McElvaney, 2015). Only one report noted LAC talking about their experiences (Johnson & Menna, 2017). Interestingly, only one paper (Tatlow-Golden & McElvaney, 2015) reported how LAC conceptualise mental health in thoughts, mood, daily living and support.

Relationship to help

Generally, papers reported that LAC felt let down by their experiences of 'help' from their biological parents. This ranged from expecting mothers to be sources of support, yet in reality this was rarely the case, leaving them with an expectation of being let down and feeling unwanted (Fleming et al, 2009; Stanley et al, 2007; Heath & Priest, 2009). One study did consider the mental health difficulties of such

mothers and the impact this has on their ability to meet the needs of their children (Stanley et al, 2007).

Studies described how LAC's low expectations of mental health help and relationships with others seemed to dictate how much they then worked to achieve these expectations. Examples from papers included misbehaving to end placements as they expected it would end regardless, expecting mental health professionals to be at a disadvantage because LAC find it hard to open up, and how they act in expectation of what they assume others think of them in order to stand up for themselves, such as being aggressive to defend themselves (Blower et al, 2004; Heath & Priest, 2009; Tatlow-Golden & McElvaney, 2015; Lee et al, 2006). There was some, albeit little, indication from studies where LAC explained where responsibility of 'help' lies. Some looked to friends for support or their foster carer (Heath & Priest, 2009; Blower et al, 2004; Fleming et al, 2009; Jee et al, 2014).

One interesting factor posited by Tatlow-Golden & McElvaney (2015) as affecting 'relationships to help' was that of 'psychological growth' and LAC's ability to reflect on their experiences. This was seen as something that was independent of developmental or chronological age, but a 'reflective trajectory' that occurs and influences LAC's ability to seek help. The centre of this was LAC's freedom of 'choice' in their help-seeking and the effect it had on their ability to reflect on more than it being 'their responsibility' that they are in care. Further evidence (Johnson & Menna, 2017; Tatlow-Golden & McElvaney, 2015) inferred such a trajectory, outlining how an increased sense of choice or understanding of foster care facilitated their ability and readiness to accept mental health help or support.

Barriers

Barriers were by far the most frequently reported aspects of mental health care and experiences. These spanned all included papers and include the following six sub-themes.

Relationship to the past

All but two papers (Lee et al, 2006; Stanley et al, 2007) described how LAC conceptualised difficulties in accessing mental health support, such as lack of trust (Blower et al, 2004; Fleming et al, 2009; Heath & Priest, 2009), suspicions of professionals (Jee et al, 2014; Blower et al, 2004) or the care system (Johnson & Menna, 2017), along with them feeling they are beyond help (Tatlow-Golden & McElvaney, 2015; Beck, 2006). As outlined above, these factors may well link or be engendered by their past experiences and expectations of systems and relationships. Consequently, LAC expressed in studies that their difficult experiences or traumas fed into their expectation of accepting that this is how life is (Heath & Priest, 2009; Johnson & Menna, 2017; Beck, 2006). This led to findings that LAC attempted to live in the present and accept that these adverse experiences happened and they had to move on and cope. For some LAC in other studies, it also perpetuated the feeling that no-one was available to them because of fragile or unstable support networks (Blower et al, 2004; Heath & Priest, 2009), and they had no one to trust personally and in the care system (Blower et al, 2004; Heath & Priest, 2009; Johnson & Menna, 2017). LAC were quite suspicious of mental health professionals' motives and mistrusted them in some cases (Blower et al, 2004; Beck, 2006; Jee et al, 2014). Following on, studies showed that LAC felt the need to self cope as a result of these

feelings (Blower et al, 2004; Heath & Priest, 2009; Johnson & Menna, 2017; Tatlow-Golden & McElvaney, 2015).

Assuming they know

All but two papers (Stanley et al, 2007; Blower et al, 2004) reported LAC believed that mental health professionals don't or won't understand them and won't 'listen' to what they are trying to tell them. These papers showed LAC expressed that professionals can assume they know what is best to help them. This was met by LAC as professionals stepping out of place as they didn't know or understand the them enough to have this type of input into their lives. Some studies showed how LAC reacted to this with anger, frustration, and the feeling that professionals were being patronising (Fleming et al, 2009; Heath & Priest, 2009; Lee et al, 2006). It also engendered a sense of mistrust. This mistrust came in the form of assuming professionals were there for their job only, and mistrust in telling a 'stranger' their personal problems (Heath & Priest, 2009; Jee et al, 2014; Beck, 2006; Lee et al, 2006; Tatlow-Golden & McElvaney, 2015; Johnson & Menna, 2017). This was also linked to the undertone of unfamiliarity described in the papers from the view of LAC toward mental health care or professionals, which also reduced how much they felt they can access support.

Dual stigma

The dual stigma of being in care and also engaging with mental health services was reported across all nine papers. Findings showed there was concern amongst LAC that their peers would think they were unstable if they were to find out if they were engaging in either social or mental health systems (Jee et al, 2014; Blower et al,

2004; Stanley, 2007; Tatlow-Golden & McElvaney, 2015; Fleming et al, 2009; Heath & Priest, 2009; Beck, 2006; Lee et al, 2006; Johnson & Menna, 2017). There were further findings (Blower et al, 2004; Jee et al, 2014; Tatlow-Golden & McElvaney, 2015) from LAC of labels or diagnostic language feeding into this stigma and being used against them. Further, in some studies, LAC outlined concerns that they would be 'treated differently' by others due to attending therapy or disclosing they were in care (Jee et al, 2014; Heath & Priest, 2009; Johnson & Menna, 2017; Stanley, 2007), along with finding it hard to engage with mental health services due to these possible negative consequences such as being admitted to an inpatient service (Beck, 2006).

Systemic factors

All papers reported a multitude of systemic factors that influenced the help-seeking of LAC. Some findings described how the continuous moves and transitions between placements, people and professionals significantly hindered LAC's ability to form and maintain relationships. They also expected placements to end because of the nature of the system (Tatlow-golden & McElvaney, 2015; Beck, 2006; Fleming et al, 2009; Heath & Priest, 2009). Four papers found that previous negative experiences also contributed to LAC's ability seek help, some due to their own objective reasons (Tatlow-golden & McElvaney, 2015; Johnson & Menna, 2017; Jee et al, 2014) but also due to experiences around unprofessional and inappropriate conduct from mental health counsellors (Lee et al, 2006). Further, papers found that LAC also felt there were logistical barriers in getting to therapy (Jee et al, 2014; Beck, 2006), perceived lack of skill and knowledge on the professionals part (Beck, 2006; Tatlow-golden & McElvaney, 2015) and fear of punishment through

disclosing difficulties or behaviours, e.g. a disclosure being used to influence placement changes or access to services (Johnson & Menna, 2017; Heath & Priest, 2009; Blower et al, 2004).

Lack of autonomy

All but one paper (Lee et al, 2006) reported LAC to state or allude to feeling as though they had little control or autonomy in decision making about their mental health or care planning. This ranged from their language of being put into services or placements (Johnson & Menna, 2017; Heath & Priest, 2009; Fleming et al, 2009), through to being told who to talk to or seek help from (Tatlow-golden & McElvaney, 2015; Beck, 2006; Blower et al, 2004). There were also reports of LAC withholding information as a source of control in their lives, particularly in response to past experiences of professionals disclosing what young people thought of as confidential and sensitive information (Stanley, 2007). Other studies reported LAC held a sense of coercion or forced mental health support (Jee et al, 2014), some of which tied to suspicion – as noted above – of professionals having an agenda in helping them.

Distress barrier

One particular aspect noted in two papers (Blower et al, 2004; Jee et al, 2014) was LAC reporting that their distress itself was a barrier in communicating it to others. LAC in these studies talked of how it felt ‘impossible’ to say how they felt for fear of it being too overwhelming, how they couldn’t find any words to describe their adverse experiences, or distinguishing between easy (sports) and hard (mental health) topics to talk about.

Facilitators

In contrast to barriers, young people in studies reported less facilitators of mental health care access or engagement. The following outline four sub-themes.

Familiarity

Five papers (Jee et al, 2014; Johnson & Menna, 2017; Beck, 2006; Stanley et al 2007; Tatlow-Golden & McElvaney, 2015) outlined how LAC would seek out familiar people to discuss their feelings. LAC in these papers seemed to emphasise a wish for people to ‘understand’ them by having gone through similar experiences. They also described that the people who they sought help from were those who they perceived as knowing, understanding or having some kind of shared experiences to relate to. A variety of sources were outlined within these studies, including case workers whom LAC had a positive relationship with, other young people (including group counselling), foster carers who themselves had been in care, or other ‘formal’ sources such as teachers and youth group leaders. No LAC within studies mentioned those working within the mental health system as ‘familiar’. Some studies however (Johnson & Menna, 2017; Tatlow-Golden & McElvaney, 2015), described that some LAC viewed their care worker as almost a parent, or wished to have one person who knew them inside out.

Parental services

Following on, LAC in included studies described wanting or being able to engage with what seemed like parental qualities in services (Tatlow-Golden & McElvaney, 2015; Stanley et al, 2007; Jee et al, 2014; Lee et al, 2006; Fleming et al, 2009; Heath & Priest, 2009). These papers showed LAC spoke of experiences where

professionals were perceived as authentic, non-judgemental and had the ability to 'listen' to them. This was counter to the perception of professionals 'assuming' they know them, which looked to be professionals facilitating a more trusting space for LAC to think about engaging with help. Consistency and a sense that the professional being there seemed important for LAC in these studies to have a continuous person to go to for support. Further, factors such as flexibility in therapeutic approach were important, particularly the ability to gauge where LAC might be on this 'reflective trajectory'.

Boundaries in not only 'knowing where you are with people', but clear messages on confidentiality and expectations were also important to LAC in the reviewed papers. Out of this, LAC reported to feel like increasing their ability to exercise choice and power over their mental health and engagement with services. This was not only in their say about accessing mental health services or therapy, but also their choices, such as what to talk about, how they manage to attend appointments, and control over disclosures and the timeframe in which this may happen.

Practical support

Authors further reported the LAC found skills based or practical support important (Blower et al, 2004; Jee et al, 2014; Johnson & Menna, 2017; Beck, 2006; Lee et al, 2006). They emphasised how positive engagement in this came from learning skills to manage their emotions, problem solving around life decisions, 'personal problems' to do with health, and getting advice around help with things such as medication or 'man to man' problems.

Professional involvement

When it came to care or health professional involvement, LAC in some papers (Fleming et al, 2009; Beck, 2006; Lee et al, 2006) seemed to report and allude to seeking help from social workers or therapists when they wanted to avoid embarrassment, particularly from people they were close to.

Service development

Studies also reported how LAC felt about how services might improve mental health care access or engagement. The following outlines four sub-themes.

'Ideal' support

LAC, in some studies, expressed that ideally they would look toward those who possess the 'parental' presence listed in other papers (Blower et al, 2004; Lee et al, 2006; Tatlow-Godlen et al, 2015) and below (results). These included 'being there', consistency, authenticity in treating them as a person, trust, and practical support. There was a sense that younger LAC would seek functional (practical) support, whereas older teenagers looked toward emotional needs and valued listening.

Improvements

Service development perspectives centred around improvements in existing services that also tied to some of the barriers above. All but three papers (Lee et al, 2006; Heath & Priest, 2009; Beck, 2006) reported LAC looked to get around 'stigma' and logistics of going to a different health clinic by suggesting mental health services to be integrated in primary care. They voiced how they felt familiar with professionals there as they had established a longer-term relationship and it was more discreet.

Another possible link from LAC in these studies was the lack of moving documents from service to service so they would not have to repeat their traumas or experiences should they access mental health care. Further, confidentiality was a key concern, and how clear boundaries or priorities for this is valued in LAC's opinion. Further, communication of health messages from an early age was felt by LAC in the above papers to help in early intervention.

More than a label

There was a sense from one study that LAC preferred descriptions of emotion without labels (Heath & Priest, 2009). This translated in another paper (Lee et al, 2006) as LAC preferring therapists or professionals to talk to them like a 'normal person' and made them feel like they weren't being 'diagnosed'. Further, LAC in the above studies found diagnostic labels within services and the public mental health conversation as off-putting, preferring services to emphasise much more of talk-based approaches to problems. These accounts seem to possibly link to the idea of stigma attached to mental health terms for these young people.

Familiarity

As a counter to the above 'unfamiliarity' barrier, LAC seemed to value those who understood their situation or had been through it before (Heath & Priest, 2009; Jee et al, 2014; Johnson & Menna, 2017; Stanley et al, 2007; Beck, 2006). These findings explained how LAC felt that this may facilitate the trust or authenticity needed in order for them to feel comfortable enough to seek help from others. From this, one paper (Jee et al, 2014) found that LAC posited the idea of group counselling to gain this familiar space and utilise things like shared experience.

Discussion of meta-synthesis

Despite the varying characteristics of the included studies, themes were synthesised. Findings from the included studies indicate that LAC viewed mental health as something that was tied to social, academic and family factors. Papers went on to describe this leading to difficulties for LAC such as self-harm behaviour or suicide, that then further exacerbated difficulties. Studies also described a conflicted relationship to help for LAC that linked to feeling let down by past parents, mistrust from LAC toward professionals and services, low expectations of help acting as a self-fulfilling barrier, alongside conflict as to who to turn to for help.

As Davies & Wright (2008) found in their review, barriers for LAC accessing mental health services were most prominent from the findings here. Studies in this review described past experiences of family and services that could block their ability to trust services or professionals. These past experiences included low expectations of help from parents and mistrust. Findings also described LAC feeling they had no personal connection to professionals who had not shared their experiences or were suspicious of their intentions of help. In the context of experiencing significant traumas (Oswald et al, 2010), this in turn isn't surprising that if LAC are not helped by those who are deemed to be a safe person – the parent - this can impact on their attachment to others and expectations of how or if they will help them (Davies & Wright, 2008). In the context of services, Reder & Fredman (1996) describe this process as the 'relationship to help'. This is based on Freud's (1895) description of 'transference', whereby individuals recreate the relationships with their past parental figures with their analyst. Reder & Fredman (1996) outline this can also apply to services and professionals, which may frame how the above perceptive barriers manifest for LAC.

Further barriers included the dual stigma of being in care and accessing mental health services hindered help seeking for LAC. Diagnostic labels and language used to describe them perpetuated this. Interestingly, although Davies & Wright (2008) talk about social stigma in their review, their synthesis did not emphasise this factor in their findings as significant for the LAC in their included studies. Systemic factors associated with the care system were also described as challenges for LAC. These included expectations of engaging with multiple professionals, sudden endings, or logistical factors meaning constant travelling or even re-telling of their traumas due to seeing separate teams. These reflect current difficulties with consistency in the social care system (Education Committee, 2018) and findings of other specific studies (Bazalgette et al, 2015; Fargas-Malet & McSherry, 2018). As a product of this, papers outlined LAC as describing a perception of no choice or power in their decisions on help, which is an important consideration for LAC (Munro, 2001). Despite constant moves and subsequent problems hindering access for LAC in these studies, in line with a lack of facilitators (see below), there was little information on what living situations or systemic factors would enable LAC to seek help were they to be able to stay in one place or have consistency with others.

Facilitators were few compared to barriers. The lack of facilitators could be in part due to the varying objectives of the included studies, however this could also be due to a lack of questioning or insight into what these could be for LAC. Studies did show that familiarity was important to access help, however this was described as those outside of the current mental health system. These people or services seemed to be described in a parental manner, particularly being authentic and LAC knowing where they stand with them. Studies did show that LAC named services having

‘parental qualities’ or ‘familiarity’ to foster trust or understanding of their problems (Tatlow-Golden & McElvaney, 2015; Stanley et al, 2007; Jee et al, 2014; Lee et al, 2006; Fleming et al, 2009; Heath & Priest, 2009). This could reflect a wish to experience a different parental figure than that of which they may have experienced in their past, and potentially wanting to create a new relationship to help. Although tenuous, this may also link the ‘reflective trajectory’ (Tatlow-Golden & McElvaney, 2015) to LAC who – consciously or not – might indicate a shift outside of recreating previous relationships to help in expressing a wish to find those who are ‘familiar’ in services or professionals. There were little descriptions however of what and when these qualities were important for help-seeking or engagement.

One important theme outside of barriers and facilitators in this review was also around mental health for LAC. This theme encompassed what LAC felt caused and were the consequences of mental health difficulties. What was missing from included studies in this review was LAC’s understanding or concept of ‘mental health’ and difficulties. Given an understanding or awareness of something is a foundational step in the help-seeking process (Rickwood et al, 2005), this would be important to explore further with LAC. Only one paper in this review (Tatlow-Golden & McElvaney, 2015) explored this, reporting that LAC generally understood ‘mental health’ as thoughts, mood or daily activities. There were few other studies (Bazalgette et al, 2015) that explored somewhat synonymous concepts such as emotional wellbeing, which was similarly thought of in terms of thoughts, behaviours and moods. Interestingly, Bazalgette et al (2015) also relayed how young people in care, and care leavers, described ‘positive’ emotional wellbeing being associated with strong relationships, safety and stability, whilst ‘poor’ emotional wellbeing was associated with the converse of those factors.

Regarding the state of research capturing LAC voices, this review highlights that at present, studies are still working to isolate current LAC voices specifically on their mental health service access and engagement. UK studies in this review still contain care leavers, questionnaire methods or group data collection, and are in a community rather than clinical or mental health settings. This is echoed by Davies & Wright (2008) in their review finding no specific qualitative studies focusing solely on LAC, particularly within a clinical setting. This review, and broader literature cited above, has found that studies have focused on UK LAC voices on their care, education and help-seeking experiences for mental health, yet some are also still combined with perspectives from carers and professionals, and yield mainly barriers. There are also further calls to explore more engagement factors in services for LAC (Fargas-Malet & McSherry, 2018).

The reviewed studies here are average in quality based on the CASP checklist. They have strengths in being methodologically clear to meet their own research aims and aiming to have local clinical and academic implications. The reviewed studies however do have variations in methodologies, sample sizes and compositions, which all serve to mix the perspectives of LAC on mental health care with others. The studies in this review are from multiple countries that also represent multiple social and health care systems, leaving a lack of UK context to existing studies.

Within the reviewed studies, there also factors that are significant to LAC yet seem to be confounded in the published manuscripts. Only three papers were rated on the CASP checklist to adequately consider the researcher and participant relationship, with four not noting this factor. Five reviewed papers were further rated as insufficient in documenting ethical considerations, particularly in relation to managing important aspects of safety, safeguarding and risk management. One

paper did not report any ethical clearance from a governing board. Although publishing has its own limitations on word count, content and the peer review process, the above aspects, as shown below (see Methods section), are important factors that need to be acknowledged and transparent in research with LAC. As such, although the reviewed studies are important for their own aims, there are still few robust qualitative studies focusing on UK LAC perspectives that can be specific to the barriers and facilitators to UK mental health care systems.

Limitations of the review

Despite the variety of included study countries most likely being due to a lack of research within the UK, it still confounds the data and interpretations made within the synthesis. This could be seen as causing the predominance of barriers within the results. Factors such as the variety of methodologies, samples and aims within the included studies further confound the idea of reviewing the experiences of LAC, particularly from a UK context. As such, the depth of synthesis was kept more toward the descriptive end of analysis.

Implications

Despite the limitations, the aim of this review is to be good enough in its searches and evaluation of the current evidence base, particularly in recognition of the difficulty and effort in finding qualitative research (Thomas & Harden, 2008). From this review and searches, although the evidence base is growing, there seems an imbalance of studies on the perspectives of UK LAC on barriers and facilitators to mental health care, particularly in relation to the perspectives of those caring for and working with LAC. This is despite organisational (Association of Child

Psychotherapists, 2018) and political calls (Education Committee, 2016) for LAC voices to continue to be heard.

Next steps

More studies are needed to gain more of UK LAC perspectives on what they feel enables or stops them from accessing and engaging in help for their mental health. As they are the individuals who are using the services, their perspectives are an important part in understanding why they do or do not access and engage in services. The broader literature and included studies paint a picture of complex factors impacting on what LAC perceive as enabling or preventing them from accessing mental health care in the UK. Factors relate to their attachment styles, past traumas, stigma and systemic difficulties. Research addressing this gap should also consider, from a professional view, how to 'balance' protection of LAC with a rights-based view on listening to this excluded population from research (Davies & Wright, 2008; Lundy & McEvoy, 2011).

Thesis aims

This thesis addresses the above gaps in the research. It looked to address clinical, political and organisational calls by focusing on LAC perspectives of mental health care access and engagement.

The aim of this project was therefore to explore LAC's perspectives on barriers and facilitators to mental health care access and engagement in the UK. It also looked to explore clinical, social or personal factors that influence screening, access and engagement in services.

Chapter 2: Method

Epistemological position

When considering the aims of this project, it was thought best approached through a critical realist epistemological stance (Bhaskar, 2008). This position has been used in relation to mental health care access research previously (Ramsden et al, 2015). It acknowledges that a reality ‘exists’, however supposes that we cannot fully capture an ‘objective version’. Instead, examination of narratives can aim to capture as much of a reality as possible. This can be undertaken through methods such as thematic analysis (to gain the knowledge) and reflexivity (to acknowledge and examine construction of the knowledge from the data as being filtered through inherent researcher bias and position).

There are disputed perspectives on how much qualitative methods such as thematic analysis can truly capture or represent reality given inherent researcher bias and subjective interpretation (Sword, 1999). It is none the less important to capture as much of a reality as possible. In relation to LAC, as shown above, the reality of their situation in relation to mental health care access and care is an important topic, one which LAC voices are lacking at present. As such, it seemed important in capturing that reality - and their voice on this - that the epistemological position and analysis attempts to represent as much of their perspectives as possible. Through these perspectives and insight into the reality of mental health care access for LAC, it may be possible to emphasise clinically relevant points that can help services understand what enables or stops these young people accessing or engaging in mental health care and services.

Methodological context

Recommendations from an NSPCC report (Bazalgette et al, 2015) into LAC services emphasise emotional wellbeing through the care and health system. It outlines a need to incorporate priorities such as: taking a proactive and preventative approach; giving young people a voice; and influencing, supporting and sustaining children's relationships. Policy and political views on LAC services further emphasise that LAC voices need to be heard when considering and planning mental health services and LAC engagement (Education committee, 2016).

