Addressing the mental health needs of looked after children in foster care:

The experiences of foster carers

Abstract

Introduction: In recent years there has been an increase in the number of looked after children. Despite well documented vulnerabilities to mental health problems among this population, there continues to be poor uptake and utilisation of Child and Adolescent Mental Health Services (CAMHS). **Aim:** To elicit views of foster carers regarding the mental health needs of children and young people in their care and their experiences of accessing mental health services. **Methods:** A Grounded theory approach and semi-structured interviews with ten foster carers. **Results:** The experience of being a foster carer was the core category, with three major themes: 1) Foster carers' psychological understanding of challenging behaviour; 2) Barriers to accessing CAMHS; 3) The importance of support. **Discussion:** A key finding of this research is that barriers to accessing CAMHS were not experienced at the point of referral, but later, once within the mental health system. A positive finding is that the foster carers demonstrated good mental health literacy and a pro-active approach to seeking help for the children in their care. The foster carers also expressed a need for more support structures related directly to the viability of the placement. **Implications for practice:** Mental health nurses have a pivotal role in providing: a more responsive and needs-led service for this population; professional support to foster carers to include facilitating peer support; and clinical interventions for the looked after children.

Key Words: Child and Adolescent Mental Health Services (CAMHS), children, Foster Carers, Looked after Children, Mental Health, young people

Accessible Summary

What is known on the subject?

- In the UK and internationally the number of looked after children is increasing year on year.

- Mental health problems amongst looked after children are significantly higher than in the general population and the uptake of mental health services for these children is low.

- There is a poor prognosis for children with untreated mental health problems; this is further compounded if the child is within the care system.

What does this paper add to existing knowledge?

- This study adds to our understanding of foster carers' experiences of the mental health needs of looked after children and demonstrates some of the challenges associated with accessing appropriate and timely mental health services.

- New knowledge derived from this research is that the barriers to accessing Child and Adolescent Mental Health Services (CAMHS) are not at the time of initial referral as previously reported , but later, once within the mental health system with long waiting times experienced particularly for specialist services.

- To our knowledge this study provides new insights into the experience of being a foster carer and the levels of support and resources needed that directly relate to the viability of the placement.

- The majority of the foster carers interviewed were from a Black and Minority Ethnic (BME) background, previously under-represented in this research area.

What are the implications for practice?

- A number of areas in current CAMHS provision need addressing with a focus on accessibility, consultation, and support for foster carers. Waiting times need to be addressed and improved communication with other agencies is also highlighted.

- CAMHS nurses are well placed to develop and deliver a comprehensive care package to foster carers, offering more tailored support to them whilst enabling the children and young people in their care to access and engage more effectively with mental health services.

Introduction

The number of looked after children by a local authority in England has increased significantly in recent years (Department for Education (DfE) 2015) with similar trends also reported internationally (Vandivere et al, 2012; Tucker & Mares, 2013). In 2014 there were 69,540 looked after children in England; an increase of 1% from the previous year and 6% since 2011 with 75% of looked after children in foster care (DfE 2015).

According to the Children Act (1989) a child is legally defined as 'looked after' by a local authority if he or she:

- is provided with accommodation for a continuous period for more than 24 hours;
- is subject to a care order; or
- is subject to a placement order (DfE 2015).

The increase in looked after children in England could in part be explained by a number of high profile cases of child deaths due to familial abuse. (Laming 2003, Department for Schools, Children and Families (DSCF) 2009; Safeguarding Children Board (SGCB) Haringey 2009; Rogers 2013) which has resulted in a significant increase in care order applications to the courts (Children and Families Court Advisory Support Service (CAFCASS), 2011). Child Protection procedures have also been under greater scrutiny nationally with recommendations for changes to practice regarding safeguarding (Munroe, 2011). Furthermore, children are staying in the care system for longer, with 13% of children in care for over five years (National Society for the Prevention of Cruelty to Children (NSPCC), 2013). These trends are not restricted to the UK, with similar observations also reported in Australia (Council of Australian Governments, 2009) and New Zealand (Murray, Tarren-Sweeney & France, 2011). Children who are looked after by a local authority have usually experienced considerable disruption or trauma in their lives with abuse or neglect being the main reasons for a

care placement.   The trauma of separation from their family can also be damaging to a child's development and mental health (Clausen et al, 1998; Kerker & Dore, 2006).

It is well documented in the international literature that looked after children have a higher prevalence of mental health difficulties in comparison to the general population (Kerker & Dore, 2006; Nathanson & Tzioumi, 2007; Tarren-Sweeney, 2008). In the UK, Green et al (2005) undertook a survey examining the mental health of children and young people and estimated that in the general population, 10% had a mental health difficulty. Comparing this to an earlier study that focused specifically on the mental health of looked after children in England, Meltzer et al (2003) found that 45% of children aged between five and seventeen had an identified mental health difficulty. The most common mental health difficulties among looked after children were conduct disorder, hyperkinetic disorders and emotional disorders e.g. depression or anxiety This would suggest that looked after children are approximately four times more likely to have a mental health difficulty in comparison to their peers. A later publication by Ford et al (2007) combined data from several surveys, including Meltzer et al (2003) to examine psychiatric disorder among looked after children in Britain compared to children in private households. This study found higher levels of psychopathology, educational difficulties and neurodevelopmental disorders among looked after children and concluded that this population had significantly poorer mental health than the most disadvantaged children outside the care system. However, these studies have yet to be repeated with a more current cohort.

It is perhaps surprising then that the uptake of mental health services by this population remains relatively low (Bonfield et al 2010; Kerker & Dore 2006; Staudt, 2003).   Meltzer et al (2003) found that only 34% of looked after children with an identified mental health difficulty in England had been in contact with Child and Adolescent Mental Health Services (CAMHS). Similarly, a study conducted

in the USA (Burns et al 2004) found that only 25% of young people investigated by child welfare agencies received any specialty mental health care in the previous twelve months.

There is extensive research highlighting untreated mental health problems in childhood have a significantly negative impact on future outcomes for the child (Meltzer et al., 2003; Leslie et al, 2005; Mount, Lister & Bennun, 2004; Tarren-Sweeney, 2008). For example, it is well established that looked after children will often leave care with poor levels of academic achievement, higher rates of unemployment, homelessness, high rates of teenage pregnancy and drug use (Viner & Taylor, 2005; Pilowsky & Wu, 2006; Zlotnick, Tam & Soman, 2012). Rates of criminality are higher among looked after children; in the UK in 2012 there were 1543 young people in Youth Offending Institutions (YOI), with 30% of males and 44% of females having been in the care of the Local Authority (Murray 2012). It is also known that 27% of the adult prison population has previously been in care (Zayed & Harker, 2015).

Previous studies have identified barriers to accessing mental health services, which include: a lack of appropriate services and poor co-ordination between providers (Stanley, 2007; Mayers Pasztor et al 2006; Sargent & O'Brien 2004) waiting lists; and the help-seeking behaviours of caregivers, including foster carers (Staudt, 2003; Villagrana, 2006; Zima et al, 2000; Bonfield et al, 2010). Few studies however have focused on foster carers themselves and their experiences of accessing mental health services for the children in their care.

According to the Coram BAAF Adoption and Fostering Academy (CoramBAAF 2015), fostering is defined as a way of providing a family life for children who cannot live with their own biological parents. As demonstrated by CoramBAAF (2015) it is usually temporary and children will often return to their birth families once difficulties have been resolved. An alternative to foster care is Kinship Care (also known as Family and Friends Care) where a child lives with a member of the

extended family or a family friend, but is still considered 'looked after' by the local authority (CoramBAAF, 2015; Sykes et al, 2002).

Studies of foster carers in the UK (Bonfield et al 2010; Sargent & O'Brien, 2004; Taylor et al 2008; Stanley 2007) the USA (Zima et al, 2000; Mayers Pasztor et al, 2006) and Australia (Villagrana, 2006) all report a high prevalence of mental health difficulties among children in foster care. However, the focus of these studies varies, from help-seeking and service use (Zima et al, 2000; Bonfield et al, 2010); beliefs and experiences of caring for foster children with emotional and behavioural difficulties (Sargent & O'Brien, 2004; Stanley, 2007; Taylor et al; 2008); accessing mental health services (Mayers Pasztor et al, 2006); and caregivers as gatekeepers to accessing services (Villagrana, 2006).