A United Nations bill outlines the right for children's views to be heard and respected (United Nations, 1989). Several considerations on how this happens have been described in research, notably by Hart (1992). He notes that some individuals feel that children should not have a voice to influence decisions on a societal level, particularly due to the view they should be protected from such responsibility. Hart goes on to argue how learning responsibility can also come through collaborative activities with other persons that have more experience or are older.

Hart subsequently outlines the 'ladder of participation' (Hart, 1992) (see figure 2). In this, each rung is divided by the level of involvement, meaning and power to which children have an influence over the project process, and translated into categories that reflect each level. These rungs range from manipulation – children used as symbols of a cause with no understanding of their actions - through to child-initiated projects that utilise shared decisions with adults for guidance. Hart goes on to recognise that instead of viewing children as providing unreliable information, particularly in qualitative studies, research instead needs to be sensitive to children's development and find alternative ways to maximise rapport and their abilities to communicate. Although Hart didn't explicitly address LAC, the

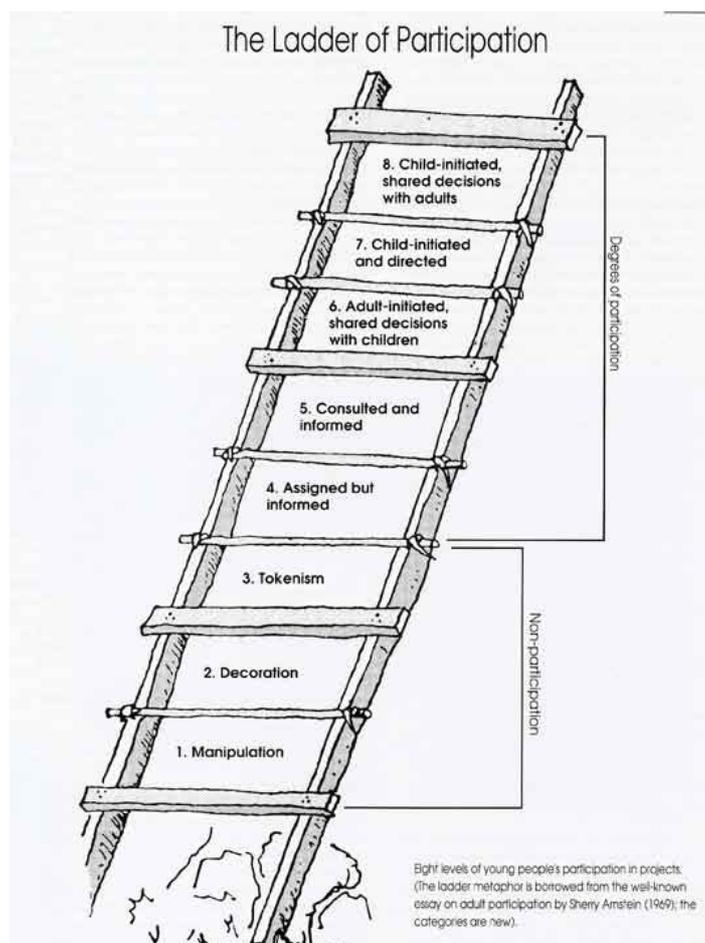


Figure 2. *Ladder of Participation* (Hart, 1992 P.8)

importance of addressing the inherent power imbalance that comes from not only perceived societal or age differences, but the positions of participant and researcher (Grover, 2004) is also important to consider in studies.

Building on this, more specific perspectives on child's rights to have their voices in research have been outlined more recently. This is particularly in the context of participatory research becoming 'fashionable', with concerns that at some point, it can be used as a regressive tick box exercise for services as opposed to an avenue for service users to create their own discourse and outcomes (Beresford, 2002; Beresford, 2007).

McNeish (1999) therefore discussed considerations such as transparency about beliefs of child participation ('vulnerable' vs adding valuable insights),

particularly on a service provision context, alongside young people being consulted on their experiences of services within their skills, confidence and comfort levels. Others have elaborated these considerations for children to think about comfortable and familiar contexts, rapport, confidentiality and opportunities to feedback (Fargas-Malet et al, 2010) all as adding to more specific factors influencing where research may land on this 'ladder'.

A more recent report by Lansdown (2011) looks to build upon Hart's (1992) work by thinking about approaches to participation with children by reducing the 'rungs' to either consultative, collaborative or child-led research categories. These however need to meet basic requirements, similar to those noted above, such as; 1) transparency 2) voluntary 3) respectful 4) relevant 5) child friendly contexts 6) inclusive 7) supported by training 8) safe and sensitive to risk 9) accountable.

In the context of this study, there were several factors influencing where it might fit into these participatory contexts. This was a Doctoral project with time and resource limitations on how much children could influence the research design process, therefore young people were not included as research partners or within a participatory element for research or topic schedule design. Hart recognises that those who have difficulties with self-esteem, or differences in areas such as social class, need particular considerations on how they are involved or included in research. Given LAC have been shown to be likely subject to both (Blower et al, 2004), particular thought needed to go into how much involvement is appropriate for them. Converse to this, professionals – including the author - deeming how much involvement is appropriate for LAC can also be problematic and hinder both progress up the ladder and their perspectives being heard (Davies & Wright, 2008; McNeish, 1999).

Based on the above factors, this project is felt to sit on the ‘assigned but informed’ rung of Hart’s ladder, or the ‘consultative participation’ level of Lansdown’s model. Importantly, although no participatory element was included in the research process, the design outlined below looked to meet ethical and participatory aspects as much as possible whilst attempting to reduce power differentials between the author and participants. In short, this project looked to be transparent about its design, abilities and limitations via information sheets. It aimed to include professional network involvement and feedback in design and risk management. The information sheets looked to enable young people to understand the intentions of the project and make informed decisions. As per the above meta-synthesis, it further aimed to be relevant to the research gap. The project itself further aimed to consider LAC comfort in being in a child friendly and familiar context in their clinical setting. To ensure safety, it looked to be supported by the authors clinical and research training in the interview and feedback process as well as being risk appropriate. Importantly, the research was under scrutiny and accountable to wider organisations such as the Health Research Authority (HRA), the clinical team’s NHS trust and the University of Essex.

Methodological reasoning

One could argue that these young people may have grown up in an environment where everything is ‘assigned’ rather than being given a choice. This could be where they live, their foster parents, social worker or many other factors that life and professional systems decide for them in their best interests (Munro, 2001). The inherent power imbalance that is already evident in the participant and researcher positions could well be amplified through the author also being a clinician. It can

also be argued that not having participants here as research partners created further imbalance in power. In addition, the trauma's that occurred and led them to going through these systems may well have also impacted on their emotional and physical wellbeing, including self-esteem (Richardson & Lelliot, 2003). All of the above may impact how valid LAC feel their contributions are in contexts such as research, and how much they feel they can control and influence the systems around them to make a difference for themselves or others (Hart, 1992). As such, it was important to consider how, in the face of the above barriers to child participation and power differentials, ethical adaptations could be made for these young people to ensure they feel able to voice their perspectives amongst inevitable power imbalances. Managing this whilst aligning with the authors pre-set aims to understand barriers and facilitators to mental health care access for this population needed further consideration, along with guidelines for child participation (Lansdown, 2011).

One qualitative methodology that was thought to balance LAC's perspectives with the hoped clinical impact and guidance was semi-structured, one to one interviews. The flexibility of a semi-structured topic guide, along with a one to one space (with support if needed) may have helped young people to feel able to participate in a safer way as opposed to focus groups. Alongside this, to facilitate them being able to voice their perspectives, factors such as: familiar people (carers) being involved in recruitment and interviews; separate information sheets for young people and carers; time to discuss with their carer's and professionals; and receiving feedback on findings may have enabled them to feel they had a meaningful role in participating. It may also have enabled them to feel that their perspectives and input were valuable, in turn opening them up further during the interview. It is important to recognise that in having a carer present in the interview, alongside the

research/clinician relationship, this may be a presence that influenced or impacted on the data, particularly as carers are also part of a system that holds power over these young people. It may also however have enabled LAC to express themselves more with a familiar person present.

Aligned with this, inductive thematic analysis, a noted method of qualitative methodology (Braun & Clarke, 2006) was thought most appropriate to apply to LAC perspectives as a way to continue to amplify their voices alongside deriving any barriers or facilitators that may be specific to them. A lack of transparency in showing how outcomes and results have been derived from thematic analysis has been noted (Nowell et al, 2017). This method however does offer flexibility in its approach. It offers a choice to inductively (data driven themes) or deductively (results driven by researcher ideas or focus) analyse data. It further offers a choice of analysing data on a semantic (descriptive) or latent (researcher interpreting meaning in the data) level. This choice is felt to be important in novel or new areas of research. This is felt important as it can be seen as a strength in being able to ensure the analysis method is suited to meeting the aims of the research (outlined below) rather than being a rigid research design.

As such, the inductive position adopted in this research derives outcomes that are data led as opposed to fitting themes within pre-existing frameworks or analyst preconceptions (Braun & Clarke, 2006). Given the imbalance of research with LAC, it was felt important that the methodology enables the perspectives of LAC to be heard as much as possible whilst hopefully deriving clinically valid points for their access and engagement to mental health support. Although complete neutrality in qualitative research is unobtainable (Sword, 1999), these data were coded at the semantic (descriptive level) prior to interpretative analysis into relevant themes.

'Trustworthiness'

The above considerations demonstrate the complexity of qualitative research. A framework to navigate these complexities would be useful to consider here.

'Trustworthiness' in qualitative research is based around the incompatibility of the concepts of 'reliability and validity' in positivist – the assumption there is an 'objective reality' that is constant and available to access through study (Lincoln & Guba, 1985) - research (Shenton, 2004). Set criteria from Guba (1981), discussed more recently by Shenton (2004), state how comparable considerations in qualitative studies can help in providing rigorous and transparent research. These considerations are: Credibility ('how congruent are findings with reality?'); Transferability ('how likely it the study to be applied to other situations?'); Dependability (Transparent research design to allow scrutiny); and Confirmability (Weighing participants ideas with that of researcher biases). Given the aim to hear LAC perspectives in relation to mental health care access whilst considering how their experience might relate to others' in similar positions, it is important to set these criteria against this study. It would be important to be transparent about how much this is possible and how this might be strived toward in future projects.

Credibility: Triangulation with other data collection methods such as focus groups was not undertaken. Focus groups are also not included in line with the above idea of facilitating a more comfortable environment in one to one interviews for LAC. Although supervision of the analysis process could aid in reducing the authors subjectivity in deriving themes, no independent rater analysis of the data was undertaken. The author did however attempt to familiarise themselves with the culture of the recruitment team through site and team visits to discuss research,

recruitment and risk management processes. In the qualitative studies with LAC in the introduction, these studies have utilised a shared qualitative methodology to this project in thematic or grouping analyses. Further, the research design in this study has implemented a process where choice from the LAC is paramount, which according to Shenton, may then facilitate motivation and ‘honesty’ in their accounts through a willingness to participate. The authors clinical background and training also adds to rapport building, which in turn could minimise the power imbalance felt between participant/researcher or clinician and LAC (Munro, 2001).

Transferability: This project was conducted within one particular LAC mental health team from a specific area of the UK. It further employed a small sample of young people (aged 12-17) on a caseload of over 100 within the team (all ages up to 18). Each interview was cross sectional and up to one hour, which also included carers within the interview where the participant wished for them to be present. Further, there was a lack of child consultation and participation in the research design and process. Having these young people as research partners could have particularly improved understanding of how best to include looked after young people in the recruitment and interview process, the topic schedule design for appropriate language and topic of questions, along with reducing the power imbalance between the author as a clinician/researcher and the young people who are Looked After. All of these factors are acknowledged as having an impact on the amount the findings can ‘transfer’ to other LAC within NHS mental health care contexts. The idea of ‘transferability’ is not however as clear cut as generalisable findings from more positivist research (Shenton, 2004). Given the dearth of research into LAC perspectives on barriers and facilitators for mental health care, this project

can firstly add to the evidence base for this population and their views. There are arguments from Shenton (2004) that projects such as these can further add to novel research areas through being part of a wider agenda, whereby a developmental approach to understanding this topic can grow rather than be revealed. Specifically for LAC, Holland (2009) emphasises that adding to the evidence base in a variety of ways is particularly important at present given the lack of understanding for this area. The project here is therefore thought to ‘transfer’ into a growing foundation of methodological and LAC perspectives of mental health care. In turn, what is important is that it ‘transfers’ the perspective and voice of LAC for academic and clinical impact whilst being aligned with national objectives (hearing the LAC voice).

Dependability: The full research design of this study is outlined below. Shenton does posit that replication of qualitative research is problematic given the naturalistic and changing nature of the aim of enquiry. It is none-the-less important to outline and be transparent regarding the study design and process. This may be particularly important here as, given the lack of research in clinical settings with LAC and mental health care, providing transparency may be useful in a wider context for future research and accountability of the findings here.

Confirmability: As stated above, ‘objectivity’ within this project’s epistemological and research position is not obtainable. As a result, Shenton (2004) describes the importance of making clear how the author and their experiences shaped research design, data collection and data analysis. In this project, this concerns how much of the LAC voice was captured on barriers and facilitators, how they were discerned

from the author's beliefs or pre-dispositions, and what steps were taken to ensure this difference was clear for as much 'objectivity' as possible.

Shenton (2004) indicates one key criterion for confirmability is triangulation. This project does employ some form of triangulation to reduce author bias in analysis, namely analysis supervision. In-depth methodological description (below) is further outlined by Shenton (2004) as important to ensure clarity on the research process and data trail, from collection to analysis. Limitations and a reflective account of the author's beliefs and their influence on the project and outcomes will also be outlined in the discussion.

The authors assumptions of LAC and how they were mitigated are important to consider here however and hold in mind throughout the results and discussion. Notably, aside from the general adolescent experience, the author has no experience in the context of being looked after, their life stories and traumatic experiences. Relating to the experience of LAC is therefore based on assumptions created through other knowledge bases, such as literature and clinical experience. In the context of the systematic review above, this unfamiliarity in relating to their experiences can be a barrier to them expressing their views or engaging. This was named as LAC relating more to 'familiar' people who have been through similar traumatic experiences and systems (Jee et al, 2014; Johnson & Menna, 2017; Beck, 2006; Stanley et al 2007; Tatlow-Golden & McElvaney, 2015). Without this familiarity, barriers to building rapport and enabling meaningful participation in expressing their views may form, such as LAC being unable to relate to another who has lived their life in relative safety or being an authority figure with significant power, such as a clinician *and* researcher, or even their carer (Totton, 2009; Berger, 2015). In this study, the level of engagement is important to ensure LAC feel able to

voice their perspectives on their mental health care as much as possible and ensuring their voice is the predominant one, thereby minimising the authors influence and perspectives.

There are several general considerations to minimise this difference. Despite not being familiar with aspects of LAC adverse or traumatic lived experiences, the author can relate through the general adolescent experience. Further, of benefit is that the author is continually practicing and receiving training in reflective practice – clinically monitoring one’s own history and reactions to clients in therapy and the impact this may have in turn on the clients – as part of their training on the Clinical Psychology Doctorate.

Guidelines were also utilised in relation to what Berger (2015) calls the authors ‘removed’ position and experiences of not having been in care, and how they may have influenced the research process. Although there are negatives in being in this ‘removed’ position, the guidelines emphasise that studying ‘others’ (not sharing the participants experiences) can be advantageous in ‘empowering’ the participant in sharing experiences that only they have been through and survived (Day, 2008), particularly in marginalised or vulnerable groups such as LAC. New perspectives or directions from the author being in this removed position are also highlighted as useful in being able to come from a ‘fresh perspective’ on the topic. It is further suggested that avoiding a patronizing stance is important given the above power differences. Further, embracing ‘humbly’ the position of uninformed (of not going through those experiences) and requesting feedback and guidance from participants on these topics was also sought. The above have been taken into consideration within this project as outlined below. In addition, using academic supervision from those with extensive experience in LAC research was utilised.

Design and methods

Research question: What are Looked After Children's perspectives on barriers and facilitators to mental health care access. Further, what are the clinical, personal or social factors that influence access and engagement?

Study setting: This study recruited participants from one LAC mental health team. Interviews took place at the clinical site of this team. This was the main site for recruitment and data collection in this project. This site was thought appropriate given the possible familiarity to young people and carers and appointments being held with the team at this centre. This also allowed close proximity to the service offices and clinicians in the event of risk or safeguarding concerns needing to be addressed.

Data collection: A semi-structured interview schedule was constructed based on existing literature surrounding mental health access for young people (Gulliver et al, 2010) and social care guidance for this population. Topics focused on specific factors of the LAC service, through to generalizable topics in relation to LAC and CAMHS. These topics included existing and exploring further barriers to mental health care in the LAC system and beyond, along with discussing facilitators to care access (appendix 3). Discussions with supervisors, social care service managers and LAC mental health teams informed both the topic schedule and considering the appropriate length and location of interviews. A guide was also consulted (Galleta, 2013) to ensure construction and implementation of these interviews were able to elicit participant views as much as possible through order of and creating open

ended questions with LAC in mind. Due to time constraints in the project, no participatory involvement was undertaken on this guide with LAC.

Sample: A sample of five young people was recruited. Opportunistic sampling was employed via a recruitment pack being given by the service at each young person's clinical appointment. This offered participation to as many young people as possible within the inclusion criteria of this project. These five participants are hoped to capture some range of experience and insight from young people in care to address the aims of this study. Further, although this sample size can be noted as appropriate within guidance for qualitative research (Ritchie et al, 2014), this project is more focused on Braun & Clarke's (2015) emphasis on the importance of the finer and nuanced points that create shared meaning between LAC perspectives and the interpretation of the author. In the context of thematic analysis (see below for analysis outline), they further emphasise that what the data represents, along with how and why it is significant, is more important than a predetermined sample number. It is felt particularly relevant here given the aim of this project, which is to understand LAC's perspectives rather than, as outlined in the introduction, others' voices or statistics on their mental health care and access.

Inclusion: Any young person between the ages of 12-17 years old who completed screening, assessment or engagement with the recruitment LAC service. Interviews were either individual, or where the young person preferred another presence, it was possible to be accompanied by their responsible carer, case coordinator or mental health and social work professional involved in their care. In order to include a

diverse range of experiences, the project aimed to recruit young people from different backgrounds, ages (between 12-17) and care arrangements.

Exclusion: Any young person under the age of 12, or those who may be deemed by a qualified professional to not have the capacity to participate in research due to lack of informed consent and insight into the process and their participation.

Recruitment: Considering the ethical focus on research with this population (Rhodes, 2015), extensive discussions with the clinical team were had to ensure the research did not interfere with their relationship to the LAC and their emotional wellbeing. *Start of recruitment pathway* - The author did not have access to participants' care or clinical records. The clinical team identified each young person on their caseload between the ages of 12-17 years old that matched inclusion criteria. Each young person and carer identified were given an introduction letter by the clinician at their individual clinical appointment, along with age appropriate information sheets and consent forms. As a necessity (those under 16) or good practice (those over 16), carers with delegated authority to make general decisions regarding the young people in care were involved as much as possible in decision making to participate. The young person and carer / Local Authority (LA) had time to consider (minimum of 24 hours) and opportunity to discuss their participation with a member of the service during their next clinical appointment with the team or by calling the team. There were variations of recruitment pathways:

Young people under 16 where delegated authority is held by the carer - After their clinical appointment, if the clinician felt the young person was suitable for the

study and has capacity to decide on their participation, the clinician signposted the young person and their carer with delegated authority to the author in the named clinical site. The author checked understanding of the information and obtained consent from the carer and assent from the young person following questions.

Young people under 16 where delegated authority is held by the carer and, at the clinician's discretion, it was useful or necessary to inform the LA of participation – Where young people registered interest in participating and prior to attending their next clinical appointment, clinician's, at their discretion for care and clinical needs and good practice, were able to contact the LA independently from the author to highlight the young person in question. Clinicians were able to provide information sheets and request consent from the responsible social worker. The social worker could then forward the relevant consent form with **young person initials only** to the clinician or author via nhs.net or gov.uk emails for secure transmission of the form. The clinician then informed the author of the relevant time of the young person and carer appointment (without disclosing personal details) to resume recruitment pathway.

Young people over 16 - the same procedure as those under 16 applied to over 16's. However, should the young person have wished to consent against the advice of their carer (and they have been deemed to have capacity and understanding of the project by the clinical team in their prior appointment), they were able to do so. Carers permission was always sought if possible, along with discussions as to why there may have been conflict of opinion between the young person and carer and how this could have been approached. See figure 3 for study recruitment pathway.