A UK study by Bonfield et al (2010) conducted a survey with 113 foster carers to investigate help seeking behaviours and Mental Health Literacy as defined by Joran et al (1997 pg. 182):

> "The knowledge and beliefs about mental disorders, which aid their recognition, management or prevention."

The study found that 49% of children with an identified mental health difficulty were not accessing CAMHS. The foster carers in the study demonstrated high levels of mental health literacy which did seem to influence the 'perceived need' for help step, but only when the difficulties were particularly severe. Predictors of help-seeking were found to be a combination of foster carer education and the impact on them of the mental health difficulty, in addition to their mental health literacy and help-seeking behaviours.

In summary there is a paucity of studies with a focus on the experiences of foster carers who access mental health services for the children and young people in their care. This topic is highly pertinent

for health and social care professionals, including mental health nurses working in CAHMS, who strive to support children and young people with mental health difficulties and their carers.

The purpose of this study is to understand the experiences of foster carers who care for children and young people with mental health difficulties and their experience of accessing mental health services.

Methods

Design

This qualitative study adopted a grounded theory approach, using semi-structured interviews. Grounded theory is a widely used and popular qualitative methodology across a range of disciplines, including mental health nursing (Lewis, 2015). Grounded theory involves a systematic and inductive approach to constructing theory from empirical data 'bottom up', with researchers moving backwards and forwards between their data and the emerging findings (Bryant and Charmaz, 2007). There are some key characteristics of grounded theory that make it distinct compared to other qualitative methodologies such as ethnography and phenomenology, including: the concurrent collection of data and ongoing analysis; the sampling of participants being guided by the emergent findings, known as 'theoretical sampling'; and the method of data analysis which is known as the 'constant comparative method' (Holloway & Galvin, 2015).

Setting and participants

The study was conducted within a single, inner city, local authority in England. Written permission was gained from the local authority to conduct the research. With support from the local Looked after Children's team to identify and approach potential participants, theoretical sampling was used to recruit the foster carers: the only inclusion criterion was that they had fostered at least one child or young person with mental health difficulties, giving them adequate experience to participate in the study. Nine foster carers and one kinship carer were interviewed; seven of the foster carers

were recruited through their supervising social workers, who acted as 'gatekeepers' in the recruitment process, and three through a local foster carer forum.

Data collection

Semi-structured interviews were conducted with the participants by WY, in a convenient location for the foster carer. In all but one case this was at the foster carer's home, with one foster carer interviewed at her place of employment. The interviews were audio-recorded and lasted between 45 and 90 minutes.

A topic guide directed the interviews and included questions on the following topics: the experience of being a foster carer; whether they have fostered children with emotional and behavioural difficulties and/or mental health issues; challenges the foster carer's encountered and strategies developed; when they might ask for help and from where; what is their understanding of CAMHS and their experiences of using this service. Prior to the interviews the proposed topic guide was piloted with two people working in caring professions and their feedback elicited. The feedback received was positive and therefore the guide was not revised.

All the participants offered a rich description of their experience. After ten interviews it was considered that the data were saturated (Glaser & Strauss, 1967) as no new themes emerged.

Data analysis

The interviews were transcribed verbatim by WY. The transcripts were read and then re-read to become familiar with the data. The interview data were then analysed using the constant comparative approach (Glaser & Strauss, 1967) with the constant comparison of data within an interview and then between interviews, constantly looking for connections and themes. The data

were coded and from these initial codes, categories began to emerge. These patterns and the integrating of the linked categories then took place, using the steps described by Charmaz (2006).

The coding and category development was conducted by the first author (WY) and discussed with the research supervisor (JJ). To ensure that a true account of the interview had been captured, the individual transcripts and an interim summary of the data analysis were shared with the participants. This was to ensure that our interpretation of the interviews were accurate and represented a form of member checking (Lincoln & Guba, 1985). All participants were in agreement with the summaries and the use of pseudonyms was also agreed.

Research team and reflexivity

WY is a mental health nurse and an experienced CAMHS clinician. JJ is a health services researcher, not a clinician and was WY's academic supervisor at the time of the study. The issues related to 'insider – outsider' status as a nurse researcher (Brunero & Jeon 2015) are very relevant to this study in terms of an awareness of the influence a researcher may have on the research process, particularly in qualitative research. WY was an 'insider' with her clinical role and expertise, but had little prior experience of undertaking research before this study. On reflection it was evident that her nursing skills of engagement and communication and knowledge of child and adolescent mental health enhanced her ability to engage positively with the Looked after Children Team for support to access and recruit participants and to develop a good rapport with the foster carers during the interviews. JJ is not a CAMHS clinician and was not involved in the interviewing; this was helpful when supporting WY during the research to try and avoid 'taken for granted' assumptions and to provide a more 'outsider' perspective to the research process and findings. It was also important to ensure that there was no conflict of interest regarding WY's role as a CAMHS clinician during the research. Accordingly, the foster carers were recruited from a different location to her place of work to ensure not having previous contact with them in a professional capacity.

Ethical issues

Ethical approval for the study was granted by a local University research ethics committee. All participants were provided with an information sheet, given time to consider their participation and signed a consent form. The participants were all informed that their participation was voluntary and that they could withdraw from the study at any time without giving a reason.

Results

Nine foster carers and one kinship carer participated in the study. All were women and had an average age of 54. **Table 1** provides some demographic detail; all names have been changed using pseudonyms to ensure confidentiality and to further protect anonymity, the number of children fostered and the number of years as a foster carer have been categorised.

Based on the grounded theory analysis, the core category that emerged was: The Experience of Being a Foster Carer. The three major categories were: foster carers' psychological understanding of challenging behaviour; barriers to accessing mental health services; and the importance of support. One interesting observation was that the experience of being a foster carer has many contradictions. For instance, when asked what it is like to be a foster carer, most identified the rewarding nature and at the same time the challenges, as the quotations below illustrate:

"It's hectic, emotional and rewarding". (Dorcas)

"You have your highs and lows. It can be quite challenging and at the same time quite rewarding." (Mary)

"Fostering is hard but rewarding". (Cathy)

All the participants talked about the mental health difficulties experienced by the children and young people they cared for, which included: depression, anxiety, Attention Deficit Hyperactivity Disorder (ADHD), conduct disorder, bipolar, attachment difficulties, Obsessional Compulsive Disorder (OCD), self-harm (including cutting and the taking of overdoses), suicidal ideation and hearing voices.

Foster carers' psychological understanding of challenging behaviour

The foster carers had all experienced behaviour that they found challenging in some way. In particular, the children and young people displayed emotional and behavioural difficulties which the foster carers then had to make sense of, trying to interpret meaning.

The emotional problems reported included frequent changes in mood, as described by Cathy when talking about a child she fosters:

"She'll be smiling and then she'll start crying. She blows from hot to cold in five minutes"

From the interviews it was evident that many of the foster children exhibited oppositional behaviour including kicking, punching, biting and spitting. A need to control their environment was identified by the foster carers as well as the children wanting their own way, as described by Anna:

"A lack of control can contribute to behaviour problems. Often they try to regain control when everything has been taken away from them". (Anna)

The foster carers also reported violent outbursts with aggression, damage to property and destructive behaviours as well as the more passive behaviours of ignoring the carer or not speaking. Some young people absconded both from home and school, sometimes for days at a time which was a huge concern, often resulting in the placement becoming untenable.

The foster carers articulated many reasons for the challenging behaviours exhibited by the children they cared for, demonstrating their awareness, empathy and depth of psychological understanding, which can be conceptualised as mental health literacy as shown by the following quotations:

"Early life experiences contribute to her current behaviour" (Michelle)

"A difficult background will mean understandably some kind of behavioural or emotional problem" (Jill)

Many of the reasons elicited for the children's difficulties were connected to their biological parents. Parental physical and mental health problems and learning difficulties were identified, as well as drug and alcohol issues and criminality:

"They [children] had such a poor home life and they [parents] weren't giving them their all. There was a mixture there of mental health problems with the parents, disability with the mum. You know that had an impact on the children" (Jill)

According to the foster carers, early life experiences including loss, trauma and the separation from their parents have also impacted hugely on the children and young people, likewise rejection, neglect and abuse. In addition to this, many of the foster carers acknowledged how difficult it is for the child when first arriving at their home.