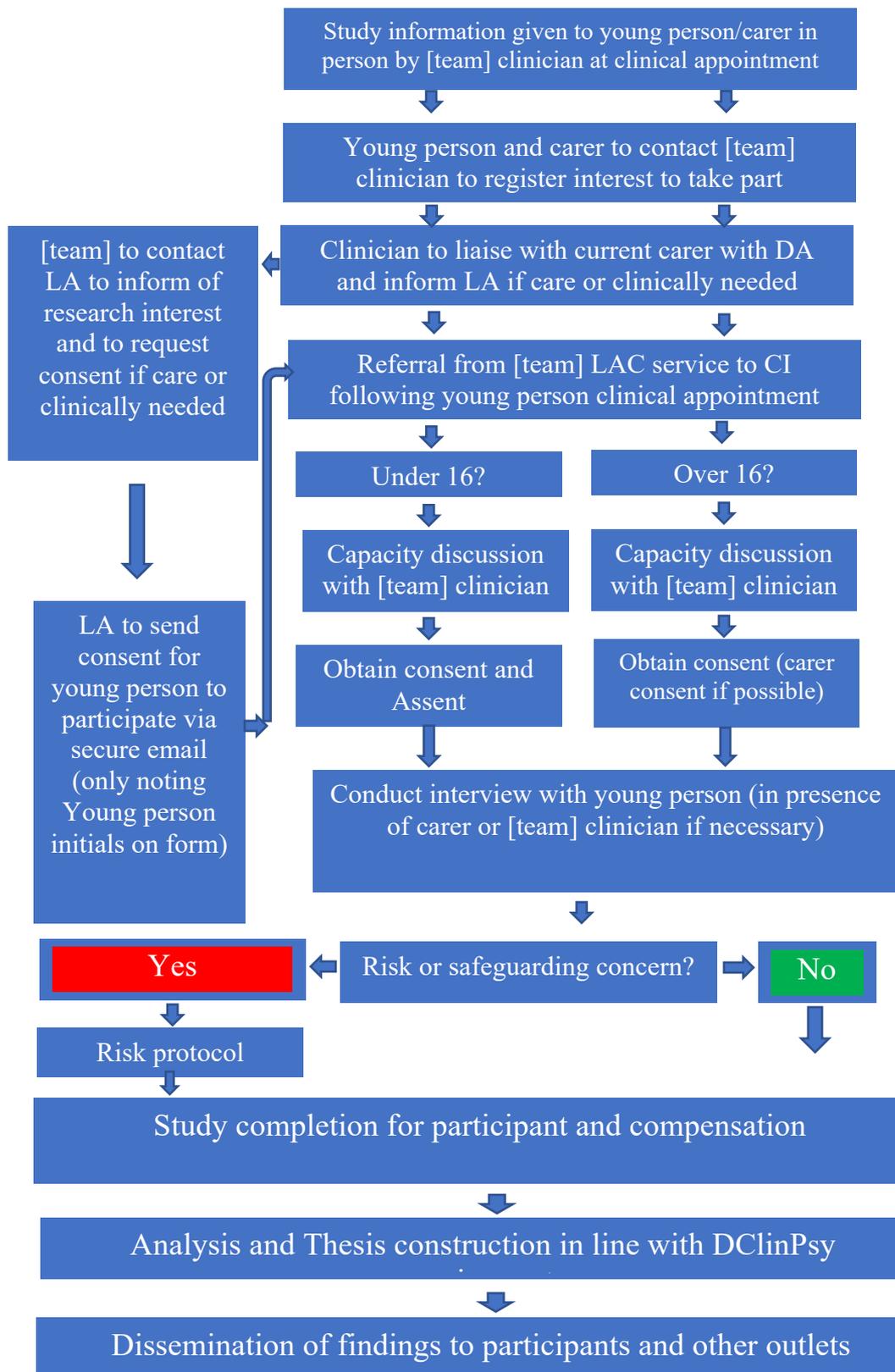


Figure 3. Recruitment flow chart

DA - Delegated Authority CI – Chief Investigator

Data Collection: Interviews were conducted at the clinical site. These were arranged to take place at the same time as an appointment to see the clinical team to save cost for family travel. Data collection was in line with the clinical team working hours in the event of any risk or safeguarding issues needing to be discussed immediately. Interviews were aimed to be between 30-60 minutes and were adjusted depending on young person's age and engagement.

Ethical and regulatory considerations

Approval: Ethical approval was obtained from the Research Ethics Service Committee London – Camden and Kings Cross (Ethics reference: 247010). Following this, ethical approval was then obtained from the University of Essex ethics committee and the clinical recruitment team's NHS trust research and development departments (appendices 4-6).

Amendments: One substantial amendment was submitted on 24/07/2019 (amendment reference: 1) and approved by both the Health Research Authority (HRA) and the clinical recruitment team's NHS trust prior to any recruitment being undertaken (appendices 7-9). This was due to concerns from the clinical team that sending the invitation and recruitment packs by post may raise concerns from the young people and carers involved with the team regarding their data protection. The team were concerned that in turn, this may interfere with their relationship with their clients. As such, a substantial amendment was submitted to amend posting these packs to all eligible young people and their carers, to the team giving these young people and carers the study recruitment pack in person as and when they attended a routine clinical appointment. The rationale would be for potential participants to feel

more comfortable with receiving the study information, along with the space to ask questions around the project should they have any.

Assessment and management of risk and safeguarding issues: A risk and safeguarding protocol was devised to link with risk and safeguarding policies from the clinical team's NHS trust in the event of any disclosure of risk to self or others requiring action, or criminal act being disclosed (see appendix 10). This was devised in relation with academic supervisors and the clinical team in which the participants were drawn from. Consent and/or assent and confidentiality conversations with participants explicitly outlined events in which this protocol could be invoked. This project did not directly ask about risk or safeguarding issues. This project was also conducted where participants are under the care and policies of the specific NHS trust in which the team was situated, therefore this study protocol was devised as a pathway to inform the team and to link to their clinical policies only. No clinical management was undertaken within this project.

Confidentiality: Interviews were carried out in a familiar and confidential setting for the young person (clinical team site). This was to ensure safety for all participants and researcher. Confidentiality was outlined in detail prior to data collection, and the exceptions in which confidentiality may be broken for duty of care/safety to self or other reasons.

Consent: There is no statute within England that determines a young person's right to consent to non-clinical trial studies. It is usually assumed that young people between 16 and 18 years old can individually consent to participation in research.

However, given the potential vulnerability of these young people, the following considerations were taken into account. For this study, those under 16 were always required to have consent from the individual or carer with delegated authority, or if useful or necessary for care or clinical needs, the LA/responsible social worker for the young person, along with assent from the young person themselves. Those over 16 were able to consent individually. Discussions with the young person's carer or professional care co-ordinator were conducted to determine competency or capacity. Participants were given information from the clinical team (see recruitment), therefore were given time to consider consenting to participate and ask questions upon receipt of the information. Capacity was checked in accordance with clinical judgement from their clinician (see recruitment) prior to signposting young person to the research project. All information concerning the study, consent forms and opportunities to ask questions was given when they received the invitation package from the service and checked again at face to face meeting with the author.

Data protection and confidentiality: All investigators and study site staff complied with the requirements of the Data protection act (1998) and the General Data Protection Regulations (GDPR – 2018). Personal data (email addresses only for this project) are kept no longer than 12 months after study completion for result dissemination purposes. Research information is kept up to 5 years (on University of Essex computers) in order to ensure completion of Doctoral Thesis, and any amendments needing to be made to this post-course completion.

Personal identifiable data was anonymised and participants given unique code numbers. The use of personal information included carer emails for disseminating results to participants. No personal home addresses of the young people were

sought. Aforementioned personal data was kept on a secure password protected spreadsheet on University of Essex secure servers. A second password protected spreadsheet (separate to participant number spreadsheet - on University of Essex computers) was then kept with this unique number to record other demographic information, for example age and gender.

No other personal data was stored outside of the clinical team's IT system.. Consent forms with personal data (full names) were stored in the clinical team's site in a locked cupboard. These were transferred from the clinical site via scanning (at the clinical site) and secure NHS email transfer (author holds an nhs.net email). These were then saved to the University site and servers to avoid physical transport of named consent forms. The clinical team also had a physical record of young people participation in research for their clinical files if necessary.

Research data containing no personal identifiable data was kept on the author's password protected laptop and encrypted with passwords on each file for further protection. It was emphasised to young people to avoid using names during their interviews to avoid personal identifiable data being captured in transcripts and analysis files. Post-project completion, the research data was archived and stored on the University of Essex servers. Research data is to be anonymised in publication via redactions and/or pseudonyms, which was outlined in consent forms.

Data will be destroyed after a maximum of 5 years post-study completion. This is to allow for any access to data in accordance with DClinPsy qualification completion or publication needs.

Indemnity: The University of Essex provided indemnity against negligent harm caused as a direct result of an employee's or a student's actions. The author was a

student of the University at the time of Doctoral studies. The sample of young people recruited in the project were also under the care of the LAC team, who are part of a specific NHS Foundation Trust, and therefore were also covered under the NHS indemnity scheme.

Access to final study dataset: The author will have access to personal information (emails) collected for the research project only. Both the author and their academic supervisors have access to research data, and the LAC clinical team only had access to data collected for research purposes on a need to know basis (e.g. risk management). No other individuals had access to personal information or research data on participants.

Participant factors: Compensation for time and effort was facilitated in the form of £10 amazon vouchers for each young person who participated, and a written record of adolescent signatures/co-signatures from responsible adult was kept via a receiver sheet to confirm compensation (appendix 11). These funds were provided by the University of Essex student facilitating research fund board (appendix 12). The benefits of this research were also highlighted to the young person in terms of developing service provision and research into a relatively unknown area of study, along with valuable – and anonymised – feedback to the clinical team for service improvement. Harm to participants, reasons for research and other relevant research descriptions were outlined in the participant information sheets.

Thematic Analysis overview

An inductive thematic analysis approach (Braun & Clarke, 2006) was undertaken on all semi-structured interviews to obtain insight into LAC perspectives on mental health care access and engagement. All interviews were audio recorded and transcribed verbatim by the author, and data analysed with the aid of the NVivo (Version 12). The below outlines the steps outlined by Braun & Clarke (2006) that have been undertaken in this project:

- 1) Data familiarisation – re-reading of data; note taking; transcription
- 2) Generation of initial semantic codes – Grouping coded segments of data
- 3) Searching for themes – Broadening groups into potential themes and sub themes
- 4) Review of themes – internal homogeneity (coded data being coherent within themes) and external homogeneity (themes being coherent in relation to raw data). Generation of a thematic map.
- 5) Definition and naming of themes – defining individual theme meanings, along with their relation to the broader ‘story’ of the research question
- 6) Production of the report/thesis

A thematic approach was is thought best suited to capture common themes within and between groups on key questions such as barriers, facilitators and mental health care pathways and outcomes. As outlined above, the flexible nature of this method allows a good fit to study design and relations to healthcare research, and both study and interviews will benefit from this research process and data collection method.

A reflexive account is included within the discussion. Given the vulnerable population, along with the personal and professional positions of the researcher, it was thought sensible to consider the impact of the interviewer (author) on potential biases and interactions within the data. An account of the analysis trail is provided below in **Results**.

Dissemination

Outcomes of this project will be disseminated via various avenues. Thesis construction was the primary outcome of this study. There is further scope for secondary practical dissemination; a report constructed for the clinical team in this study, LAC services and other relevant stakeholders within the NHS trust in which the LAC team is situated. Feedback in the form of a newsletter to participants regarding the outcomes of this study and its findings will also be undertaken. Further academic dissemination will also be; publication of study findings and qualitative qualities within social welfare and/or psychological journals; presentations to relevant clinical or social care authorities; as well as academic conferences.

Chapter 3: Results

Sample

This project recruited five LAC who were interviewed face to face. See table 2 for participant characteristics. Four participants chose to have their carer present in the room during the interviews. Ann chose not to have their carer present and was over 16 at the time of interviewing. Of note is that recruitment had to be halted as a consequence of the Covid-19 Pandemic. This stopped face to face contact in the clinical service where recruitment was being undertaken. This is explored in the discussion.

Participant number (Pseudonym)	Age	Sex	Legal Status	Placement type
1 (Dan)	12	Male	Long-term Foster care	Long-term
2 (Ben)	13	Male	Long-term Foster care	Long-term
3 (Joe)	14	Male	Long-term Foster care	Long-term
*4 (Ann)	16	Female	Long-term Foster care	Long-term
5 (Jay)	17	Male	Long-term Foster care	Long-term

Table 2. *Study participant characteristics * Carer not present in interview*

Thematic Analysis process

Inductive Thematic Analysis was undertaken in accordance with Braun & Clarke's (2006) approach. Following each interview, audio files were transferred to the authors laptop, deleted from the dictaphone, and transcribed verbatim by the author. Each file was transcribed directly and immediately after each interview as opposed

to transcribing when all data was collected. Each interview was transcribed into a word document, and then imported into NVivo software to aid analysis.

Each interview was listened to repeatedly during transcription. Following completion of transcription, each interview was then listened to at least twice more. These were to initially ensure correct transcription and familiarisation of the data.

Progressive semantic coding was undertaken when each interview was transcribed, checked as outlined above and imported into NVivo. This was as opposed to when all data collection was complete due to time constraints on completing the project in line with DClinPsy thesis timelines and deadlines. There are no recommendations against this in Braun & Clarke (2006). They do recommend a systematic approach with an emphasis on in depth familiarisation of the data, which the above transcription, checking, familiarisation and systematic approach to each interview aims to achieve. Each transcript was analysed one by one for semantic codes.

Semantic codes were developed by systematically selecting segments of text from each transcript – from start to finish of interview - that pertained to a particular topic or interest described in that selected segment. There was no limit on the length of text coded or amount of semantic codes that were derived from groupings of text segments. This was then repeated systematically, one by one for each transcript. The author reviewed semantic codes across the data set once data collection was complete, and the last interview went through transcription, checking, familiarisation and initial semantic coding. This was to evaluate this stage of semantic analysis along with re-familiarising with the data.

Broader and interpretative themes were progressively devised from such semantic codes. Semantic codes were grouped based on their content to

progressively develop the broader themes. These were further reviewed following completion of all codes being grouped to provide an overview of internal (themes being internally cohesive) and external homogeneity (themes being related to the raw data) of the developed themes, along with how they fit with the overarching research question of the project.

Following this, analysis supervision on the process and NVivo file was sought to review the semantic and more interpretative themes. This was sought on two occasions between March-June 2020. The first supervision served to consider, discuss and reflect on the semantic and interpretative analytic process at that point. The second supervision session continued this, whilst re-checking internal and external homogeneity of themes. It also set the developed themes against the research question, the story of the data, and aimed to mitigate the authors own bias and beliefs in data analysis. Given the impact of Covid-19 on data collection for this project, supervision also helped with accounting for the richness of the data. Given ‘Saturation’ has been considered a recently misused concept from Braun & Clarke (2019), the idea of ‘enough’ data was also reflected on. Data collection was subsequently stopped given the Covid-19 situation (an inability to recruit face to face), DCLinPsy timelines and a richness of data with the included participants here.

From transcription through to developing interpretative themes, analysis notes were taken to start ‘writing’ as soon as possible (Braun & Clarke, 2006). Such notes helped inform the analysis process by gathering the authors questions and reflections on the data for semantic and interpretative themes. The notes also served to reflect on the authors own position and impact on the data, along with how psychological theory might start to relate to what participants were expressing.

Results overview

Overall, 24 subthemes were categorised in seven superordinate themes. See table 3 for thematic matrix of superordinate and subthemes. The seven themes derived included – 1) Understanding mental health and emotional wellbeing 2) Perceptions of responsibility for help seeking and engagement 3) Help seeking with others or services 4) Engagement in services 5) Appreciating the parental qualities of the service 6) Developing reflective capacity in young people? and 7) Service development. Barriers and facilitators are discussed within Help seeking and Engagement themes. Personal and social contexts were intertwined with barriers and facilitators. In turn, it is hoped they show there is a wider and complex picture that feed into barriers and facilitators.

Figure 4 outlines a thematic diagram for the developed themes. Within this figure, connections between each theme are posited. Each line denotes a possible link or pathway between themes and subthemes. Sharp rectangle boxes denote superordinate themes. Soft cornered rectangles denote subthemes. Important information is written on links for context.

Themes are outlined in depth below, with supporting quotes. Themes and their connections are complex, therefore the diagram is an aid for visual reference on how themes may interact for young people’s barriers and facilitators to engaging and accessing mental health services. An example pathway of connections could be explained with reference to young people encountering *barriers to help seeking*. The *stigma* they encounter may be parallel, but not interacting factors, of being in *care* and having *mental health* difficulties. In turn, they encounter separate *judgement* from others for *both factors*. This may then contribute to another *personal barrier* to help seeking, namely ‘burying’ their distress rather than seeking help.

Understanding Mental Health and Emotional Wellbeing	Perceptions of Responsibility for help seeking and engagement	Help seeking with others and services	Engagement with services	Parental Service	Reflective capacity	Service development
Concept of Mental Health	Family responsibility	Housing and Home	Barriers (Systemic)	Parental qualities	Age	Parental service qualities
Causes of Mental Health	Friend responsibility	Barriers (Stigma, Personal, External)	Facilitators (Bridging the gap, choice, therapeutic and parental qualities)	Connecting these qualities across contexts (home) and relationships	Not wanting to repeat the past	More information needed on mental health and services
Consequences of Mental Health	Systemic responsibility	Facilitators (Home, Getting to know and being known, Systemic)			Understanding their past and recognising change	
Emotional wellbeing	Self-responsibility				Understanding their current difficulties	
Perceptions of other Young People with Mental Health						
Perceptions of young people getting help for Mental Health						
Signs of Mental Health						

Table 3. *Thematic matrix*

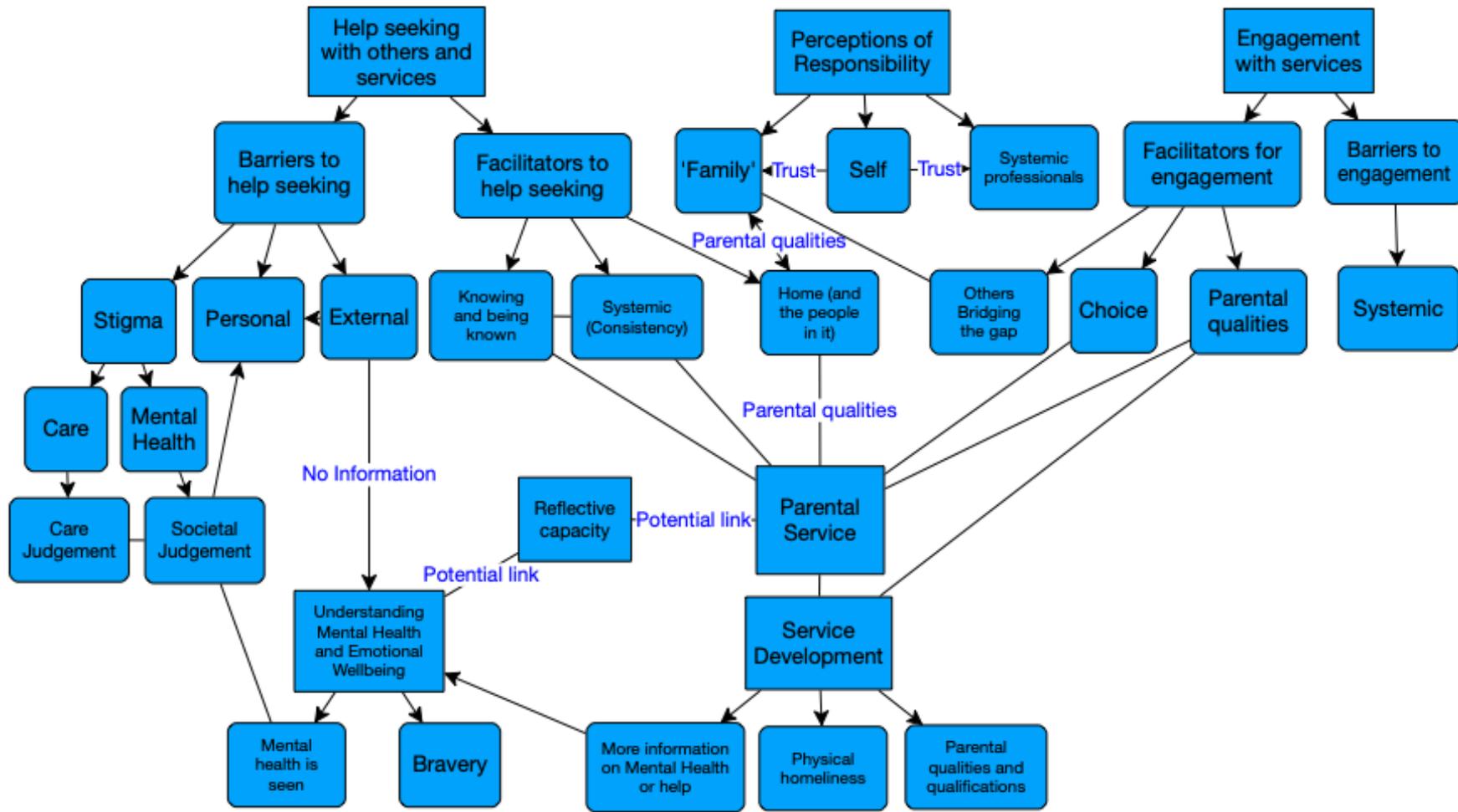


Figure 4. Thematic Diagram

Understanding mental health and emotional wellbeing

Participants were asked about their understanding of the word's 'mental health', 'emotional wellbeing', and how they perceive others with mental health difficulties and who seek help. Understanding and perceptions of 'mental health' are important to explore how this impacts on the help-seeking process.

Participants understood the words 'mental health' in many different ways. Dan expressed negative connotations to the words 'mental health' (see below). Ann considered 'mental health' to be a neutral term indicating overall health. Remaining participants found that the term mental health indicated a 'problem' or 'illness'. Ben voiced that mental health as an 'illness' can leave people open to judgement:

So where like, someone's like ill, [...], people judge people just by like, their look, there's like the saying don't judge a book by its cover, like people judge you by how you look and how you act, but they don't know that you've got like, like mental problems (Ben, 13)

Several participants went on to describe emotional wellbeing as not being so distinct from the term 'mental health', stating that both terms described similar things to do with emotions or thoughts. The interviews were therefore tailored to what term the participants preferred to use. Dan felt however that emotional wellbeing was more 'human' in its description of distress:

[...] wellbeing sounds better than mental health. Sounds like mental's like whoa, you got mental health, but then if your wellbeing, it sounds like you're well in your

being. Your body being, so human being, so wellbeing, [...] sounds better than mental health (Dan, 12)

Only one participant – Dan - described what they thought caused mental health difficulties. He spoke of past trauma or stress as a direct cause of the difficulties that looked after young people may experience. Further factors were confusion due to constantly shifting care arrangements:

[...] I had to leave my mum, and my sister [...] I was fostered, and then, my little sister was fostered, but then me and my little sister were split apart [...] And really that's just stupid cause there was a thing on the radio saying about how it affects people if they're separated from their family. [...] there's a shortage of fostering but they should be put together, cause, [...] they can get depressed, they can get upset...
(Dan, 12)

The majority of participants were able to describe the consequences of mental health difficulties. Joe stated mental health was traumatic and stressful. Dan and Ben described it can lead to wanting to escape their current lives through alcohol, drugs or self-harm. Dan described this as a 'second life' or 'different mindset'.