"Often children coming into care are fearful....Imagine being ripped away from parents and ending up with strangers" (Josie)

<u>*Barriers to accessing mental health services*</u>

The foster carers all had frequent contact with a number of different agencies, including the local CAMHS, with at least one child under their care. Referral to CAMHS for the looked after children were generally made via social services; through either the foster carer's supervising social worker or the child's social worker. Overall the experience of the referral process was reported to be good as the following quotations illustrate:

"Straight forward process. [The] referral was made, appointment arrived followed by an interview and assessment" (Emma)

"[I] would use it for other children. Smooth and straightforward [referral process].... Did not have to wait long for appointment" (Mary)

Once a referral had been made however, a number of problems were identified relating to: waiting times; not being listened to; engagement; and times of transition.

Waiting times

The waiting list for treatment was a huge frustration for the foster carers and could cause great anxiety. Waiting lists were generally for long term treatment or a specialist assessment for conditions such as ADHD, as explained below:

"It took a year for everything to be diagnosed properly [ADHD]......The wait can be problematic because there are issues or behaviours that you don't know how to deal with and the child needs help with them.   And even to the point that this placement is going to break down if you don't get help soon. It's not a threat because if you're saying something like that you're at your wits end". (Jill)

"But obviously there is anger and she needs to deal with the anger, I mean I am not qualified to, I don't know how to, I manage what I can….. Eventually the child was seen for assessment – then placed on long waiting list (2 year wait) for psychotherapy." (Michelle)

More positively though, the CAMH service was reported to be more responsive where risk was involved for example, the therapeutic follow up after a psychiatric emergency:

"Good response from CAMHS following overdose. No wait. Lots of follow up. The counsellor rings her on the day of the appointment to remind her of appt. The counsellor then calls me if she does not answer. I then remind her of her appointment. She attends regularly." (Dorcas)

What is evident from the interviews is that whilst there are clearly barriers to accessing mental health services, they are not at the point of referral but occur once within the mental health system itself.

Not being listened to

Not being listened to by professionals across the different agencies was another frustration reported by the foster carers. The foster carers expressed the view that they know the child better than most of the professionals involved, but that this is often not heard or valued, as the following quotations illustrate:

"As a Foster carer you have this child 24 hours a day – you know the child – they [social worker] come and see them once every six weeks. […] They don't really know that child but they're not prepared to listen to what the carers have to say." (Josie)

"We're everything to that child: we're a mother, we're a father, you know, we could be a nurse when they're not well, you're there looking after them, you know, you can also be a therapist to them but you're also punch bag....and everything else, more than just a social worker, so you'd think they would listen." (Michelle)

Transition

Times of transition were highlighted by the foster carers as being especially difficult, for example a move to a new CAMHS service in a new area, a new school, foster care back to biological family or foster care to independent or semi-independent living. Transitions are representative of yet another change for the child and are often anxiety provoking situations as the following quotations show:

"At times of change there is a risk that children can fall through the net.......There should be a bridge between CAMHS services in different areas – a good handover –not struggling in this grey quagmire of nothingness". (Lorna)

"I was really worried about her going to secondary school, just how she'd cope really with everything. Because she had big attachments to two mentors in primary school and they don't have mentors in secondary. And oh my gosh, we are now going backwards". (Michelle)

"He's due to move out to semi-independent [supported accommodation], so you know...that's going to be a bit of a hard time because he's been a part of the family for 10 years. His brother moved out last year and he's struggling and we don't want that for this one." (Jill)

Engagement

The foster carers also explained that sometimes the young people themselves disengage from the service and stop attending and as a consequence, they get lost in the system and are not followed up.

"After the assessment there was a change in professional – the girl didn't go back.....they lost her.....you can lose a teenager by turning him or her over to someone else......For this girl her story was horrific to start with and she says she didn't want to relive it with somebody else. It was bad enough doing it the first time". (Josie)

<u>*The Importance of Support*</u>

All of the foster carers expressed that having support and to be able to ask for help from an accessible point of contact is imperative to their role, which can be emotionally and physically demanding.