Despite mixed understandings of mental health, four of the five participants were able to attribute observable consequences that they or others would notice if someone were having difficulties or distress. Some described day to day activities being impacted, such as not being themselves or behaviour and routine changes, along with other indicators such as not being clean or looking fatigued. More

distinct indicators included young people explicitly telling others that they were being hurt, having outward expressions of distress such as crying or self-harm:

um, not having all their clothes or having, or being clean, or having bags under their eyes

Author. do you think they might do anything else, or might say anything else, that might let other people know that they're really struggling?

Self-harm, so when they self-harm and other people can see, and that's when they need to tell someone (Joe, 14)

In the face of mental health being an 'illness' and the impact it has on lives, there was a perception across several participants that those who experience and seek help for mental health difficulties are 'strong' and 'brave'. This was in the face of mental health difficulties making young people stand out in comparison to others:

um, like they're brave and that they know that if they, if they get help for it then they know that they'll, they might overcome it (Ben, 13)

Author. what do you think that label does when other people see this person has mental health problems?

It really makes you stand out in some ways not good at all (Ann, 16)

Overall, participants had mixed understandings of mental health. A majority described it as a problem, illness or in negative terms. There was no distinct preference for other terms such as emotional wellbeing, however Dan described this

was a more ‘human’ term that may not instil a sense of it being an ‘illness’ or something to be judged. Although there were some descriptions of coping by drugs, alcohol and self-harm, what was apparent for the majority of participants was the noticeable consequences of distress on activities, emotions and behaviours. Participants felt that young people who had experience of mental health or help-seeking were brave in standing up for themselves. They were overcoming a perceived difference in ‘standing out’ or being ‘judged’ from others, and from that came a positive message that help-seeking is important.

Perceptions of responsibility for help-seeking and engagement with services

Participants described who they felt had responsibility for help seeking or engagement in services. This was felt important to explore given the high number of carers and professionals around these young people, and if there were any distinct others who they look to or value for support.

All participants referenced family as holding responsibility to notice their difficulties or help them engage in services. There were no particular sex of carer or ‘parent’, however these were family that were relationally close to them:

I'd definitely think my foster carer, although if someone offered me help I would probably listen to anyone in the family (Jay, 17)

Several participants elaborated that this was based on the family or carers knowing or understanding the young person, listening to their distress, or participants being able to trust them enough to feel comfortable to disclose their distress to them:

[...] they understand you [...] Even though you haven't told 'em, they can like they can read you like, read your body posture [...] they can tell if you're like, sad grumpy and that, cause sometimes you can like, you can just show it by your face and that (Ben, 13)

Alongside family, systemic responsibility of teachers and social workers was noted by three participants (Ann, Ben, Joe). They described how these figures provided confidentiality or discreetness should they not want to go to their carer. This is however underpinned by a need for these young people to have consistency and trust with them for this to happen:

Social workers I think as well. Being able to, cause if you move into care, your social worker can stay if you want them to, if they're not leaving or anything, so you should already have trust with them if they're not new, or you can build it up with a new one anyway [...] and you can have that discreetness of hey, can I go see this person and talk to them, and it doesn't necessarily have to be a foster carer (Ann, 15)

Friends were also viewed by two participants as having some responsibility for noticing or helping young people seek support.

One factor that three participants (Ben, Joe, Dan) mentioned was their own responsibility to seek help. These three expressed that young people have to take the first step in order to let people know they were in distress, particularly to trusted people:

Author. Who in the home do you think is responsible for getting that young person help for their mental health?

Well technically it's your [his] responsibility (Dan, 12)

um, that if they're keeping it to themselves they should like, like, tell people who, or friends who they know who they can trust (Ben, 13)

Participants described trusted people - family or consistent professionals - are those who are responsible and safe to notice, listen to or support young people in accessing help. This is in line with previous research, but also connects to a need for such individuals to be trusted and hold strong relationships with young people. A portion of participants also referenced themselves as responsible for seeking help. They described including trusted others, such as peers, teachers and social workers may provide a sense of confidentiality or discreetness. This discreetness however may also come from the self-responsibility noted above, or possibly even concerns of being 'judged' should they tell others of their distress.

Help seeking with others and services

Help-seeking was explored, particularly what participants perceived as barriers and facilitators to this. Stigma, their current living situation, the relationships in their placements, and who participants view as 'responsible' in these relationships were discussed. These factors are described in barriers and facilitators to help-seeking below.

Barriers to help seeking

Stigma

The majority of participants described and alluded to stigma when they were asked about the words or experience of ‘mental health’. Although participants described ‘mental health’ briefly above, they predominately focused on these words as mental health difficulties or problems. In turn, several participants described the label of ‘mental health’ as making them ‘stand out’, being ‘mental’ and an ‘illness’ that causes you to be ‘judged’ (noted above). One participant described that this serves to reduce a child to an ‘other’ to be judged rather than someone to get to know:

You look at someone else you judge them, but then you can't really do that. You have to get to know them, you have to talk to them. If no one judged anyone we would all be in a better lifestyle, everything wouldn't be bias. That's the word (Dan, 12)

As such, some participants described feeling different from others. The majority of participants expressed concerns that in having mental health difficulties, this would drive others away as they would not understand the young person's circumstances:

Author. how likely is it do you think that people will judge you if you have a mental health problem?

Sometimes it's like very likely. Like if they're like, people who don't know that you have like the problem, they would judge you without even getting to know you and it's like just like, you go up them and they just like run off or something (Ben, 13)

It makes you stand out in some ways not good at all. [...] We sort of see it and we don't know how to cope with it sometimes, and it can be at homes, or it can be with peers around you, it can be anything but you do notice it and some people react differently to others (Ann, 15)

In connection, all of the participants were astutely tuned into what they perceived to be prevalent societal stigma toward those with mental health difficulties. Several participants felt that this was driven by a lack of understanding on mental health difficulties in the public domain. Similar to Ben above who felt that people are judged by others in not opening their 'book', Dan expressed this in more depth:

People go with their lives thinking about their self, people are so obsessed about what they look like [...] someone could have really nice clothes and then they could be quite poor [...] it's like judging a book by its cover really. You can't really do that, you have to open the book and read about them, that sounds a bit weird, but you have to know them, you have to talk to them, you have to help them. If they got a bad page, or a page ripped out, that might be because they don't want that memory, or they don't like that about their personality.... (Dan, 12)

Ann elaborated that due to this lack of shared understanding on mental health difficulties in society, they perceived this to make young people 'stand out'. Further, they felt this also leaves more top down attempts to explain these difficulties (such as isolated TV interviews or programs) not being enough to understand or capture what these are like to experience:

[...] I feel like a lot of people don't understand mental health or truly get what it means, and you see it on the TV, and you see people sitting down having interviews on national television and they try to explain it but I don't think people truly grasp what it means, and so it kind of, it's a big factor in why I think people can't speak out because there's no understanding or, sort of, education about it (Ann, 15)

No participant explicitly described dual stigma of being in care and mental health difficulties. There were several participants – Dan, Ben, Joe - who were able to describe the stigma they felt due to being in care. This was in response to questions around what might hinder young people in care seeking help. They described what seemed to be a double-bind position; wanting others to know their story (as mentioned above in ‘Understanding mental health’), but when they reveal any part of this, others then use it against them:

Author. ok. So you have people that you would go to, to help you. Is there anything you think would get in the way of...

[cut off author mid-sentence] People who like, who do judge you of how you act, or like just people who, who know like your story, and take that for advantage for them, for like picking on you, bullying you, and that, cause I've had that before (Ben, 13)

Ben went on to say how this can then make children in care question who they can tell their story to, and how much they can then trust others. Joe elaborated this can be to the extent of lying to others and dismissing their ‘real family’:

If you tell, uh, if you tell people that you're in care then they take the mick, then you sometimes just tell them like lies, saying that you're not in care and that you're back with your real family, but even though the carer's turn to be your real family because they look after you and care for you (Joe, 14)

As a consequence of stigma and not fitting into societal expectations of 'normal', some young people did not want to seek help for fear of judgement and standing out:

[...] a lot of people will become overly nervous about speaking out about something, about them which isn't normal, or the society's norm, and so it would become difficult for them to book an appointment or say to someone that they need to see someone or something like that (Ann, 15)

Stigma of mental health difficulties was therefore a significantly felt experience and barrier for participants. They talked of a lack of public understanding due to little education for others, leading to prevalent societal judgement. Participants further described being stuck in a double bind of wanting others to know their story to understand their distress, but parts of their story also being used against them due to stigma of being in care. These factors then made it difficult to seek help as they could not trust others with their stories for fear of 'standing out' from societal norms, which, for adolescents developing their identities, may be very difficult.

Personal barriers to help-seeking

Not recognising or being able to overcome mental health difficulties was a significant barrier for several participants. Ben and Joe described being 'too young'

to recognise their difficulties in the past. Further, in contrast to those young people who are 'strong' in seeking help, Dan felt mental health difficulties and distress itself be a difficult barrier to overcome and seek help:

you can either be really scared, you could have a bladder problem, you could do this [seek help from someone], I then oh ok, thank you, and then you feel lighter and be like oh, that was quite easy why did I never do that a year ago or something. But then people say, wait, why could I not do that, but for other people it's very hard to do that, so they struggle talking about their feelings, they could be depressed, they could be uh, emotionally unstable (Dan, 12)

Following on, those who did recognise their own difficulties found themselves 'burying' it, with four of the five participants expressing this. Several participants (Ben, Ann) described holding their difficulties in due to being unsure how others will react or worry that others will think it's 'bad' that they are in distress. Ann described how young people can be worried that institutions such as schools may not understand and minimise their struggles if they tell them. She described young people not wanting to be told they were 'wrong' about the amount they were struggling. Dan and Ben went on to describe how burying it can lead to being 'sick' or, as noted above (in 'Understanding Mental Health'), to the point of having no option to but seek ways of self-coping:

[...] you got those people who just bury it, and like, it's like oh, it'll go away eventually, but then it just gets worse, and then their like oh ok I can bury it even more, but then it gets too heavy that it's like, well, it's the end so then, it's like that,

you can just feel like you do anything. Like, you wanna kill yourself, you wanna do drugs, you wanna do something that makes you in a different mindset so something what makes you like a, second life really.... (Dan, 12)

Dan and Ann described that although they recognised their difficulties, there was a lack of connection or internalisation of their past family experiences that contributed to not understanding these difficulties enough to either recognise/accept help:

Author. How much choice or power did you think you had in that process of being brought to the doctors?

Um, at the time, it felt forced because I wasn't used to having support, so it felt wrong and it felt indifferent, and something that shouldn't be happening and it felt like, the only reason why I was getting it was because I was a child in care and had I been at home, or had I been somewhere else, it may not have happened... (Ann, 15)

External barriers to help-seeking

Participants also described barriers from 'others' or systemic issues. Participants said 'others' who are meant to be safe (parents, schools), directly or indirectly hindered help seeking. Dan described being threatened from an adult to 'kill [him]' if he were to disclose his difficulties related to the home situation. Joe and Ann said how carers or teachers who 'don't care', 'don't talk to them' or dismiss and minimise their difficulties can be a liability themselves and hinder help-seeking. Several participants elaborated that this can leave young people feeling powerless and without a voice, as they take in the narrative of 'adults know best':

[...] growing up it was hard to open up to people cause it's like, you're a child or, a lot of the time you'd hear it's not that bad, it's stress, it's this, it's that, and so, it was constant knocking you down, making you feel like maybe you shouldn't look for help, maybe you shouldn't reach out and ask and then it becomes serious when that builds up and builds up and builds up and someone tries something that they might regret, and so it kind of sucks (Ann, 15)

All five participants also noted systemic barriers. These centred around those who are meant to be safe individuals or organisations, such as schools, social care or mental health services. Ann said how they felt the school pastoral system left young people feeling unheard. She went to elaborate that schools can also be part of a postcode lottery in the response they have to help seeking:

Mainly because I feel like, where your school is and how your school does in the system, affects the type of treatment you get as a student, and so to have something outside where those factors don't matter and to just, be more medical than, medical than school (Ann, 15)

There was a perception from several participants that the social care system also hindered their help seeking. This was particularly in reference to not feeling familiar or safe enough with new people to express their difficulties:

Um, it really depends on how you view where you stay as a child in care, because if you feel a bit ostracised where you stay, because you're new there or cause you struggle opening up, it can feel like you're a liability to your foster carers, even

though they're dedicated to be there for you, they didn't sign up for the job to sort of, not be there for the children they want to look after (Ann, 15)

Jay elaborated on situations where constantly meeting new people, such as frequent placement moves, significantly stopped him feeling as if he had enough continuity to get support. He also described the reverse as also hindering help seeking - the constant changes in staff, such as residential homes:

[...] there were so many people that came into that residential setting, I couldn't really differentiate between them. There were many staff members. I think 30 possibly, and I'd never see the same one on a day to day basis, there'd be weeks between seeing them because there were so many, as well as, the families of the other children there, um, they would come in, um, independent visitors, and there were just so many people it was impossible to differentiate between someone directly helping me or just another visitor (Jay, 17)

Lastly, all participants either could not name mental health services for children in care or young people, or they referenced a lack of information in the public domain as hindering help seeking. One participant (Ann) only knew of third sector services from friends or their current mental health service, linking with her above comment of the school lottery who could point them to services (if they told others of their distress) to seek help.

Barriers to help seeking included personal barriers such as not recognising difficulties, an internal fight to bury or express them, along with aspects of their past experiences that might stop this. Connecting to this, stigma seemed to feed into

burying difficulties in concerns around how others will react. This could also link with participants' concept of mental health as an 'illness', young people's sense of self-responsibility to seek help, or potentially in relation to negative past attachment experiences, expectations of help, or indeed 'relationships to help'.

Externally, 'others' were described as hindering help seeking, primarily from those who are meant to be safe 'others'. This was either directly intentional via threats, or school or carers not noticing or diminishing their voices. Participants also noted systemic barriers. They described not knowing about services and needing to be lucky to know or be in contact with others to let them know help is available. For those in care, constantly moving placements, or those around them constantly moving was difficult. This is poignant as it stopped any consistency or trust being built with, or even differentiating, safe individuals such as those in a 'family' who may be responsible for noticing or helping seek out support. In these 'safe others' being inconsistent or unreliable, this is may also be another double-bind that leaves young people without a perceived safe other to turn to.

Facilitators for help seeking

Housing and Home

Participants were asked about their previous and current care arrangements in relation to their concepts of a house and a home. This was explored to gain insight into factors such as the relationships to individuals living in their placements, and how this or other factors may relate to help-seeking or engagement with services.

Several participants talked of a house as a physical property they had no deep connection with, for example a friend's house. Joe went on to describe a house in relation to negative feelings:

[...] a house is where you can stay, and you're not loved (Joe, 14)

Ann summed up the transition from feeling unloved in a 'house' to having a sense of belonging in a home. This was engendered by a place of safety from the stress of life:

[...] home is where you feel comfortable, and where you get home, you take off your shoes, you take off your bag, and you just sigh with relief, because your day is done and you can relax and having that feeling where you don't have stress of I'm going through someone's door, this isn't where I belong, it's a very different feeling (Ann, 15)

Ben elaborated on the above. He described how a house is 'not sturdy' or where you would be comforted, whereas a home gives you a sense that you can 'trust the place'. He described that it 'won't fall on top of you' 'physically and mentally'. When asked to elaborate, he described that it is those in the home can stop a home falling on you mentally.

Several participants elaborated on the emotional connections to their current home that transcended the physical properties or negative associations with 'houses'. They talked of those in the home meeting their basic needs such as food and having a room. Dan talked of 'feeling secure' in a home and someone being there if they were upset or if things go wrong in the home:

uh, well technically, if someone has mental health and stuff, uh, if you could, if you're, if you, if other people could go to that house to like unwind or something

that would be much easier for them, and they could feel secure or there's other stuff, they feel good about themselves [sic]. If they felt upset (Dan, 12)

Following on, all participants described how it was predominantly the connections to the people who live in the house that made it their home. They spoke of the feeling of family as a foundational aspect of making it a home for them:

Um, like the people around you in, in like the place. So where like, where like, the house can like, well the home can like give you any, like loads of like different feelings and that. Like it can give you comfort, love and that. Yeah (Ben, 13)

For Jay, he noticed a stark difference in having a home in foster care when compared to other care settings he had been in, such as residential care:

Life is so much better than my time in a residential. Um, we have two dogs and a cat, which is amazing, considering there were no pets allowed in a residential, um, and also, it's a family setting, which is so much better than a residential because, I've been accepted as part of a family, and they treat me like I was their sibling (Jay, 17)

He elaborated further, describing how he felt accepted by being included in planning and attending family events, such as staying at the foster carer's daughters houses on the weekends and being included in Mother's Day meals.

Overall, there was a sense that participants considered a house as being a distinct physical property. It held negative connotations for some as a place where

they reported being unloved or unhappy. Conversely, a home was described as something transient, made by those around them. Echoing aspects of ‘secure’ parental attachment, a home provided a sense of security, comfort, love and belonging that stemmed from family or ‘safe others’ being there for them. As with ‘secure’ attachment, all of these factors were also important to repair things when they ruptured or went wrong within the home.

Getting to know and being known by others

Exploring the concept of a home was important. This was explored above as, given young people in care do move into and between placements, they are likely to encounter ‘houses’ and ‘homes’ dependant on people within them. What the above section distinguished was participants attributing a home to the type of people and relationship qualities within it. Participants here described parallels to these people and relationships to those that enable them to seek help.

Initially, several participants expressed a turning point where they decided to seek help instead of burying difficulties. This was for several reasons. Dan reflected on seeking help to not repeat his past experiences prior to going into care:

Well at first I was like oh, new people, great. But then, if you think of memories, like you have to move every 5 seconds, been to like 26 schools, boring stuff, like lahdeedahdee stuff. You have to go to new, you have to stay at this place, wait at train stations, you have to get cars. It’s just all that all over again, but when you’re younger you don’t really notice that, but then when you get older it feels odd, it doesn’t feel right (Dan, 12)

Ben reflected on expressing their distress at the ‘right time’. He connected with this in line with the above idea of young people being ‘brave’. Ben said that providing someone is there who they can trust, they may be able to go from thinking about, to expressing their difficulties rather than ‘burying’ it or self-coping:

Um, just like courage and like, bravery sometimes. But then sometimes it could like be, like, so where you’re like so sad that you just tell them. Like you’re just like confused about it and just want to like ask someone or tell someone about it (Ben, 13)

Connecting with someone ‘being there’, all participants emphasised that there was a relational factor in knowing others, and being known by these others, that facilitated seeking help. This was described as a difficult process:

Because at first you’re like, [...] oh ok can someone help me [...] if you have a door but it’s locked or there are lots of doors that are locked, they slowly open all the doors then you can get through to them, and then they eventually help you. If there was a house on fire, you have to open the front door, and then you go up the stairs [...], and then there’s all this debris on the floor, and then you have to avoid all that, then you go into the room, get the person, then go back down the stairs or chuck out the window or whatever (Dan, 12)

To facilitate this knowing or being known, there was a predominant description of parental relationship qualities – similar to those in a ‘home’ - from others toward the participants that took time and effort. Ben described that at the start, it is those who

are consistently ‘there’ for the young people, including ‘family’ and carers, teachers, social workers and friends. Others listening to and hearing young people’s voices was a key factor. Both being there and listening were connected to others noticing or understanding the young person’s distress:

Um, the main things is, actually listening and talking and being able to be heard and when you’re struggling it’s a lot more open (Ann, 15)

They’re the best mum and dad ever, that they understand you like, and what like what’s been happening and that. Even though [...] you haven’t told ‘em, they can like, they can read you like, read your body posture and that, and like they can tell if you’re like, sad grumpy and that, cause sometimes you can like, you can just show it by your face and that (Ben, 13)

Coming from or running alongside the above factors - consistently being there, listening and understanding – for all participants was the significant factor of trust in who they turn to in order to seek help. Some participants felt this was important for young people in care who may have not had this previously, particularly having a home and safe ‘others’ to trust:

Um, well when I first began to talk to him, I didn’t really like him, it felt odd seeing someone new, but then when you see them, you get, you get to know them more, you slowly get, give them your trust, and um, he, they, um, tell you more what their jobs are about and they says oh you can tell me anything and I won’t judge you and all

this other stuff, and they say I'm open and everything and so, just gets better from there really (Dan, 12)

Sometimes when its new people you wont trust them for a little while, but then when you get to know them, then you will (Joe, 14)

Ann went on to describe that over time, these qualities and 'getting to know and being known' process facilitates trust with these 'safe others' to seek out support if necessary. Ann described her own responsibility to express difficulties, but also others' responsibility to be there, listen and understand. She described this slowly built trust and conversations around difficulties, which also facilitated accepting help rather than feeling unfamiliar or indifferent toward it:

Author. ok. What did they do to help you get over the rough start?

um, be supportive but also let me have my own space, and to feel like they were, had to constantly be around me. I was, happy being where I was, but I was checked up on, didn't have meals alone, I was having them with them, but I didn't necessarily have to say anything, and it was nice to build up trust and slowly build up conversations (Ann, 15)

[...] I was in a rough patch. I just come into foster homes and I finally settled down and everything, but my mental health was all over the place and, um, something was found in my belonging that very worried them, so I was brought to the doctors and they were like, you need to be open, and so I opened up and said I was struggling

with mental health, and so I was referred here, and yeah, that was kind of mainly it (Ann, 15)

Systemic factors

Systemic factors were the other aspect for participants when seeking help. These factors included consistency within the system as important. This related to consistency in participants' placements and with social workers, primarily to feel they have permanency, trust and a place to call home where they feel safe:

Author. why would you think having a home is important for young people who might want to reach out and get help?

Mainly because if you're trying to get help, you don't wanna go back to a home where you don't feel it's a home. You could have a big session where it's very stressful for you, or you could go to the doctors and or even just come home from college or school or primary school with an issue in your mind, and have to hide that and not feel like you're supported or loved or happy where you are (Ann, 15)

Um, uh, something quite minor, but having the same social worker would help, because I again have had multiple, um, and, I've never had the same one for more than a year really (Jay, 17)

Across help seeking, participants described complex factors that feed into barriers and facilitators. For barriers, participants described stigma, personal and external barriers to help seeking that are reviewed above. Participants went on describe facilitators that counteract these barriers. 'Homes' and those who make them were

important and described in almost 'secure' attachment language. This centred around parental relationship qualities in 'safe others', such as consistently being there, listening and understanding. Participants described these factors contributed toward a meaningful process in getting to know and being known by others. In turn, somewhat epistemic trust was built and those responsible, such as 'family', were available to them via strong relationship or attachment experiences. This then may have enabled them to seek or be open to receiving help rather than burying distress. These 'others' weren't exclusively carers as social workers and consistency in the system was also important. However, 'family' within a 'home' was a significant relational component of the above processes to instil trust and aid help seeking.

Engagement with services

Barriers and facilitators to Initial (after seeking help) and continual engagement (with one particular service) were highlighted by participants in the interviews. Some participants referenced previous or current engagement with their mental health service, whilst others thought of past experiences of other mental health services and how this might impact generally for looked after young people and their engagement with services. The above factors such as participants' living situation, relationships in their placements and systemic factors were prominent. The subthemes have been clustered under barriers and facilitators to service engagement.

Barriers to service engagement

The majority of barriers to initially engage with any service was expressed by all participants as due to practical or predominantly systemic factors. Practically, Ann described the logistics of travel to a clinic as difficult for some young people.

Regarding systemic factors, Ben described these as inconsistencies in the system, such as staff absences causing clinician changes. Connecting with this, Joe expressed lack of choice when initially attempting to engage with services, particularly around referrals to a clinician they did not like. Jay and Ann also described how they had been bounced from one service to another in the past through referrals. This caused Ann to have to open up to new people, or Jay to feel unheard after being referred to many services he felt were inappropriate for him.

Relational barriers (to clinicians) were also described that hindered initial engagement. In reference to past services, Ann described feeling that someone was just there for a 'pay cheque' rather than being there for the young people or their love of the work. Connecting with relational barriers, several other participants felt like their carer's were more aligned with their current clinicians than them, which made them feel the session was more for the carer than them:

Author. do you think it makes a difference having her [carer] in the room?

Well, mmm, she's always talking anyway. No one talks to her at home, so, she comes and talks here. It's like, you got like, me who comes, and that's the whole point, I come because Dr [Consultant Psychiatrist] wants to talk to me, but then you got, bob the builder here [carer] who's like well I talk, and ah, centre stage (Dan, 12)

For continual engagement, four participants (except Joe), in relation to their past services, talked about more prevalent issues such as having no information of some referrals or no felt sense of choice attending clinical sessions. Several participants described how this lack of choice caused dissonance between a young person and

services, hindering any meaningful engagement. Jay illustrated how, in a past engagement with his current service, this can be a mismatch within therapy:

[...] I didn't really know how art therapy was gonna help me because I can't draw. So, although it wasn't about that, it was more the talking, um, I just felt that, I'd have a go and attend the session, but I wasn't sure whether it would help with the situation at hand (Jay, 17)

Overall, participants described systemic inconsistencies and no choice as engagement barriers in other services, or past engagement with their current service. Changing clinicians, locations and teams all fostered a disconnect and hinder young people building, as described above, important aspects of relating to others and positive attachment – understanding, trust, consistency. This would also hinder the opportunity for services or clinicians to provide a possibly different experience to young people's past relationships to those in caring or helping roles. In not having choice, some participants also gave into to others' suggestions (Jay), replicating 'adults know best', and possibly perpetuating the inherent power imbalances that already exist between clinicians and young people in care. For participants, this created dissonance between them and services, further creating distance due to them going along with support that adults suggest rather than what they feel may help.

Facilitators to service engagement

Participants expressed multiple facilitators that addressed the above barriers. These included others bridging a gap between them and services, choice, therapeutic qualities, alongside 'safe others' with parental qualities.

For initial engagement, most participants described how safe and trusted others created a bridge to engage with their current services. Several participants described their carer helping them relay their story or facilitate trust when seeing a clinician for the first time:

Because like um, as like, they know 'em, like, as they know 'em and they introduced you, then you know that you can trust 'em more than like, than like if you can if like you're just like, if just like your mum knows them or something (Ben, 13)

Contrary to the barrier, having choice was a key factor to initially engage in services. Particularly in reference to their referral, four participants expressed the important role of a familiar carer or social worker in discussing it with them before proceeding. Jay expressed how these discussions can be helpful in consent and collaborating:

Yeah my foster carer asked me beforehand whether or not I thought the sessions would benefit me and we both agreed that they would, so we both tried to organise it (Jay, 17)

Joe also described having consistent communication with his social worker in relation to his opinion on his referral. He interestingly stated that having a choice of accepting or declining this referral was unexpected, which could be an indicator to how much power or voice he or other young people feel amongst adults making decisions around help. He also highlighted an important factor in the motivation to then engage if a decision feels within their power or they are heard:

Author. so the social worker asked you if you wanted to come back here?

Yeah

Author. what was it like having a choice of whether you can come back here or not?

Unexpected, cause I, it helps a lot, but I can have the choice of if I wanna carry on or if I wanna stop (Joe, 14)

Following on with continual or re-engaging with services, there were three participants who knew of clinicians within their current service from other support groups or past engagement. This was important in not having to re-tell their story to someone new and already having trust with a familiar person:

Author. what's that been like, seeing the same people when coming back?

Fine, cause then you know them and you can trust them (Joe, 14)

Further, Dan alluded back to choice within the therapy room in relation to continuing with his current service. Tying in with taking time to know each other and being there, he described a process that recognised his choice in what help he would like to receive or make use of:

Mhmm, and then uh, with [art therapist] I saw her more so she got to know me more and then I was quite open with her if I wanted to and If I didn't feel sad or anything.... (Dan, 12)

Therapeutic qualities were also alluded to and valued by participants as something that facilitated continual engagement. Participants however did not put much

importance on any specific therapeutic models, which indicates that, although they may not know any models, they could have also valued most a therapeutic approach that incorporated the parental and positive relationship qualities noted above. This centred around the finer point of knowing and getting to know others. Ann notes that this even starts with the bond a clinician has with their job. She goes on to elaborate that, converse to the above (in engagement barriers), those who may have this bond with their work instil a sense of ease and calm in getting to know others:

Author. what do you think it is about them that makes you think, I can open up to them?

Um, I think it's the feel of who a person is. So, when they walk through the door you can get a basic understanding of who this person is, and a lot of people here are really nice and just sort of calm and really do treat you like you're a person, and do treat you like you're your age, not a child or an adult, you are who you are, and it's good to be treated like that because there's a lot of people who treat, especially 16 year olds as children, but, a lot of us don't want to be treated as children (Ann, 15)

The process of getting to know and being know was recognised by most participants as hit and miss at times. Collaboration was an important factor in getting through this, both in negotiating confidentiality or managing the depth of the work into their history and difficulties. Balancing this depth whilst incorporating other aspects such as fun were reported as valued aspects of their current support:

Author. what's the one thing that really stood out for you that helped with that person 4 years ago?

Um, she was like funny (Ben, 13)

Finally, those in services with relational and parental qualities were by far the most voiced aspects of engagement facilitators by all five participants. They described factors they felt were most important to engage young people in care generally. Participants' experiences of their own help will be outlined below in 'Parental Service'.

As with help seeking, a sense of others consistently 'being there' was voiced as important for young people in care. This included multiple aspects such as being seen in a familiar environment or seeing the same therapist. Several participants described a need for services to be there and available for young people outside of their appointments:

[...] if you're upset or if something went wrong that day you can discuss like, how you feel, what's happening, um, if you're like, you can be open with them, you're not isolated (Dan, 12)

In case like, you have an appointment which is a little while, further away, but you need them now, so you can go talk to them now (Joe, 14)

For other participants, there was a need for clinicians to relate to them in a natural and human way. Generally being a nice person, 'smiling' and showing interest in LAC as people went a long way when thinking about what would engage young people and increase their confidence to do this:

Author. what do you think the therapist would do in that situation to help them do that?

Um, they might ask a few general questions in the first few sessions, just to sort of, gain their trust a bit and then also, interact with them, not outside of the therapy but ask them questions about their interests and hobbies and try and make them a friend (Jay, 17)

What the above qualities - consistency, being there, listening, understanding - seemed to facilitate was replicating the above process of knowing others, being known and working toward trust and strong relationships or attachments, this time with clinicians. Adaptability and choice were again important in this process of 'knowing', which may have enabled the young person to feel they have some power over, and voice in, their situations, therapy and sessions:

Author. and what do you think these services would do to help?

[...] if they didn't necessarily need hour long sessions then at least having [...] like a 15 minute session or something where it's not as long but you can still be heard.

[...] when they're like slowly leaving, coming out of here or even going in and having the need to build up trust, having a different type of session where it's different so that people don't necessarily feel overwhelmed, or if they have trust issues they can slowly build it up and not feel like they need to be there (Ann, 15)

Facilitators, similar to barriers, were complex and numerous. Barriers to engagement centred around relational and systemic inconsistencies, along with no choice. This was described as hindering relationships, trust and therapeutic synchronicities.

Participants described several facilitators that addressed barriers to both initial and continual engagement. Having a trusted ‘other’ as a bridge was important in navigating how much they felt able to trust and form relationships with clinicians. Choice in both referrals and their type of support or clinician was particularly important for initial and continual engagement. In having this, participants described themselves and other young people feeling heard, collaborated with or perceiving more control in their engagement, and possibly reducing the power imbalances that can occur in such relationships. Therapeutic qualities connected as a way to manage this collaboration and the pace of the work. Parental qualities from clinicians and the way the service operates were however described as underpinning what engaged participants and young people in care. These qualities were parallel to those in the help seeking processes and contexts, such as consistency and knowing and being known. These also replicate relationships to those in a home, or the clinicians themselves working through this process with young people themselves. These factors were described by participants as moving young people toward a position of safety and somewhat epistemic trust with services, and possibly the service also being a ‘safe other’ or representing a positive attachment or relationship. This may also provide a different attachment or ‘relationship to help’ experience than that of those in a helper or caring role who provided fragmented or unstable experiences.

Appreciating the parental qualities of the service

There was significant overlap between parental qualities emphasised in help seeking and engagement, and the type of help participants describe in their current service. The perceptions described in this theme directly linked to their own support experiences from their current LAC mental health service, along with examples of

this. It was felt important to distinguish this from a facilitator as this was also talked about by participants in a much broader sense that linked across contexts. This was particularly in reference to ‘home’, the underlying parental qualities valued by LAC, and how this is linked to their current service in moving toward a safe or trusting relationship with it. Participants emphasised and valued what seemed to be a parental and relational service as opposed to a ‘therapy’ service in an evidence-based sense, for example a ‘psychotherapy service’.

The majority of participants described being involved with their current service for help with their own or carers’ understanding of their ‘mental health’, emotions, or understanding their past. Only Dan and Jay noted any form of help as ‘therapy’, of which both noted art therapy in past engagement. Elaborating on what their ‘help’ looked like, Ann described how the service is ‘there’ for them for support or safety:

Um, mainly supporting me with my mental health. Making sure that I’m safe and happy but also making sure that I’m being checked in on, so that I’m not like, constantly, cause I’ve, in the past I’ve left but then had to come back, but it was like, the door’s always sort of open, and it wasn’t like difficult to come back and sort of resituate or anything, so that was nice (Ann, 15)

All participants expressed that being heard and understood was a large factor that they noticed and valued from the service. Ann elaborated that clinicians showed they were listening to their experiences, which made them feel heard and understood. Several participants elaborated this can be from even small or non-verbal communications, such as clinicians being generally kind, smiling and their eye contact. Feeling heard seemed to help with abating feelings that their difficulties

had been dismissed in their past or feeling like a ‘pay cheque’ (Ann, 15). It also seemed to abate uncertainty of whether support would help or if they were ‘worthy of support’ (noted previously in barriers in relation to participants’ past experiences):

Author. and what you were saying earlier about kind of understanding, or hearing you, were those factors involved in helping you get over that uncertainty of not knowing, or was there something else that this team did to help you through that?
No it was, it was understanding a person and speaking to them and making sure that they felt comfortable all the time, because it’s a new environment and something that you’re not used to when coming in with overall support and so, sometimes it can feel very strange to a person (Ann, 15)

In services being consistent, being there and participants being heard, this facilitated, in time, trust, safety and knowing/being known by their clinicians. This, described by all participants, contributed toward them starting to feel like clinicians will not ‘judge’ them and to start to open up about their distress or difficulties:

Author. have they done anything that’s also helped you trust them?
Yeah, um, just like, like they listened, they’re like um, they’re like funny and they’re like happy all the time like to me. They’re like, whenever they say something they don’t judge you on what you say (Ben, 13)

Being treated as they wanted to be was another factor that participants held as important to building and maintaining this trust. Two participants – Dan & Ann -

described that this contributed to not feeling judged and more like a ‘normal’ person in society. Connecting to this, Ann and Jay alluded to another parental quality in the service, namely recognising an individual’s development as a young person. Tied with wanting to feel recognised as a person in society was the also the recognition needed toward a young person’s transition to a young adult, and the autonomy that comes with this. This was both in the clinician’s general approach to one participant, along with an active therapeutic stance for another:

Author. how important is it to you to be treated like a, what would you say you would want to be treated like actually, that’s probably the first question I should ask?

I’d want to be treated like an adult because, I am, going into college or I’m doing apprenticeships. I’m getting out of high school I’m no longer in that, 5 a day, do GCSE’s. I’m looking to the future, I’m planning for universities, I’m, getting a job, I’m becoming a person in society, so I want to be treated like that, not just a child (Ann, 15)

Author. is there anything specific that this therapist is doing that lets you know it’s helping?

Um, um, sort of challenging me about things that I say, and also trying to, give me some more independence and, not just look at my foster carer for answers in all of the sessions (Jay, 17)

Participants went on to describe how, once there was this connection and getting down to speaking of their experiences, the result of this for some participants was

allowing or accepting fundamental containment and support in regulating their distress. Some described in opening up to their clinicians, there was a visceral sense of ‘releasing’ something (Ben) that was held in or taking a weight or ‘bag’ off their back (Dan).

Considering how this translates to a parental service and connects across previous themes and contexts, Ann eloquently described connections between those who make the home and those who make the service. Although a large section of transcript is included below, it was felt important to include as Ann outlines the majority of parental qualities, how these may develop in a service, and how this can create a connection between what she now feels are ‘homes’ that enable her to seek, engage and accept support:

Author. how was that, knowing that this would be here if you needed it?

It was good, because it felt sort of like, I dunno, any, any issues at all it's always like, it's like an open door, sort of like a home but you don't live there

Author. what do you think gives it that home quality then?

Um, I dunno. I think it depends on the person. Mainly for me, just respect and kindness can make anything seem homely. Sort of being nice to a person

Author. so it feels homely and there's respect and kindness in there. You also said that you felt heard. How do you know that you felt heard from the people that you see here?

Um, mainly because I, I mean I've been going here a while now, and um, every time I've ever had a problem, I've always been listened to and I've been helped, or if I haven't been able to be helped, then we've at least spoken about it and, if there's an

issue then like, a plan is formed or something so that I know I don't walk away feeling like nothing's happened, which is nice

Author. how do you think they're helping you now, the team?

Um, mainly supporting me with my mental health. Making sure that I'm safe and happy but also making sure that I'm being checked in on, so that I'm not like, constantly, cause I've, in the past I've left but then had to come back, but it was like, the door's always sort of open, and it wasn't like difficult to come back and sort of resituate or anything, so that was nice (Ann, 15)

Overall, participants described this parental service as an integral part of how they understand they are receiving help. This was in contrast to little emphasis on specific therapeutic models as being 'help' or support. The understanding of their parental service seemed to replicate or build up relationships where a positive and safe connection was the foundation, thereby fostering parental and service 'homes' through these qualities. This seemed to enable a connection or positive attachment that supported young people to look to epistemically trust clinicians enough to speak about their experiences and work toward understanding and managing their distress. It also seemed to expand the contexts – physically and emotionally - in which they felt able to get support, and counteract wider contextual barriers, such as stigma, self-responsibility or 'burying', and past experiences that may have fostered negative perceptions or 'relationships to help'.

Developing reflective capacity in the young people?

The reflective capacity of participants is outlined here in relation to their current support from their mental health service. Some young people talked of their past or

current difficulties from a meta-position. This was not explicitly linked by the young people to the ‘parental service’ or support they received, however in reflecting on their experiences, they described what they originally felt the service was helping them with, such as understanding their past or managing their difficulties.

Ben talked of understanding the circular nature of his anger in his siblings’ actions, his reaction, and their wish for his reaction in their original behaviour that made him angry:

Author. and your brothers. What’s it like, living there at the moment?

Um, its like good, we’ve got like a big garden, a big house. But, as I’m the youngest, sometimes like, they, sometimes they hurt me and then I react to them, like give them the reaction that they want, and then like, you get told off for it, and then that annoys you more and then like we start shouting (Ben, 13)

Dan also described seeking help as he did not want to continue ‘moving around’ in care and repeat the past. Ann talked of similar recognition of current difficulties and need for ‘change’, which facilitated a position of being open to help should the right person be there:

Author. has there been any time that when someone has done that for you – um, feeling like you would be able to open up someone new?

Oh, yeah, yeah I’ve met a few people who that have been like I could, if I needed to, open up to this person which is nice, because it means that I have, if I really really really need to change, which I really do now, it would be very easy to sort of open up to them (Ann, 15)

Interestingly, an aside is that the above reflective stance may be the converse to one particular barrier to help-seeking for LAC. This was described and quoted previously as some participants having no understanding of how their past or the connections - if linked – connected to their current distress. Being younger was a factor described by Dan and Jay that may hinder this reflective stance on understanding or recognising why they may be in distress.

Overall, this capacity was described as something that facilitated a recognition to seek help or continue to understand their current difficulties to manage or allow others to support them. As such, although this link was not explicitly stated by participants, this capacity could span across help seeking and engagement as a factor in their access or use of services.

Service development

Some participants were able to feedback on their ‘ideal’ services. Continuing with the idea of their ‘parental service’, participants mainly expressed that those who work in services would have both parental qualities and qualifications. Listening, understanding, dedication, trust and safety all came up alongside being a qualified person working in a service:

There’s always gonna be someone to talk to. Uh, there’s never, like, it’s never, there’s never no one here, or there’s um, you can talk to more people at once, so you can get more help, or they can get involved with other companies and teams to help
(Joe, 14)

They'd need to be good at listening for, uh, length of time, and also, they'd need to understand the mindset of the young person's particular age group (Jay, 17)

More information and education was also noted by Ann as something that needs addressing. They felt that others need to know they are not alone in their distress:

My message would probably be, that, you're not alone, and that if you really do need that support, there is more than just what meets the eye, and that you just have to be honest. I think honesty is the main thing, rather than trying to hide something or pretend it isn't there (Ann, 15)

Ann further thought that more responsibility needed to be taken by others to educate the public on mental health. She emphasised that this would shift responsibility from young people having to find out their own information to it being typical to just know it, in some ways mirroring a parental quality of the service by the information 'being there' for the young people:

[...] like it has to have uh, a lesson where they explain what mental health is and the types of mental health and not just have it as an assembly and a quick one off and a hey here's a number, and to have adults also be taught, or even re-reminded [...] It could be like, I dunno, if people watch TV, or an article [...] or just something out there that's more educational, that people know about and not, I should google this, it would be more, I know about this (Ann, 15)

Finally, Dan also brought in further examples of the service being another ‘home’ in its physical surroundings. He described that at times, the physical space where young people go for support can be ‘foreboding’ and ‘prison like’ that dissuades others from attending. In adjusting the physical space to replicate a home feeling, this may help young people engage:

[...] if it looks like a prison for some people [...] you have a building, and the building has like a label at the front, [...] and you scan that label, [...] say it's a phone it's so much easier, then [...] put this on the headset. You put it and it says, choose the feature you really like, so it says rainbows, [...] something really cool, [...], something what makes you feel like you're at home.... (Dan, 12)

Chapter 4: Discussion

Summary of findings

This study has explored the views of young people who are Looked After Children on barriers and facilitators to mental health care screening, access and engagement. Participants' living situations, relationships, understanding of mental health and perceptions of responsibility for help seeking and engagement were seen to be wider contextual factors within barriers and facilitators.

Participants described mixed understandings of 'mental health'. One prominent understanding was that mental health difficulties were noticeable to others. Participants also talked of a double bind of stigma from others toward mental health difficulties and being in care. They described finding it hard to connect their difficulties to past experiences. Participants subsequently described the aforementioned factors leading them and other young people in care to bury their difficulties and not seek help. External and systemic barriers to help-seeking centred around a lack of safe 'others'. These barriers stopped consistency in placements or with others to build these important trust-based relationships, leaving young people in care without this 'safe other' to express their difficulties to. Facilitators of help-seeking were also described by participants. Participants explained that having a 'home' was linked with a sense of permanence, space and time that young people can use to build trust and form relationships with 'safe others'. They further described 'family' as responsible for help-seeking and having parental and relational qualities in line with these 'safe others'. In having these factors in their lives, participants said they and other young people may then be able to express their mental health difficulties. They may also feel heard instead of judged, along with being able to accept help instead of feeling indifference toward support from others

or services. Consistency within the care system was considered important and time to build such relationships in relation to a 'home'.

For initial and continual engagement barriers, participants' – in relation to their current, past and other services - again described inconsistencies in their experiences of services and with clinicians. They elaborated on having little choice or autonomy in their referrals or how they receive support. These factors hindered important trust-based relationships with clinicians. Participants also indicated it minimised young people's voices, reinforced the narrative of 'adults know best', and created dissonance in their engagement and therapy. Participants went on to describe facilitators to engagement, such as existing trust-based relationships within a 'home' as a bridge into trusting others. Choice was described by participants as important to provide a sense of control in engaging meaningfully with services. Encompassing these factors and therapeutic qualities were the parental qualities present in those within a 'home'. These again served a similar purpose to help seeking facilitators – moving young people toward a position of safety and trust to enable them to engage on a meaningful level.