"All foster carers need to be able to ask for help and not feel a failure if unable to manage a particular child, otherwise you can feel very isolated." (Jill)

"Mentally it can really drain you. Especially when you have new situations that are right outside of the box, that you have no personal experience of and you think how on earth do I deal with that?" (Anna)

The foster carers discussed the different kinds of supports that they access, from more professional sources to that from their peers in formal settings such as an organised group or more informally. Everyone described their relationship with their social worker as fundamental, especially through the more difficult times, as explained by Miriam:

"Having a good support worker – that's brilliant. You know you've got someone who is always there for you, you know, at the end of the phone. Especially if you've got difficult children." (Miriam)

"I have my support network, the forum, supporting one another. I always go to my social worker first or the fostering network." (Cathy)

Several foster carers mentioned having friends who are also foster carers as well as the support groups and talked about the value of having this shared experience as described below:

"My support network is my friends who are foster carers, not necessarily in this borough (area). They can be a good source of help and more information like if you're in a crisis or not sure what to do. Your ordinary friends who don't do what you do have no idea, they wouldn't relate". (Anna)

"There is the group and some of us have already made friends any way so we can just call each other and that is very good. My cousin, she is also a foster carer and so we're also there for each other". (Miriam)

Discussion

To our knowledge, this is the first study to highlight that the barriers to accessing mental health services clearly exist, but not at the point where previously reported. From this research it appears that there is generally good access to mental health services in the first instance following referral but that the real barriers exists once within the system, particularly when access to more specialist mental health services is being sought. The majority of children and young people cared for by these foster carers had been referred to CAMHS and the foster carers reported a quick referral and initial assessment via their supervising social worker or the social worker of the child. However once in the mental health system, barriers were experienced in terms of delays between the onset and recognition of problems and the delivery of services. For the foster carers in our study the experience of long waiting times for specialist assessment and long term treatments, such as psychotherapy, generated real feelings of anxiety and powerlessness. Interestingly this emotional response has not been discussed specifically in the literature but was certainly an issue for the foster carers interviewed. A number of reports highlight waiting times and accessibility as a national problem and priorities for service transformation have been outlined (DCSF/DH 2010; DH 2015; Mental Health Task Force 2016).

A key finding is that the foster carers interviewed demonstrated a good level of understanding, empathy and mental health literacy, which is also reflected in the wider literature (Bonfield et al 2010). They had a clear understanding of emotional and behavioural difficulties that are often the result of earlier life experiences, including trauma and attachment difficulties, which is consistent with the findings of previous studies (Morgan & Baron 2011; Howe & Fearnley 2003; Clausen et al

1998; Taylor et al 2008; Sargent & O' Brien 2004). Furthermore all the foster carers interviewed were conversant with referral pathways to CAMHS and were aware of the services available.

The foster carers however, did not always feel listened to or valued by the professionals, especially during times of crisis and this echoes previous research (Mayers Pasztor et al, 2006; Murray et al, 2011). As highlighted by a recent review of 18 studies of foster carers' experiences (Blythe et al, 2014) the relationship between foster carers and child welfare professionals has a significant impact on the wellbeing of foster carers. When communication is poor and professionals are perceived to be unresponsive and dismissive, then foster carers can feel frustrated, undervalued and not respected. Whereas when relationships are good, as some foster carers in our study reported, as well as in the wider literature (Blythe et al 2014) then foster carers feel more valued and are involved in key decision-making. This perhaps in turn promotes effective foster care with more positive outcomes for the child.

The importance of support for the foster carers was a significant theme in this study and was directly related by the interviewees to the viability of the placement. This is of particular concern for looked after children, as the placement breaking down can result potentially in multiple placements for the young person with the associated detrimental effects on their mental health, thereby further exacerbating their difficulties (Morgan & Baron, 2011).

The foster carers in our study highly valued the support of peer foster carers, who could fully comprehend the complexity of what the other was managing, as opposed to other friends and family members who had not shared this experience. Previous studies support this finding (Samrai et al 2011; Murray et al 2011) and that individual personal support networks for foster carers as well as other types of carers (Worthington et al 2013) are an essential protective strategy against their own emotional and physical burnout.

Transition points are a key time when looked after children and their foster carers require particular support. Children and young people ordinarily have a number of transitions which become more numerous and significant if the child is in care. These include changes in foster care placements, which often trigger moving schools and CAMHS and transferring from CAMHS to adult mental health services. At these times the child is particularly vulnerable and at risk of experiencing further psychological distress. Some of these transition points have been previously documented, such as the transition from CAMHS to adult mental health services (e.g. Murcott 2014; National Institute of Clinical and Health Excellence (NICE) / Social Care Institute for Excellence (SCIE), 2010; DH 2008) but other transition points are less acknowledged.