Participants connected these relational and parental qualities to how they experienced help from their current service. They emphasised factors that came within safe others and those within a home – being there, listening to, understanding and recognising participants as developing young people. This even led to one participant (Ann) expanding her 'homes', which for her created a safe other in the service or clinician, and 'developed' an ability to engage with or accept help. Participants described these parental and homely qualities as important for service development, along with increasing information on help for young people and mental health for the public.

Relevance of findings to existing literature and Psychological theory

As shown in this thesis, there is relatively little literature on LAC's perspectives on barriers and facilitators for mental health support. As such, relevant psychological theory is also drawn upon to discuss and consider these findings and their implications. Given the organisational (Association of Child Psychotherapists, 2018) and political calls (Education Committee, 2016) for more LAC voices to be heard in relation to this topic, it is appropriate to consider psychological theory to consider the implications of these findings to the above agendas. Following on from this point, although interpretative links are made within the results section, it was felt appropriate to also balance the above themes with a slight descriptive tone. It is hoped this will allow participants' voices to be at the fore of this project. A more interpretative lens on participants' views and interviews is presented below. In the process of writing and reviewing the results section, although it was felt important that the thematic analysis encompasses an interpretative lens, in keeping with the aims of this project to hear participants' views, it was also felt important to nuance more descriptive and interpretative tones within writings of the results and discussion sections respectively. These differences may also facilitate a more distinct evaluation of what participants expressed here against what was interpreted in the below discussion.

Below, the findings, literature and psychological theory are considered in relation to the aim of exploring barriers and facilitators, how wider social and personal factors feed into these, and on what level – individual, societal and systemic – these may play out.

Barriers

Individual - The role of attachment and understanding mental health

Personal barriers and factors described here are considered in line with existing knowledge, particularly the role of attachment and LAC's relationship to help.

Participants in this study alluded to not being worthy or able to accept help (Ben, Ann, Jay). This could be understood through an attachment framework (Bowlby, 1978). Given that LAC can have significant traumatic past experiences in relation to others, and multiple care givers and involved professionals, they may well have negative, 'insecure' or confusing internal working models. Additionally, they will hold these constructed views of the self, others or world based on their past, and not always positive, caregiver interactions that influence current relationships in general and in times of need (Howe, 2005). This may frame why LAC's and participants' 'relationship to help' (Reder & Fredman, 1996) might feel unfamiliar (Ann), undeserving or 'beyond help' (Tatlow-Golden & McElvaney, 2015; Beck, 2006) if they received none from their past parents (Fleming et al, 2009; Stanley et al, 2007; Heath & Priest, 2009). Further, when participants did recognise mental health difficulties, they expressed it was hard to understand how and why they were experiencing them.

In conjunction, participants also alluded to not connecting their past experiences with their current distress. This may speak to the 'reflective trajectory' (Tatlow-Golden & McElvaney, 2015) or 'reflective capacity' noted in this study. This was posited by Tatlow-Golden & McElvaney (2015) as LAC's relationship to help depending on how much insight they had on their difficulties and why they were in care. In this study, Dan explained LAC may not understand why they act out towards their carers. It may be that in barriers restricting safe others such as

‘family’, carers or services being present, this could hinder LAC’s ‘reflective trajectory’ through hindering help seeking and opportunities to understand their past. In not connecting with causes of their distress, it may also perpetuate young people’s understanding of ‘mental health’ as observable behaviours. More understanding of this is needed to clarify if and how this reflective trajectory, capacity and systemic barriers impact on LAC seeking help.

Participants here did understand their mental health difficulties as observable by others. What was also apparent for participants in this study was the ‘problem of mental health’ being reflected in observable behaviours, which at times was not understood as due to, or connecting with, their past experiences. Previous reviews on LAC views of mental health (Davies & Wright, 2008; Meltzer et al, 2003) did not however capture or explore LAC’s conceptualisation of mental health difficulties. Few other studies have asked young people in care how they understand ‘positive’ or ‘poor’ states of emotional wellbeing (Balzalgette et al, 2015). From the systematic review presented in this thesis, only one paper explored ‘mental health’ with vulnerable children (Tatlow-Golden & McElvaney, 2015) and quoted it as being understood as mood, thoughts or daily living. Considering a concept or awareness of difficulties is proposed as the first step toward seeking help (Rickwood et al, 2005; Gulliver et al, 2010), this seems an important factor that has been missed in previous research and also may need further exploration or monitoring.

Armstrong et al (2000) has shown that for young people in general, understanding of mental health is vague and young people make sense of it based on what is available to them. For participants, the focus on mental health difficulties as observable behaviours may hinder their understanding of distress as connected to internal or past experiences through an outward focus. Armstrong et al (2000)

further noted family and friends usually play a role in understanding and managing mental health, which for LAC, may not be available. Given LAC are likely to have traumatic pasts (Oswald et al, 2010) and potentially a lack of, or unstable family environment to help them understand their distress, the external focus of ‘distress’ may play a role in hindering help-seeking through distracting others from underlying difficulties or ‘dismissing’ these behaviours and ‘childish’. The role of others, such as a carer, in understanding such ‘behaviours’ as possibly connecting to past experiences is therefore important to consider. This is a particularly relevant finding in this study given that current research indicates a need to increase mental health literacy to aid help-seeking in carers (Bonfield et al, 2010; Mount et al, 2004).

Attachment history, relationships to help and their understanding of mental health difficulties are all factors that provide insight into how participants and possibly other LAC may relate to others, particularly in a helping role, and how they may express their difficulties based on their understanding of ‘mental health’ or ‘emotional wellbeing’. The understanding of mental health and difficulties as being observable by others is particularly relevant as this has not been explored much with LAC in other research. It also relates to the below societal factor of stigma and participants ‘burying’ their difficulties.

Societal – The role of relational stigma

Participants perceived society to hold significant stigma toward those with mental health difficulties. This is discussed here in relation to previous research and the current understanding of stigma for participants.

Mental health difficulties are described here and in other studies (Blower et al, 2004; Jee et al, 2014) as difficult to ‘overcome’ and to seek help. Alongside it being

too ‘overwhelming’ in these previous studies, some participants here talked of not being ‘too nervous’ to go through it for fear of how others will react or minimise their struggles (Ann, Ben). They went on to describe needing to be ‘brave’ (as above). This is similar to other studies that note stigma (Callaghan et al, 2003; Davies & Wright, 2008; Jee et al, 2014; Heath & Priest, 2009; Johnson & Menna, 2017; Stanley, 2007; Fargas-Marlet & McSherry, 2018) and may be one aspect of stigma for LAC that leads them to bury distress in fear how ‘others will react’ or will worry about them.

Participants in this study however elaborated more on the societal and relational factors that contribute to stigma. In a previous systematic (Davies & Wright, 2008) and the current review in this thesis, young people voiced ‘dual stigma’ hindering help seeking and engagement. They worried peers or others would not engage with them or would ‘treat them differently’ (Jee et al, 2014; Heath & Priest, 2009; Johnson & Menna, 2017; Stanley, 2007) if they knew they experienced mental health difficulties or involved with health services or social care. There were similarities in this study, predominantly that participants felt there was a ‘difference’ between them and others in society due to their mental health difficulties.

An important distinction in this project however is that stigma was associated with perceived negative public perceptions of ‘mental health’. Participants felt this ‘difference’ to others was not driven by them being the ‘problem’ in having mental health difficulties, but the problem being a lack of understanding and education of others. This ‘difference’ subsequently led participants’ to feel they ‘stand out’ or feel outside of ‘societal norms’, which has been noted in the systematic review in this thesis (Jee et al, 2014; Heath & Priest, 2009; Johnson & Menna, 2017; Stanley, 2007) and another study (Famer et al, 2013). Some participants here subsequently

described a need to tell their stories to let others know they were children rather than 'judging them by their cover'. However, most participants also described needing to be 'brave' and 'strong' to do this and seek help. Further, when stigma around being in care was expressed, participants then described others taking advantage of their story and ridiculing them. There are several important points to consider to this.

Firstly, instead of the double stigma in previous research, participants here described a double bind (Bateson et al, 1956; Visser, 2003). Societal judgement of mental health difficulties seemed to put them in a position where they want to tell their story or difficulties to distinguish themselves from the 'cover of their book'. However, when they do tell others their stories, others, such as peers, ridicule LAC, hindering trust in others to express themselves. Bateson et al (1956) describes how this leaves people in a state of disorientation. Others, for example Gale (2007) have also discussed that stigma for children may form in a more relational way. Gale (2007) discusses the relational factors involved in this process that were also expressed by participants in this study: being associated with someone with mental health difficulties – or participants here being associated with social care; being labelled and judged; and the child's own perceptions of mental health based on interactions with others (noted above as observable difficulties). The aspect of labelling and judging has further been shown to contribute to stigma from other studies with LAC (Blower et al, 2004; Jee et al, 2014; Tatlow-Golden & McElvaney, 2015; Bazalgette et al, 2015). The relational factors that lead to this double bind of stigma is therefore important to consider. Building on a felt sense of dual stigma shown from the previous research, findings here show the role of others in perpetuating relational stigma for young people in care and placing them in a double bind. This may serve to perpetuate them burying difficulties due to worry or

fear of how others will react, or through ‘disorientation’ and not knowing who to turn to or trust for help.

Secondly, the impact of this relational stigma on identity is unknown, particularly in the context of LAC. Gale (2007) describes that for young people in care specifically, it is important to consider if stigma itself influences the severity of their distress. She described ‘problems related to identity’ as part of this distress. Although Gale did not elaborate, of relevance is that some participants here and in previous studies (Lee et al, 2006) repeatedly expressed feeling ‘different’. As a result, they wished to be treated as ‘normal’ and a ‘person in society’, along with recognition of their transition to young adults. Part of identity formation in adolescence is in relation to others (Erikson, 1968; cited in Rageliene, 2016). Other findings show that positive relationships to others specifically relate to positive identity formation and mental health in adolescence (Rageliene, 2016). In light of this, it is also worth considering how relational stigma may not only hinder help-seeking but subjugate identity development. In hindering LAC’s ability to feel they ‘fit in’ with others or society, this could also impact on LAC’s identity development and perpetuate their distress.

Thirdly, there is a need to consider the language of needing to be ‘brave and strong’ in relation to stigma. Research has shown that ‘battle’ metaphors in cancer treatment can increase fatalistic beliefs about prevention and treatment (Hauser, in press). This led those who do not have cancer to engage less in healthy behaviours and paradoxically be less vigilant in their help-seeking behaviour in the event of a cancer scare. The applications of this to fight or be ‘brave and strong’ against stigma of mental health could be thought of here as having a similar impact on reducing help seeking. Ben talked about needing to ‘overcome’ his difficulties to seek help in

his interview. It may therefore be important to consider the language and approach in reducing stigma for young people in care, particularly in campaigns. There have been joint NHS and Young Men's Christian Association (YMCA) campaigns that look to challenge the language of mental health, labels and increase information on mental health difficulties in young people for the public (YMCA, 2016). The campaign language itself however still uses words such as 'tackling' stigma, which conjures images of confrontation.

Overall, relational stigma was described as a significant factor not only in help-seeking, but participants' day to day lives and where they fit into society. The role others play in perpetuating this – directly in ridiculing LAC and indirectly through framing a battle that needs to be won – and the impact of this on LAC's identity and distress is an important factor that needs to be explored further. This should not only be in academic realms but thought of in real world applications, particularly campaigns and who in particular may be placing LAC in the double bind of stigma.

Systemic – A key fork in the help-seeking and engagement road

Alongside personal and societal barriers, systemic barriers played a predominant role in the help-seeking and engagement process. Participants in this study talked of a turning point of a 'safe other' being there to listen, understand and be there to address the above barriers (see facilitators below). However, external barriers seemed a significant factor in this study that hindered this. These external or systemic barriers centred around supposed 'safe' others, such as parents or systems, hindering help seeking either directly via blackmail (Dan), or indirectly via schools or carers not understanding or minimising participants' distress (Ann, Ben, Joe).

Interestingly, Armstrong et al (2000) also noted in their study that young people trivialised their problems when compared to adults, which may further link to the minimisation of distress from these supposed ‘safe others’, an internalisation of the narrative of adults know best, and perpetuating the burying of distress described by participants here. This further creates another double bind (Bateson et al, 1956) for participants and other LAC in ‘safe’ people being the ones who also hinder help, creating further confusion as to who to turn to or trust for help.

Focusing on systemic barriers specifically, these continued when ‘safe’ organisations such as schools or social care were inconsistent following frequent placement or residential staff moves for participants. These frequent placement moves and separation from siblings (Dan) not only have an impact on mental health (Hegar, 2005), but also hinders a ‘safe other’ being present since young people are often with carers or professionals who are new and they may not trust. This not only connects with the idea of frequent placement moves for LAC (Greenfield & Marsh, 2018; Oakley et al, 2018) but also previous studies that indicate this difficulty then may replicate and perpetuate LAC’s low expectation of services (Tatlow-golden & McElvaney, 2015; Beck, 2006; Fleming et al, 2009; Heath & Priest, 2009) and their historical relationship to help (Reder & Fredman, 1996), along with being another factor that may impact on identities of young people in care (Bazalgette et al, 2015). This concern around placement stability has been noted by the UK government (Education Committee, 2018) yet this still continues (see *theoretical evidence base and guidelines* below).

Ultimately, the above personal, social and systemic barriers to help-seeking may lead young people in care to feel they have to ‘bury’ or attempt to manage their difficulties themselves (Blower et al, 2004; Heath & Priest, 2009; Johnson &

Menna, 2017; Tatlow-Golden & McElvaney, 2015) whilst stuck between multiple barriers, contexts and double-binds of stigma and no 'safe' other to turn to.

Similar to help seeking barriers, participants described barriers to engagement as centred around and replicating relational or systemic inconsistencies. Participants in this and other studies (Tatlow-Golden & McElvaney, 2015) expressed low expectations of clinicians who are just 'there for a job' and see young people as a 'pay cheque'. One participant (Ann) felt she could sense these individuals, explaining they did not have a 'bond' with their job, therefore no bond with their young people. Given LAC's potentially past traumas (Oswald et al, 2010) and the impact of these on their relations to others and help seeking behaviour (Reder & Fredman, 1996), this may elaborate why there is the noted 'suspicion' or low expectation (Blower et al, 2004; Beck, 2006; Jee et al, 2014) toward others.

Further systemic barriers however perpetuated this suspicion or low expectation of services or clinicians. Participants talked of being referred from one service to another, creating service fatigue. Considering participants here described understanding mental health difficulties as observable behaviours which may hinder understanding of their distress, there are arguments that CAMHS mirror this external focus of difficulties in their exclusion criterion for their services (SAMH, 2018). There is evidence that specifically for LAC, CAMHS are less clear on accepting 'behavioural' difficulty or attachment referrals when compared to 'likely' disorders such as anxiety (Roa et al, 2010). In deeming 'behavioural' referrals as 'unsuitable', this creates a further barrier for LAC, and again confusion for them in a 'safe organisation' minimising what they perceive as expressing significant distress.

A lack of choice or autonomy was also a significant factor that hindered engagement for the participants in this study. This has been shown as a large barrier

for engagement in other research (Fleming et al, 2009; Heath & Priest, 2009; Jee et al, 2014; Johnson & Menna, 2017; Beck, 2006; Stanley et al, 2007; Tatlow-Golden & McElvaney, 2015; Blower et al, 2004). For this study, a lack of choice was particularly relevant throughout engagement – from referral to continued support - and related to systemic inconsistencies such as changes in and having to see disliked clinicians, along with a lack of transparency from professionals on referrals. A lack of choice may also extend to what service they engage with, which can be dictated by multiple referrals as show above. For one participant in this study, this may well have instilled the feeling of powerlessness when it came to engage with or feedback on factors such as therapy (Jay). In not having choice, they have a lack of perceived control and power over their own help and support. Joe particularly highlighted this in his ‘surprise’ at having a choice and say in his referral, which led to him feeling in control as to whether he wished to engage. Other research has also shown the importance of considering power in working with LAC, which is underscored by taking time to genuinely to listen to LAC voices, value their opinion and build trust (McLeod, 2007). Importantly, all of these factors are described by the participants in this study and highlight the importance of the following sections on facilitators.

Facilitators

Positive contexts and parental qualities

The facilitators described in this study addressed the above barriers. Participants described a significant overlap between what they felt would facilitate young people in care seeking help and engaging with services, therefore both are considered under this section. These are elaborated in detail here and below due to the lack of understanding on facilitators in previous research (Davies & Wright, 2008).

The concept of a home is an under researched area for LAC (Natalier & Johnson, 2015). Participants in this study however described a home as important to their help-seeking and engagement.

Broadly, there was a distinction between a house and home. A house, for some, was attributed to being ‘unloved’, ‘unhappy’ and with people they cannot trust. In stark contrast, the idea of ‘home’ was not attributed to physical property, but the people within it. The parental qualities emphasised around those in the ‘home’ were in direct opposition to the difficulties above with others or organisations. They were, amongst other things, ‘there for’ participants, consistent, kind, caring, loving, safe, and ‘listen’, all of which instilled trust. In time and in general, what this may serve is to address LAC’s attachment or internal working models of feeling ‘unloved’, not ‘belonging’ or being indifferent. It may further address factors such as identity, understanding ‘mental health’ as observable behaviours, and double binds of stigma and supposed ‘safe’ others hindering help-seeking. Importantly, Dan also emphasised that even if things go wrong or they were upset in this home, those in it were there to repair this, which is a key factor in sustaining ‘good enough’ attachment, particularly for LAC and their carers (Gurney-Smith & Granger, 2010). Interestingly, Natalier & Johnson (2015) echoed the above findings in care leavers: a house was associated with instability and negative relationships; a ‘home’ was where they claimed ‘normal’ identities, stability, control, caring relationships and was a symbol for a less turbulent future.

From this, concurrent with previous research with LAC (Heath & Priest, 2009; Blower et al, 2004; Fleming et al, 2009; Jee et al, 2014; Fargas-Malet & McSherry, 2018) participants here indicated that it was predominantly their ‘family’s’ responsibility to help them seek support. ‘Family’ here was emphasised

as those within a 'home', indicating that 'appropriate sources' for LAC in help-seeking (Rickwood et al, 2005) are those who hold these parental qualities that instil trust. Participants also noted that professionals can hold these parental qualities, although it is unclear whether this stems from having this with carers first or built alongside them. Again, this factor may relate back to an attachment framework (Bowlby, 1978; Kernberg, 1995; Howe, 2005), in that 'being like a parent' and holding such qualities may have enabled these individuals to be a 'secure base' (Bowlby, 2005). This in turn may have addressed barriers above, including burying difficulties and past negative internal working models or relationships to help.

This also connects with previous research showing LAC wish for 'familiar' people who will 'understand' or 'know them inside out' (Tatlow-Golden & McElvaney, 2015). However, in this study, this is distinguished as a transactional process of being known by others and also getting to know them. This process centred around parental qualities being present, but within those, importance was laid on listening, understanding, even down to non-verbal communications such as smiling and eye contact, which is also noted in the last LAC mental health review (Meltzer et al, 2003). This is explained here because, as a consequence of getting to know and being known, this seems to be a defining fork in the help seeking road, namely that these 'parental or safe others' seem to 'be there' as an 'appropriate source' (Rickwood et al, 2005). This helped participants here express their difficulties rather than feeling responsible themselves to hold or 'bury them'.

Following expressing their difficulties, these 'parental others' or 'secure-bases' (Bowlby, 2005) may enable LAC to start to also explore their relationship with clinicians or services. For continuing engagement with services, there were further therapeutic qualities such as collaboration, managing pace and direction of the work

and flexibility in sessions that enabled continued engagement, which has been found to be important in previous research (Tatlow-Golden & McElvaney, 2015). These therapeutic qualities did circle back into what participants emphasised as parental and relational qualities in their current service.

These parental qualities and the process of at least ‘being known’ has been referenced in previous research (Tatlow-Golden & McElvaney, 2015; Stanley et al, 2007; Jee et al, 2014; Lee et al, 2006; Fleming et al, 2009; Heath & Priest, 2009). In the absence of participants describing any particular ‘therapy’, the importance of these qualities and relationships with others is clear, particularly in making a safe other available for LAC to express themselves within a safe place, which again has been reflected in previous research (Bazalgette et al, 2015; Fargas-Malet & McSherry, 2018). Such a safe place, for example a ‘home’ and those who make it, is also a distinguishing factor that this study highlights that has not been explored previously. Further, previous research has shown that LAC felt they have no-one within the health or care system to trust or rely on (Blower et al, 2004; Heath & Priest, 2009; Johnson & Menna, 2017). This study therefore sheds light on how this may be facilitated within such systems and its impact on help-seeking and engagement with services.

Parental service qualities – addressing individual, societal and systemic barriers

In practice, the parental and relational qualities in the participants’ current service seemed to have several implications for overcoming barriers along with key therapeutic elements and facilitators. A brief description of how these components may fit together is outlined below along with specific *barriers* they may address.

The important elements of clinicians or services ‘being there’, listening and ‘hearing’ participants all seemed to counteract the possible negative past experiences that could have led to expectations of being unworthy or unfamiliar with help (*Individual barriers*). These and other aspects, such as listening, being treated as they wished, or recognition of their development may have further counteracted narratives that their struggles were ‘childish’ and provided an exit to the double bind of stigma (*Societal barrier*). In the consistency, stability and provision of choice in working with these participants, this may then have developed into trust and a further exit to the double bind of ‘safe others’ hindering help (*Systemic barriers*). This trust seemed to negate past or current feelings of judgement and worked toward a position where security with the clinicians could be drawn upon to get down to the young people’s experiences and difficulties. In providing choice alongside this process, this seems to enable participants to have some control, choice and voice in their support. Given that LAC have been well documented to have encountered significant power imbalances and a lack of choice and voice in their lives – both in social care (Munro, 2001) and therapy histories (Stanley et al, 2007) - this was a particularly important ingredient in this process.

This process is described as there are three elements that could be considered as important. The first is, in moving toward a ‘secure-base’ with professional or a service, the possibility of moving LAC toward epistemic trust – a individual’s willingness to consider new knowledge from another person who is trustworthy - with clinicians also becomes likely, which is a significant factor for any therapeutic input to have an impact (Fonagy & Allison, 2014). This is particularly relevant for LAC given their pasts and the impact it has on trust. The second is the element of this parental service linking to the parental function of being a ‘container’ (Bion,

1962; in, Malone & Dayton, 2015), of which participants in this study emphasised as a way of working with their service. Given that LAC may well not have had much experience of consistent adults acting as a 'container' to explore and learn to regulate their emotions when growing up, this seems another particularly important clinical factor to isolate and emphasise. Thirdly, this way of practicing further replicated positive aspects of 'family' experiences in other contexts, such as in a 'home'. One participant (Ann) in this study went on to reference this service feeling like another 'home', and as such, felt safe in attending, indicating what could be seen as a positive attachment to the service also. This 'home' connection also seems particularly important given the sense of 'normality' they felt in this context (Natalier & Johnson, 2015) and how connecting this to other places could further counteract barriers such as stigma and its impact on aspects such as identity. An unclear implication however is if this way of practice directly influences the 'reflective trajectory' (Tatlow-Golden & McElvaney, 2015). There was evidence that the language participants used upon reflecting on their difficulties may have come from the above epistemic trust and therapeutic influence. This also seemed irrespective of age, which is similar to what Tatlow-Golden & McElvaney (2015) posit, however this is unclear and needs further exploration.

Other studies have shown the importance of such parental and relational qualities in working with LAC (Callaghan et al, 2004; Tatlow-Golden & McElvaney, 2015; Stanley et al, 2007; Jee et al, 2014; Lee et al, 2006; Fleming et al, 2009; Heath & Priest, 2009). There have been studies that aim to capture relational aspects of help within Psychological (Ardito & Rabellino, 2011) and Medical professions (Greenhalgh & Heath, 2010) yet the consensus in such research is one of subjectivity when it comes to what and how these relational aspects are important.

Further, ‘therapy’ in this and other studies are not emphasised by LAC on what they perceive or want as help from services. This brings into question how much what they feel ‘helps’ connects with current clinical guidelines for LAC (see *theoretical evidence base and guidelines* below). What this study does highlight compared to others is the detail on what, why and when such parental, relational and contextual factors impact on help seeking or engagement for LAC in mental health services. However, given this study is approaching this from a specific question and limited sample of LAC perspectives, there is a need for more input from young people in care into what they feel is valued in accessing and engaging in mental health services (McAuley & Davis, 2009).

Implications

Service development

Participants in this study and others (Blower et al, 2004; Lee et al, 2006; Tatlow-Golden & McElvaney, 2015) valued clinicians who were qualified and embodied the parental qualities listed in this and previous studies. These qualities and way of working could be particularly important to emphasise to CAMHS staff in order to understand what could be underlying a ‘behavioural’ referral (Roa et al, 2018). Participants (Dan and Ann) also described service development as linked to the service being ‘homely’. The physical space of clinics was noted as needing to be homely (Dan) in order to engage young people more, which isn’t highlighted in previous research. This links with more consideration of late as to how health geography may play a role in shaping the mental health service environment (Curtis, 2010; McGrath & Reavey, 2019). Linking with a lack of understanding, both on a LAC and public level, participants here and in other studies (Lee et al, 2006; Fargas-

Malet & McSherry, 2018) further emphasised that more information needs to be shared to both children and in schools. This in turn could combat LAC's feeling of stigma and burying difficulties. Interestingly, Davies & Wright (2008) noted the role of TV media as a way to consider positive representations of young people in care or with mental health difficulties. The idea of positive representations could also circumvent the fighting or battle talk of 'overcoming' or 'tackling' stigma.

Considering particular barriers stated in this study, one in particular is that of sensing the bond staff have with their jobs (Ann). This was framed as 'suspicion' and linking to participants relationship to help, however there is the reality of systemic pressures on mental health staff (Children's Commissioner, 2016) that can burn out this bond to their job and subsequent quality of care they provide (Green et al, 2014). What may be relevant here is to highlight the role of supervision in services. This could be used to identify difficulties that both clinicians and LAC encounter. Particularly in working with trauma histories, studies have emphasised not only the importance of secure attachment in the client-clinician relationship, but also the supervisor-supervisee relationship to mitigate difficulties and improve relational ways of working (Bennett, 2008).

Local and wider implications

Regarding local clinical implications, a service report will be constructed to feedback to the clinical recruitment team. This will include the findings of this study and the above service development points. It is hoped that this feedback may help adapt or clarify how young people access and engage the service, along with learning for practitioners in their approach to mental health care for LAC. Further, participants in this study will receive an outcome letter. Not only is it hoped that the

feedback will emphasise the importance of their participation, but will provide an insight into other LAC's experiences of help and how this information will be used (as outlined in *dissemination*).

On a national clinical and policy level, it is difficult to consider the implications at this time. As noted above in 'transferability' (Method section, p.g. 49), it is hoped that this study can developmentally grow the evidence base (Shenton, 2004; Holland, 2009) for research on LAC perspectives. In the longer term, it is hoped research including LAC's voices can influence national commissioning or policy makers on what they value in their help-seeking and engagement (Education Committee, 2018). In turn, it would be hoped LAC contributions would instigate change in service provision or guidelines based on what they feel is important in help seeking and engaging in mental health services.

This may start with the political level. What can be achieved with this project is contributing to conversations within avenues such as the All-Party Parliamentary Group (APPG) for LAC and Care Leavers (Become, 2020). Given the political agenda for 'hearing the voices' of LAC (Education Committee, 2018) in relation to service provision, this project can look to at least make those in political circles continue to be aware of such projects and their findings of what LAC value as important as 'help', their help seeking, and engagement in mental health services. The last meeting of this APPG for the mental health and wellbeing of LAC (Become, 2018) emphasised several important points that are applicable to the findings here: LAC need to be involved more in the decisions that affect them; reducing barriers to accessing mental health help; and having more information available to LAC of mental health help. The value of participants' views in this study is clear in relation to these issues highlighted by the APPG. Participants

described the need for more understanding in society on mental health; a multitude of barriers that impact on and perpetuates distress; how, why and with whom the facilitators can help LAC to seek support, thereby reducing barriers. Their perspectives also highlighted the disparity of what they value as 'help' against what is dictated in UK recommendations and guidelines for services (see below). This study, alongside other and further research, could again highlight to those connected to government or policy makers to consider how valuable the voices of LAC can be when considering what is valued by them in service provision, development and guidelines.

Theoretical evidence base and guidelines

Currently there is an imbalance, from a LAC perspective, on understanding the specific barriers, facilitators and wider contexts that influence help seeking and engagement in LAC in mental health services. Although limited, this study adds to the existing research that can contribute to clinically relevant changes in line with what LAC value in mental health services.

One way of looking at clinical relevance for this study is to consider what participants and other LAC voiced as important for their help seeking and engagement in mental health services against what their current provisions and guidelines are. What is becoming apparent from this and previous studies (Bazalegette et al, 2015; Fargas-Malet & McSherry, 2018) is that LAC value relational and parental qualities or working that seems to facilitate help-seeking and engagement. The current National Institute for Health and Care Excellence (NICE, 2015a) and Department for Education (Department for Education, 2015) recommendations are generally in line with this, outlining that LAC need

collaboration, stable placements, a place to develop identity and a voice to express what they need support with. However, when looking at specific guidelines, contradictions start to become apparent not only within what is recommended, but also what is provided in reality.

The predominant advice on attachment-based working for LAC (NICE, 2015b) merely includes ‘modification’ of current interventions for things such as play therapy, physical and sexual development, transition to adolescence or re-connecting with emotions and experiences. This dismisses the vital role of the clinician in relation to what LAC noted in this and other studies, predominantly through focusing ‘help’ as separate and outward interventions from clinicians rather than them being ‘in’ the intervention itself through relational processes. The use of ‘modification’ may also indicate that LAC are still predominantly accessing general CAMHS services that are overstretched (Children’s Commissioner, 2016), underfunded (Children’s Commissioner, 2017; Kelly et al, 2018) and include significant waiting times (NHS Digital, 2018). Even if LAC manage to be referred to or access CAMHS, these services may not take them due to placement instability (Callaghan et al, 2004), high ‘thresholds’ (Children’s Commissioner, 2016) or have time or resources to consider relational ways of working – which takes time as emphasised in this study – with LAC or across the professional network (Callaghan et al, 2004). All of this is despite LAC’s clear and distinct needs (Ford et al, 2007).

A scoping document from NICE (NICE, 2017) reviewed both the ‘effectiveness of interventions’ for LAC and developing new guidelines, which are due to be published in 2021 (NICE, in progress). Two criticisms were felt applicable to this. The first is the relevance of their concept and measurement of ‘effectiveness’. Organisations such as NICE, who are influential in developing

service and therapy guidelines in the UK, have been criticised for their predominant reliance and biomedical assumption that Randomised Controlled Trial's (RCT's) are the gold standard measurement of 'effectiveness' for guideline development (Guy et al, 2012). There have been further concerns from those who are using services based on these guidelines that such methods of measuring 'effectiveness' do not take into consideration the complexity and individuation of how therapy works for each person (McPherson et al, 2018a). This is particularly relevant here given participants in this study expressed valuing a relational way of working, meaning that little of these parental and interpersonal qualities will be captured by a traditional measurement of 'effectiveness in interventions' by RCT. Ironically this may mean that, in continuing in this way of guidance review, part of the 'best or effective evidence' of 'what works' for LAC may be missed for service design or delivery.

The second is that, although they do list consulting LAC and carers for their current guidelines (NICE, 2015a), the 2017 scoping document has no mention of including LAC voices in revising this guideline. This is despite their own recommendations to include these 'at the heart of service design and delivery' (NICE, 2015a). In the scoping document, they report to only consult 'topic experts', namely Public Health England and Social Care Institute for Excellence (SCIE). This ties in with further concerns that, even when these voices are included in guidelines from organisations such as NICE, they are at best tokenistic (Hart, 1992) or conflated by semantics such as 'patient choice' rather than voice (McPherson et al, 2018b; McPherson & Beresford, 2018).

There is recognition that LAC need specific services (NICE, 2015a) and do face challenges in stable placements (NICE, 2015b). This does match the reality of unstable services at the moment, both expressed from others (Greenfield & Marsh,

2018; Oakley et al, 2018) as well as the felt sense of unstable placements from participants here and in other studies that hinder their help seeking and engagement (Fleming et al, 2009; Johnson & Menna, 2017; Beck, 2006).

What these points emphasise is the importance of continuing to meaningfully hear and include LAC views rather than ‘adults or experts knowing best’ about ‘effective’ support. More LAC voices could continue to make practical, clinical and meaningful change in a positive way.

Strengths and limitations of this study

This study contributes to balancing research toward hearing more of UK young people in care, and what their views are on barriers and facilitators to mental health care access and engagement. Different from previous research, participants were in clinical care and physical settings. As outlined throughout this thesis, this is a priority for political, third sector and commissioning organisations, particularly for service implications. This project is therefore an important contribution in addressing this priority and adding LAC perspectives needed in research. It further looked to fill gaps in understanding on areas such as facilitators to help seeking, and particularly engagement, or new contexts for LAC that contribute to this. Further, it is transparent in its research design for clinical settings involving young people in care, which could be important for the ‘balance’ in working with clinicians and systems (Davies & Wright, 2008). The ethical process from the HRA, University of Essex and the hosting NHS trust has also been rigorous.

This project does have several limitations. Given the lack of research with LAC, it would have been important to include a participatory element to this project, particularly in the developing stages of the research and topic schedule design.

Having LAC as research partners, and employing aspects such as focus groups involving young people in care would have added particular value in developing research or topic schedule design. This may have enabled more insight into what other contexts or factors these young people see as helping or hindering access and engagement to mental health care. It may also have facilitated insight into framing questions or factors to make participation in the study more comfortable for LAC, as well as reduce the power imbalances that occurred toward participants and LAC.

On the topic of balance, participants are predominantly male (N=four), with one female participant. All participants are in long-term foster care, therefore other voices from those in different stages or experiences of care are not included in this project. These young people were further already accessing a clinical service for therapeutic input, therefore others who are not yet in contact with services, are at different stages of service contact, or are experiencing barriers to service input are also omitted from this study. Further, there may have been an influence on the interview data and LAC voices from external sources due to carers being present in some interviews. It is difficult to say whether this hindered or helped participants express themselves. One participant did however say that it helped to have their carer present as a 'secure base' in talking with others.

There were also limitations imposed from others. One social care team declined to take part in this project due to concerns about LAC being involved at such a sensitive time in their lives. As such, the clinical service involved here – a specific mental health service where LAC were already engaged – was approached and accepted to act as a recruitment site. Participants retrospectively thought of their experiences of what did and did not help them access and engage in services, which may have influenced their perceptions of this. Further, the clinical service also had

control of the recruitment process for data protection reasons. Given the noted anxieties held by clinicians about including LAC in research (Davies & Wright, 2008), this may have also influenced their decisions on 'who is best' to participate, however these anxieties were never verbalised or explored with the team themselves. It is recognised however that there is also the clear need to maintain relationships and safety with the young people in their service, particularly given the above findings of relational working. This in itself is evidence of how hard this 'balance' (Davies & Wright, 2008) can be.

Further, the Covid-19 Pandemic that started in January 2020 within the UK significantly impacted this study. For the LAC clinical service, it stopped face to face sessions, meaning that recruitment also had to be stopped. At that time, recruitment was up to seven participants. This was when the author was in their third year and working within a course timeline toward submitting a thesis on 7th April 2020. The author was in a position of still recruiting in January 2020 due to noted amendments and slow recruitment up until then.

Several options were considered by the author, the clinical team, the academic supervisor and the University of Essex research sponsor. Telephone interviews were raised as an option to continue recruitment, however the author, supervisors and the University sponsor had concerns around this. These concerns centred around the interviews being with LAC, talking about mental health and their past, and the face to face element specifically being linked to the risk and safeguarding protocol in relation to their clinical service. Further, at that time, the HRA were prioritising Covid-19 related research, meaning that even if the - what was thought by the sponsor and University department Covid guidelines as 'substantial' - amendment

was to be submitted, this would take a significant time to be reviewed, which the author did not have.

The second option considered was changing methodologies to Interpretative Phenomenological Analysis (IPA) or Grounded Theory. However, this was also felt inappropriate given materials such as the interview schedule had been geared toward thematic analysis. There were further factors to this. The epistemological position of this project fit in line with being used in previously similar research (Ramsden et al, 2015). The approach of grounded theory or IPA also felt too focused on latent (underlying meaning) levels and interpretative methods. In light of LAC perspectives still being few and far in between in the evidence base, this not only felt like a mismatch between approach and research need to add more from these young people in studies, but further risked the authors beliefs becoming too entwined with these voices given the depth of the analysis needed for these approaches. Further, this left thematic analysis as best placed to emphasise LAC perspectives as much as possible given its flexibility to work on a more semantic and descriptive level, with less interpretation and room for personal influence from the author.

Future research

Given the relatively little qualitative research on the project topic, it is hoped this study will help grow the knowledge base on LAC views of mental health care access and engagement. This project may also contribute in the search for the 'balance' in research in clinical settings. Development of this research design can contribute toward navigating the intricacies of this research area and be adapted to continue LAC involvement in studies.

Following on, this and other studies show that LAC can participate in research, contribute their opinions on the services they receive and how they can or cannot access them. This is clearly vital to continue given the disparity of what is being recommended for and valued by participants here when compared with the reality of what is being recommended in guidelines. In continuing these studies, researchers and the LAC clinical or social care teams involved need to consider the balancing act (Davies & Wright, 2008) of engaging LAC at their comfort levels whilst avoiding they themselves silencing these young people.

There are various other elements that can be considered for future projects. A meaningful and valued participatory element or approach should be in future studies, firstly around how best to ethically and comfortably involve them in research - this 'comfort' being both for LAC and clinicians to explore the 'balance' (Davies & Wright, 2008) above. These participatory elements are particularly important at this time as: there is an imbalance of research with LAC voices specifically on mental health care access and engagement; the disparity between recommendations and need above; due to this, LAC have a chance for their input to shape future research or service designs around areas of importance to them; and this in itself could provide a meaningful experience for LAC rather than it being a tick box experience (Beresford 2002; Beresford 2007). Further, given the lack of power for LAC and choice highlighted throughout this thesis, this could be all the more important in hearing LAC voices in not just a research context, but also the policy or guideline process.

This project engaged participants who were 12-17 years old, had already accessed mental health services and were primarily in long-term foster care or adopted. Echoing other research calls (Davies & Wright, 2008), research should

consider exploring how to involve younger children in care for their experiences of help-seeking and mental health. Other varying populations of LAC to include in research could be those at different points of care or service engagement. Hearing from those who are still to access help or varying placement situations would be important to explore how they experience help, understand mental health and how the systems around them may influence their help-seeking. Further, understanding more of how relational stigma presents for LAC and how to mitigate this looks to be important. Research could also explore if there are any distinguishing parental qualities or contexts that LAC value in help seeking and engaging in mental health support or services, for example the concept of ‘home’ and those within it.

Reflexive account

There are various factors that influenced both my position and experience within the study, and conversely how my positions and beliefs may have influenced the project. These are important to outline in the context of confirmability and transparency (Shenton, 2004).

The project design and process has influenced my position and experiences within it and toward LAC. As discussed in the method section, my initial relation to this project was one of a ‘removed position’ in not having been in care myself. At that time, it was felt important to distinguish this prior to the results and analysis to ‘disclaim’ that in being in this position, there were clear advantages and disadvantages. My inexperience with the care system was regarded as a barrier to being able to connect and understand what these young people have gone through. Equally, this brought the potential of bringing a ‘fresh perspective’ to the data. The exploration and interest in this study was particularly driven by my clinical

experience, which highlighted the role of health and care systems in help-seeking and engagement for young people in care. This drove me to explore these factors from these young people's perspective. As such, there was an element of either/or thinking that dichotomised my position. As the study progressed however, the experiences of conducting the study shifted these advantages and disadvantages into greyer areas, or both/and (Dallos & Draper, 2015) positions. Although there is a reality that I have not experienced the care system and the experiences that precipitate and perpetuate staying within it, there were factors (outlined below) that reflect what it may be like for LAC within the care system.

Although this research project was designed and carried out by me, this project was also shaped in response to larger systems of the DClinPsy course requirements, the NHS, and social care. The timeline of the DClinPsy thesis construction requires it be completed in a set time amongst a multitude of other academic and clinical responsibilities. This then shapes the aim, design, sample and size of it, along with limits in resources. Then there is the NHS ethics process needed for this project. The applications and documentation needed to 'access a vulnerable population' engaging with the NHS is one of significant length and depth (see appendix 4). Amendments in relation to service requirements or requests is further a significant undertaking that requires time and effort in response to what the NHS perceive as 'minor' or 'substantial' categories. Alongside this process is also one of finding a NHS or social care team that was willing to participate. This required the responsible adults (clinicians) agreeing to be a recruitment site. They would need to consider if they have capacity to support the project amongst their clinical duties and the willingness to forge new professional and research relationships. Multiple influences on and from young person, professional, service

and organisational levels, within academic and clinical spheres, not only shapes but places barriers that then determine the project path. This conjures the information referenced within the introduction of children frequently bouncing and moving from place to place in response to systemic influence and barriers.

Connecting all of the above factors, Davies & Wright (2008) note that aspects such as achieving the ‘balance’ needed for LAC clinicians in research can be complicated, along with processes such as NHS ethics itself complicating factors such as consent and research set up. For this project, this has certainly been my experience. It has been set time limits, scrutinised from various agencies and has been dependent on ‘responsible adults’ not only saying yes to receiving and supporting the project, but also recruiting for it, leaving control to these adults. All of these factors were needed to satisfy other responsible adults in control of the ethics process. These factors and frustration from myself as the researcher, to an extent, seem to bear similarity to what participants have expressed in this study; uncertainty, lack of control, a lack of voice in decision making processes. As understandable as it is for there to be protective gatekeepers keeping watch for this vulnerable population, my experiences of this project alongside what participants have expressed here have given insight into how much these gatekeepers may also block LAC voices from coming through the other side.

The above is not to ignore that I have exerted my own beliefs and positions onto the project design and outcomes. I recognise that I myself am also a ‘gatekeeper’ by virtue of being a clinician who has and still works with LAC. There was tension in this role, and at times it proved hard to hold a both/and position (Dallos & Draper, 2015) alongside the needed ‘balance’ to hearing participants’ voices in analysis (Davies & Wright, 2008).

To elaborate, I hold a belief similar to Hart (1992) that children can have their voices heard through collaborative responsibilities, such as research participation. On one side of this ‘balance’, my previous and current clinical work has shown me the insight and capacity LAC can have in expressing on their own health needs and feedback on services. I did attempt to hold the ‘right to be heard’ side of the ‘balance’ when designing and implementing this project. This was through ensuring participants had thinking periods to participate, separate information sheets, support in interviews and feeding back the impact of their participation. Throughout my clinical training, I also feel I have had enough reflective and reflexive training and practice to be ‘good enough’ to manage this balance.

My clinical position is however also one of hearing and seeing the impact of their past trauma’s and just how vulnerable these young people can be. There may well and probably were times when this balance was slightly skewed toward the ‘protection’ side of the ‘balance’. This is particularly relevant during the interview process, where my role as a clinician and viewing these participants as ‘vulnerable’ may have engendered a projection (Lemma, 2016) of my own anxieties onto participants, predominantly from the fact that I had no clinical input to contain them if they became distressed (of which no participant observably did). In turn, this could have hindered asking personal but other contextually appropriate questions on their past or support, therefore adjusting what they expressed and the subsequent data analysed here.