The characteristics of the foster carer participants in our study is worthy of discussion. The ethnic composition of the sample reflects the ethnic diversity of the population where the research was conducted. We know however, that in the UK foster carers from Black and Minority Ethnic (BME) groups are under-represented (McDermid et al 2012). Although it is acknowledged that this study included a relatively small sample, the inclusion of foster carers from Black and Minority Ethnic (BME) is of interest and worthy of attention in future research.

Implications for practice

This research suggests that there are a number of areas that require attention by commissioners, policymakers and health and social care professionals involved in the care of looked after children and their foster carers. The foremost priority is partnership working; to work in collaboration with foster carers, acknowledging their expertise, valuing and respecting their views, listening to their experiences and ensuring their knowledge of the child they are looking after is incorporated into the child's care and treatment plan.

It is evident from this study that there is a timely response at the point of referral to CAMHS but there are then delays waiting for treatment, unless a high level of risk is identified. More joined up multi-agency working with improved access to specialist treatments needs to be developed and a named, accessible point of contact for foster carers when they need it. In addition, services need to be more vigilant at times of transitions to ensure that children and young people are not overlooked; more robust multi-agency systems need to be in place around the child to prevent this from happening.

The Role of the Mental Health Nurse

A key finding of the research is the value placed by foster carers on receiving ongoing support. Mental health nurses have a pivotal role in providing professional support to foster carers who are caring for children with mental health difficulties, as well as actively promoting peer support, which the foster carers in this study found particularly helpful. Mental health nurses have the skills to facilitate foster carers' support groups and provide training and education with a focus on child and adolescent mental health difficulties, challenging behaviour, attachment issues and parenting strategies. This study has demonstrated that the foster carers already have good mental health literacy but additional training and support from mental health nurses can support this development further. These groups could also play an important role in supporting the foster carers' own mental health and wellbeing, ensuring they are emotionally and physically robust to undertake the often challenging work required.

Mental health nurses working in CAMHS can play an important role in helping foster carers to navigate what can often be seen as the complex CAMHS health care system. CAMHS nurses are also very familiar with outreach working and are skilled in engagement and consultation as well as group work. They also have the expertise in providing short term clinical interventions such as a Cognitive Behavioural Therapy (CBT) approach to vulnerable children and young people (Dogra & Leighton

2009; Fayter et al 2013; McDougall 2006). These interventions could form part of a formalised comprehensive package for foster carers, to improve access to CAMHS for the child or young person.

CAMHS accessibility and responsiveness need to be prioritised in providing timely treatment for all children and young people with identified mental health difficulties and not just when things are at crisis point. The priorities for service transformation that have been highlighted (DH 2015; Mental Health Task Force 2016) may go some way to address some of these deficits, in particular improving access and reducing waiting times, however this particular vulnerable group of children and young people need to have specialist services, specific to their individual needs made more readily available to them.

A future avenue for research is to hear the voice of the child, to understand why initial engagement with CAMHS may be difficult or why they may drop out of treatment. There are however various ethical considerations in this area (Heptinstall, 2000); in particular the complexities around gaining consent for the looked after child to participate.

Study Limitations

It is acknowledged that the study has a relatively small sample size, although the saturation of themes from the interviews was achieved. In addition, the study was confined to one geographical area that included a single CAMH service. It is therefore recognised that the findings are not generalizable, although it is relevant that many of the findings mirror findings of previous research on this topic.

Asking foster carers to participate voluntarily means the sample is not representative of all foster carers. These carers may already have an interest in mental health or a previous experience of CAMHS so there may be some bias. This is however an under-researched area, particularly from the

perspectives of foster carers from black and minority ethnic groups, and it is still considered that the findings will have relevance and contribute to the body of knowledge on this topic.

Conclusion

Foster carers play a significant role in the lives of many looked after children. They have an intrinsic knowledge of the child in their care that needs to be fully acknowledged and utilised. In particular, foster carers have demonstrated good knowledge and mental health literacy regarding the children's behaviour and mental health issues. It is the responsibility of professionals across agencies to provide comprehensive and timely support to enable foster carers to manage often challenging behaviour and emotional difficulties most effectively. Thus, in turn improving long-term outcomes for the children and young people in their care.

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