Further, by virtue of me being a clinician and a researcher, this automatically puts me in a position of power (Totton, 2009), which in itself could have influenced what participants chose to express to me, particularly given the likelihood of their own histories with ‘professionals’ (Berger, 2015). It could have further played into

some participants' perceptions in this study of the 'professional' (me) being there 'for their job' rather than being there to listen to them. In order to 'balance' this, as interviews progressed, the importance of a 'crash course' of 'getting to know and being know' became clearer. This was attempted to the best of my ability through hobbies, friendly talk and connecting on shared interests. Being a clinician in this position also helped in building this due to the awareness of power and practice in my career so far with young people (Munro, 2001).

Feedback from participants on the interview process did show that they valued the slow and 'non-invasive' approach taken. This information did help to gauge that my anxieties may not have hindered questioning as much as I thought, and struck a good enough balance of questioning and sensitivity for participants to feel comfortable to take part as much as possible in the interviews. However, it is worth acknowledging that this was also obtained face to face at the end of their interview, where the participants may have also not felt able to feed back as honestly as they might have in writing or anonymously.

There are several other external factors to reflect on prior to considering my analysis below. One factor that is evident to others is my gender, being male, which could have influenced the LAC service to feel more 'comfortable' to recruit the predominantly male sample, however this was not elaborated with the team. The slow recruitment prior to a significant shift to faster recruitment efforts (just prior to the Covid-19 pandemic) was also not explored with the clinical recruitment team.

Regarding my own beliefs and influences on data analysis, one immediate link that could have influenced this was the consequent frustration from the above barriers that I encountered in the research process. This is clear given the length of my reflection on this above. These barriers did leave me with less than what I had

hoped for in my sample, which in turn left me with a pressure to ‘do a good analysis’ on the existing data. I feel analysis supervision helped in mitigating my reach with what data I had and the discussion above to ensure participants’ voices predominated, however this is a clear point to acknowledge. Another factor of this frustration was potentially that my own perception of how participants and other young people in care may feel from their experiences – lack of voice, control and uncertainty - could have focused my analysis toward ‘society’ and ‘others’ being a significant source of barriers for these young people. It could well be why I seem to react strongly to organisations such as NICE above and my perceived ‘mismatch’ of their ‘best practice’ when compared with what participants are describing they value in this study.

My above frustrations and ‘others’ contributing to barriers for LAC could also have placed me in a ‘rescuer’ position (Karpman, 1968) that shaped my conveyance of what I felt participants expressed in order to be ‘saved’, namely the parental qualities and service. I do feel that previous research, the amount of quotations included and analysis supervision does back up this concept coming mainly from participants. I further feel that in sticking with thematic analysis, despite the smaller sample size, this helped in distinguishing my sense of ‘rescuing’ against what participants described as valuable to them. Despite this, it is an interesting point to hold in mind for those reading this, for my own future research and clinical practice, along with other researchers in how likely it is to move toward this rescuer position given LAC’s ‘vulnerability’. This position is particularly relevant regarding access to research for LAC which, as shown previously, can be very much entangled in this process (Davies & Wright, 2008).

Conclusion

From a LAC perspective, there are many individual, societal and systemic factors that contribute to barriers to mental health care access and engagement. The facilitators expressed by participants here are clearly important in addressing these. However, given the need for more exploration of facilitators for LAC, the importance of hearing more of their voices on this matter is even clearer. This is particularly relevant given the mismatch of participants' emphasis on relational and parental qualities against current UK guidelines for 'best practice' and the 'evidence base'. Understanding these qualities as coming from and connecting across multiple contexts is important to show it is a network of factors and people that support LAC to access and engage in help. How well this network functions is therefore also important to consider for carers and professionals in social and health systems.

Continued research needs to include LAC's voices and perspectives on what they value as facilitating access and engagement in help and services. Given the understanding of facilitators are still growing, alongside this, research needs to also look into the impact of barriers that are placed in front of LAC by others. This is particularly important considering the role relational stigma and systemic barriers have in perpetuating distress. In order to instigate meaningful change from these suggested directions, studies and findings also need to be considered and shared outside of academic realms. Sharing studies and findings with carer or LAC communities or councils, mental health campaigns for young people or those in care, APPG's and organisations such as NICE would be important considerations in reaching organisational and political agendas. Underscoring these directions is a need to include LAC in a meaningful and participatory role in research and initiatives.

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Appendices

Appendix 1. Introduction Meta-Synthesis review search strategy (Cooke et al, 2012)

S = Looked after child or care/foster population

PI = Mental health

D – Specific methodology

E = Constructs

R = Qualitative

1 S = Looked after child* OR Looked after young pe* OR foster child* OR resident* child*

2 PI = mental health OR Psycholog* OR emotion*

3 PI = care OR utili* OR access* OR engag*

4 D = interview* OR focus group* OR narrative OR view*

5 E = barriers OR facilitat* OR engag* OR help seek* OR belie* OR attitude* OR percep* OR perceiv*

6 R = Qualitative*

Combination – (1 AND 2 AND 3) AND (4 AND 5) AND 6

Appendix 2. Quality Assessment Framework table (Introduction meta-synthesis)

Quality assessment points	Focus group	Post Q'aire	Individual interviews						
	Stanley et al. (2007)	Beck (2006)	Fleming et al. (2009)	Heath & Priest (2009)	Jee et al. (2014)	Johnson & Menna (2017)	Lee et al. (2006)	Tatlow-Golden & McElvaney (2015)	Blower et al. (2004)
Was there a clear statement of the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓
Is a qualitative methodology appropriate?	✓	✓	✓	✓	✓	✓	✓	✓	✓
Was the research design appropriate to address the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓
Was the recruitment strategy appropriate to the aims of the research?	?	✓	?	✓	✓	✓	?	✓	?
Was the data collected in a way that addressed the research issue?	✓	✓	✓	✓	✓	✓	?	✓	✓
Has the relationship between researcher and participants been adequately considered?	x	?	✓	✓	x	?	x	✓	x
Have ethical issues been taken into consideration?	✓	✓	?	✓	?	?	?	✓	?
Was the data analysis sufficiently rigorous?	x	?	?	✓	✓	✓	✓	✓	?
Is there a clear statement of findings?	✓	✓	✓	✓	✓	✓	✓	✓	✓
How valuable is the research?	Stated	Stated	Stated	Stated	Stated	Stated	Stated	Stated	Stated

✓= Yes x = No ? = Can't tell Stated = Authors stated the value of their research for clinical or academic means within the paper

Appendix 3. Interview topic schedule

Topic schedule

Length: 30-60 minutes

Considerations and key words: mental/emotional health; services; difference between [Clinical] team and CAMHS; help vs support; guardian/carer/parent?

Opening – [team] experiences and current engagement

How have you found being with this team you saw today?

How did you come to be with this team?

Who did you come to see today? How was it?

What are they doing with you (in this team)?

What do/did you see this team doing for you?

Are they helping you in any way?

Mental health conceptualisation

What do you understand by the term mental health? And emotional wellbeing?

What do you think of when you hear the words mental health or emotional wellbeing difficulty?

How can you imagine a young person experiencing difficulties with their mental health/emotional wellbeing?

What are your thoughts on young people who may experience difficulties in their mental health/emotional wellbeing?

What do you think of young people who may get help with their mental health/emotional wellbeing from professional services?

Services

Do you know of any NHS services that help young people with their mental health/emotional wellbeing? What do you understand about these services?

What has been your experience of mental health/emotional services?

Which services have you been involved with/involved in now?

Do you/did you think you needed them being involved? At the time? Now?

How would/did you seek support for mental health/emotional wellbeing difficulties (or for their reason they gave above about being with [team])

Has there been anything that has got in the way of you seeing mental/emotional health services?

At what point would you be worried about a friend and ask them to seek support? – where is the line between self-reliance and recognition to seek help?

Where would that support come from?

(Able to ask about placements?) – Autonomy and independence

Where are you living now?

Who are you living with? How is it?

What's your experience of living there?

What stands out for you in this home and the person/people you are with?

How does it compare with other places you have lived?

Does any other placement stand out for you in the way they provided a home?

Where have you felt most at home?

Why is that? Who lived there with you?

Do you think there is a difference between a house and a home?

How many different places have you lived?

When thinking the people who support you at the moment; Who's responsibility do you think it is for you to seek support for mental health or emotional wellbeing? Is there anywhere specific that comes to mind when talking about this?

Has this been different depending on where you have lived?

Who would you most likely listen to if someone advised you to see mental/emotional services for support? (facilitator to explore)

Ending

What is important for mental/emotional services to do to help young people in care?

Do you think services are currently doing that?

When do you think it is important for young people to see mental/emotional services?

How would young people get involved with these services?

What would support for mental health/emotional wellbeing difficulties look like?

What type of people would you like to see in these teams or services?

Feedback

Was there anything you liked about the last hour (or other time frame)

Was there anything that could have been different?

If you were interviewing me, how would you have done it?

References used in construction – most recent/relevant to the topic and UK services from brief literature search

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Appendix 4. Health Research Authority (HRA) approval letter



Mr Nathan Parnell
University of Essex
Wivenhoe Park
Colchester
CO4 3SQ

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

20 May 2019

Dear Mr. Parnell,

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title:	Barriers and facilitators to screening, assessment and mental health care of Looked After Children
IRAS project ID:	247010
Protocol number:	not applicable
REC reference:	19/LO/0471
Sponsor	University of Essex

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **247010**. Please quote this on all correspondence.

Yours sincerely,
Laura Greenfield

Approvals Specialist

Email: hra.approval@nhs.net

Copy to: Ms Sarah Manning-Press [Sponsor Contact]

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Essex Indemnity letter]	1	16 July 2018
HRA Schedule of Events	1	08 March 2019
HRA Statement of Activities	1	08 March 2019
HRA Statement of Activities	1	03 April 2019
Interview schedules or topic guides for participants [Topic schedule]	1	01 January 2019
IRAS Application Form [IRAS_Form_27022019]		27 February 2019
Letter from sponsor [University of Essex Sponsor letter]	1	25 February 2019
Letters of invitation to participant service letter for participant information pack v2 with tracked changes for REC responses]	2	20 April 2019
Other [Risk Protocol]	1	12 February 2019
Other [University of Essex Public Liability insurance]	1	30 April 2019
Other [HRA assessor and HRA REC committee responses cover letter for provisional opinion]	1	30 April 2019
Participant consent form [Carer consent form for young person to participate (carer is non-participant) v2 with tracked changes for REC responses]	2	20 April 2019
Participant consent form [Young person assent form for under 16 v2 with tracked changes for REC responses]	2	20 April 2019
Participant consent form [Young person consent form over 16 v2 with tracked changes for REC responses]	2	20 April 2019
Participant information sheet (PIS) [Carer information for young person Over 16 to participate (carer is non-participant) v2 with tracked changes for REC responses]	2	20 April 2019
Participant information sheet (PIS) [Carer information for young person under 16 to participate (carer is non-participant) v2 with tracked changes for REC responses]	2	20 April 2019
Participant information sheet (PIS) [Young person information sheet over 16 v2 with tracked changes for REC responses]	2	20 April 2019
Participant information sheet (PIS) [Young person information sheet under 16 v2 with tracked changes for REC responses]	2	20 April 2019
Research protocol or project proposal [Research Protocol]	1	12 February 2019
Summary CV for Chief Investigator (CI) [CI CV]		12 February 2019
Summary CV for supervisor (student research) [Primary Academic supervisor CV]	1	24 February 2019
Summary CV for supervisor (student research) [Secondary Academic supervisor CV]	1	24 February 2019
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study flow chart for recruitment and data]	1	12 February 2019

IRAS project ID	247010
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Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

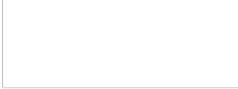
Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
1 site type	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	As per the statement of activities, participating NHS organisation(s) will not receive funding.	A Local Collaborator is expected to be in place at the participating NHS site	Should prior contractual arrangements with the host NHS site not be in place, the researchers undertaking research activities at the NHS trusts would be expected to obtain Letters of Access on the basis of Research Passports if University employed, or NHS to NHS confirmation of pre-engagement checks letters if they are NHS employed, or have already Honorary Research Contracts. Enhanced DBS checks and occupational health clearance would be appropriate.

Appendix 5. University of Essex ethical approval letter

University of Essex

13 June 2019

MR NATHAN PARNELL



Dear Nathan,

Re: Ethical Approval Application (Ref 18019)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Officer on behalf of the Faculty Ethics Committee.

Yours sincerely,



Lisa McKee
Ethics Administrator
School of Health and Social Care

cc. Research Governance and Planning Manager, REO
Supervisor

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

School of Health and Social Care
T 01206 872854
E hsc@essex.ac.uk

www.essex.ac.uk

 @uni_essexhealth  /EssexHSC  /uniofessex

Appendix 6. NHS trust confirmation for capacity to conduct recruitment

Nathan Parnell
University of Essex
Wivenhoe Park
Colchester
CO4 3SQ

28th June 2019

Dear Nathan,

Re: [redacted] Letter of Access for research - RD #19 247010 Barriers and facilitators to screening, assessment and mental health care of Looked After Children

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that such checks as are necessary have been carried out by your employer and that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. This letter confirms your right of access to conduct research through [redacted] Trust for the purpose and on the terms and conditions set out below. This right of access commences on **26th June 2019** and ends on **1st October 2020**, unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to [redacted]. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through [redacted] Trust, you will remain accountable to your employer Essex Partnership University NHS Foundation Trust but you are required to follow the reasonable instructions of your nominated manager [redacted] Research Manager, in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [redacted] Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of

[redacted]

Practice [redacted] and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

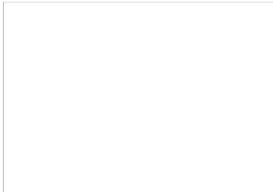
[redacted] Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.



Appendix 7. HRA substantial amendment favourable opinion letter



London - Camden & Kings Cross Research Ethics Committee

NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

25 September 2019

Mr Nathan Parnell
University of Essex
Wivenhoe Park
Colchester
CO4 3SQ

Dear Mr Parnell

Study title:	Barriers and facilitators to screening, assessment and mental health care of Looked After Children
REC reference:	19/LO/0471
Protocol number:	not applicable
Amendment number:	Amendment 1, 22/07/2019
Amendment date:	24 July 2019
IRAS project ID:	247010

The above amendment was reviewed 20 September 2019 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

This was to the amendment to change recruitment information supply to participates. The [redacted] Clinical team will provide appropriate and eligible participants the recruitment information in person as opposed to mailing this material to their caseload. This will be handed to eligible participants and their carers as and when they have a clinical appointment with their [redacted] clinician.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering letter on headed paper	3	13 July 2019
Notice of Substantial Amendment (non-CTIMP) [Nathan Parnell Substantial Amendment number 1]		24 July 2019
Notice of Substantial Amendment (non-CTIMP) [Nathan Parnell Substantial Amendment number 1 24-07-2019 final]	Amendment 1, 22/07/2019	24 July 2019
Other [STUDY FLOW CHART]	2	13 July 2019
Other [Cover Email]		24 July 2019
Research protocol or project proposal [LAC protocol]	2	13 July 2019

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: <https://www.hra.nhs.uk/planning-and-improving-research/learning/>

19/LO/0471:	Please quote this number on all correspondence
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Yours sincerely



Mrs Julia King
Alternate Vice chair

E-mail: nrescommittee.london-camdenandkingscross@nhs.net

Enclosures: List of names and professions of members who took part in the review

Appendix 8. HRA substantial amendment approval email

nrescommittee.london-camdenandkingscross@nhs.net <noreply@harp.org.uk>
Fri 04/10/2019 16:39

- Parnell, Nathan M;
- Manning-Press, Sarah E L

Dear Mr Parnell,

?

IRAS Project ID:	247010
Short Study Title:	Barriers Facilitators to Mental Health Care Looked After Children V1
Amendment No./Sponsor Ref:	Amendment 1, 22/07/2019
Amendment Date:	24 July 2019
Amendment Type:	Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the conditions outlined in your categorisation email.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

Please contact [hra.amendments@nhs.net]hra.amendments@nhs.net for any queries relating to the assessment of this amendment.

Kind regards

Mrs Claudia Bywater
Approvals Specialist
Health Research Authority

Ground Floor | Skipton House | 80 London Road | London | SE1 6LH

E.hra.amendments@nhs.net

[W. www.hra.nhs.uk](http://www.hra.nhs.uk)

Appendix 9. Clinical team's NHS trust capacity confirmation email to implement substantial amendment

[email address]

Mon 07/10/2019 08:46

☐

Dear Nathan,

Study title: Barriers Facilitators to Mental Health Care Looked After Children V1

IRAS Project ID: 247010

Amendment number and date: Amendment 1, 22/07/2019

I am writing to confirm that the amendment has been reviewed at the [NHS] Foundation Trust and can be implemented.

Kind regards

XX

XXX XXXX

Senior Research Facilitator

Research and Development

Appendix 10. Safeguarding and risk protocol

Risk, safeguarding or criminal activity protocol

This research study does not ask any direct questions regarding risk issues such as suicidal ideation, deliberate self-harm or criminality. However, given the topic of access to mental health care, disclosure of mental health difficulties and risk matters may arise in the process of interviewing.

Given the research design, a disclosure of risk to self or others to the Chief Investigator (CI) would only be possible during the interview, which would be undertaken in close proximity to the [team] clinical team. Managing risk will be discussed with young people and their carer's prior to conducting the interview. This will be in the context of an outline of confidentiality and the exceptions in which a breach is necessary. It will also be discussed that consent from the young person and carer, where possible, will always be sought to share information that may be relevant to risk management.

Any disclosure of risk to self or others that would require breach of confidentiality would be dealt with in and immediately after the interview. If the young person does become distressed as a result of the interview or disclose any risk information, the young person and carer (if applicable) will be informed that this information will be passed onto the appropriate [team] clinician and they will be offered a call back from the [team] clinician or team within 24 hours. The CI would then inform the responsible clinician in contact with the family, or another appropriate clinician in the [team] team in the event of the responsible clinician being away. At this point, the appropriate advice from the [team] clinician would be sought for any subsequent actions needed from the CI, along with the risk policy and procedures within the [team] team and their NHS trust being implemented. In dealing with risk issues immediately after the interview, this would encompass all possible risk situations – emergency or otherwise - and place the care and management of these within an appropriate NHS clinical service.

Safeguarding

In the event of a safeguarding issue being disclosed, two pathways will be employed.

- 1) In the event of a safeguarding issue being disclosed by the young person and/or by those with parental responsibility/carer concerning persons outside of that dyad, the same process as risk will be employed in informing a responsible clinician within the [team] team.
- 2) In the event of a young person disclosing a safeguarding concern regarding those with parental responsibility or their carer, it may be necessary to use clinical judgement to assess if there is a need to inform a [team] clinician without the knowledge of the person with parental responsibility or carer who is in question. This will be covered under the explanation of confidentiality prior to conducting the interview, in which it will be outlined that those involved will be informed of said breach if necessary or practical, however there may be exceptions where informing them first may not be practical or in the best interests of the safety of the vulnerable person. If it is necessary to raise a safeguarding concern with the [team] team in this situation, the young person involved will be informed of this need, and the responsible or appropriate clinician will be informed immediately. At this point, the safeguarding concern will be handed to the clinical team for management of the situation in accordance with their NHS trust policies.

Appendix 11. Compensation signature sheet (University of Essex Policy)



SCHOOL OF HEALTH AND SOCIAL CARE

Participant Payments

I have taken part in a study carried out by Nathan Parnell for which I claim the sum of £10 in an amazon voucher. I have not received any other payments from the University in the current tax year (ie since 5 April 2018)

OR

I have already received the following payments from the University since 5 April 2018.
£.....for.....

NOTE: If you have received more than £20 in total already, you **must** tell us so that this and future claims can be processed through the University payroll system, to ensure compliance with the tax laws of the United Kingdom.

SignedDate.....

Guardian signature
Date.....



SCHOOL OF HEALTH AND SOCIAL CARE

Participant Payments

I have taken part in a study carried out by Nathan Parnell for which I claim the sum of £10 in an amazon voucher. I have not received any other payments from the University in the current tax year (ie since 5 April 2018)

OR

I have already received the following payments from the University since 5 April 2018.
£.....for.....

NOTE: If you have received more than £20 in total already, you **must** tell us so that this and future claims can be processed through the University payroll system, to ensure compliance with the tax laws of the United Kingdom.

SignedDate.....

Guardian signature
Date.....

Appendix 12. Facilitating Research Fund compensation approval

<p>School of Health and Human Sciences</p> <p>Application for support from the Facilitating Research Fund (FRF)</p> <p>(Application to be typed/word processed)</p>	
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For PhD/MPhil/Masters by Dissertation/
Professional Doctorates in Health and Social Care Students only

Name: Nathan Parnell	Supervisor: Dr Susan McPherson
Programme: DClinPsy	Year of Study: 1
Amount requested: £150	Date of Application:

Request for Conference Support (give FULL details of Conference, whether you are giving a paper or not, and cheapest available costings)
N/A

Request for other support (give FULL details)

These funds are being requested for participant compensation for time given in a University of Essex research project. This project is being conducted as part of a Doctorate in Clinical Psychology. This study plans to recruit adolescents between the age of 12-18 years old that will have spent time travelling to their mental health service site, and extra time spent of their day participating in this project following their appointment (should they consent). As such, these funds will be important in ensuring participants are compensated for their time and effort in the form of £10 amazon vouchers for each adolescent. This study aims to recruit 15 adolescents in total, therefore the amount of £150 is requested for the purpose of participant compensation only.

Details of previous funds received from this or the Research Endowment Fund (give dates and purpose)
N/A

Student's Supervisor Supporting Statement

Nathan is undertaking a project involving interviewing young people in care and who are a particularly hard to reach population whose voices are very much under-represented in the literature to date. It will be important for recruitment for him to offer some recognition of their time for taking part in the research.

Application to be submitted by e-mail to relevant programme administrator
Updated October 2014

Outcome of application (to be completed by Head of School/ Director of Research/Programme Lead)

Approved
Rejected
Partial Funding (State below what is funded)

Comments and conditions of approval

(please include here any conditions of approval such as required to present at a School research seminar, or work toward further dissemination/ publication)

Cost code to be used

Signature



Date

28/9/18

Head of School/Research Director/Programme Lead

Application to be submitted by e-mail to relevant programme administrator
Updated October 2014

