UK TRAUMA COUNCIL

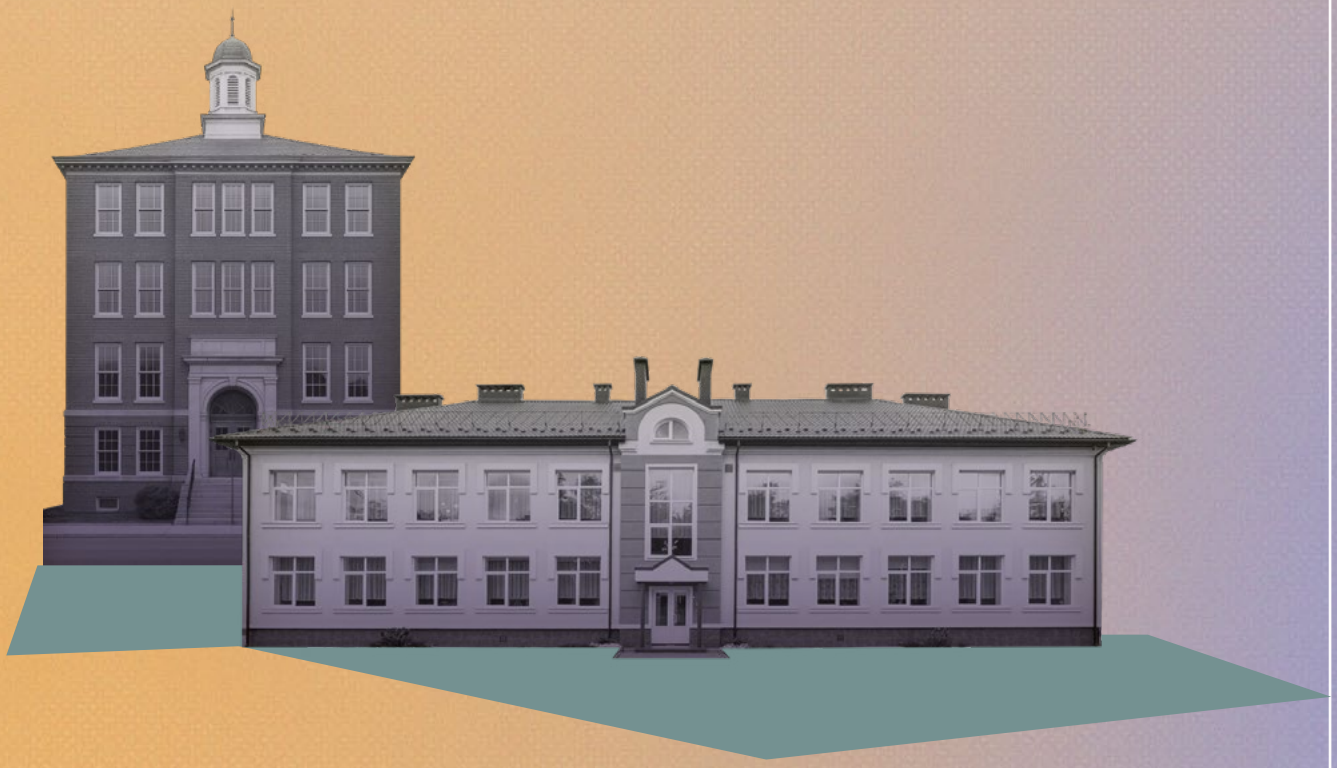
An Anna Freud project

UCL

NIHR | National Institute for Health and Care Research

Shaping Futures Together

Recognising myths and misconceptions: Building evidence informed mental health provision for children in care



What is evidence-informed commissioning and decision-making?

It is very well established that children and young people in care have high rates of established common and trauma-related mental health difficulties, such as depression, posttraumatic stress, anxiety, and conduct problems.

This resource supports mental health and children's social care commissioners, decision-makers, and service leadership. The goal of the resource is to support considerations and reflections on whether and how the services in their remit are offering best-evidenced mental health provision to care-experienced young people. This will ultimately support them to know **what works** so that funding is spent on services that offer children in care the same high quality mental health support as other children.

Offering high quality mental health support requires:

01

Commissioning services that offer best evidenced interventions, thus avoiding myths and misconceptions about what therapies are suitable for children in care.

02

Referring to the NICE guidelines for mental health for the recommended evidence-based therapies and interventions for the treatment of specific mental health needs e.g., depression, PTSD.

03

Drawing on clinical experience and young people's feedback to shape and adapt how best to deliver these therapies for individuals and populations of care experienced children and young people.

04

Regularly reviewing service data and outcomes for children and young people to understand how effective a service is.

01 Myths and misconceptions

First we highlight some myths and misconceptions that can result in care-experienced young people not receiving the treatment they need.

'The evidence base wasn't developed from studies with care experienced children, and we therefore can't use it.'

Most clinical trials studying therapies for traumatised children – especially specific trauma-focused therapies – include children who have experienced more complex traumas, such as abuse. Whilst it is true that many therapies still need to be directly tested with children in care, this is not a justification for ignoring the evidence. Children in care are children first, and it is well-established that they have high rates of common- and trauma-specific mental health needs (like anxiety, depression and posttraumatic stress) that do have best-evidenced treatment approaches. Over time, these treatments will hopefully adapt and improve, but innovation should come from a baseline of well-evidenced practice.

'Children in care don't engage with talking therapies. They need something different.'

Children in care have often been let down by adults in their life – including professionals. They have also often tried to seek help - sometimes over many years - but not received this help until they reach crisis. These types of experiences may mean that they need more time to develop trust and rapport with a mental health professional. However, this is not a reason to move away from evidence-based care.

Children in care should be offered the same evidence-based mental health care as any other child. Of course, they are free to decline assessment or treatment offers - as are all young people – but this is not a reason not to offer it, and ensure a young person is able to make a fully-informed decision.

There is even some evidence from the US that shows, when systematically evaluated, children in foster care actually disengage less frequently in evidence-based trauma-focused treatments than other young people (Yasinski et al., 2018).

The full picture of engagement and dis-engagement is also an important area to systematically explore through service data, so strategies can be developed to improve engagement.

'Children in care will be re-traumatised by doing mental health questionnaires or by doing therapy, especially those focused on trauma'

There is no evidence that good quality assessment or therapy 're-traumatises' children. Of course, assessments and treatment decisions should be made with young people. But there is a large amount of research showing that questionnaires and assessments are well tolerated (and liked, if they feel like they could facilitate support). We also know that best-evidenced trauma-focused therapies help children get better – even those who may have complex or co-occurring mental health needs. There is also no evidence that young people 'drop-out' of trauma treatments at higher rates than in any other treatment; and no good evidence that children become 're-traumatised'.

'Children have to be in a permanent stable placement to be able to start therapy'

Of course, it is ideal if a young person is in a stable placement with a caregiver who can support them through therapy. However, we know that children who experience more frequent placement breakdowns are often those with the greatest mental health need. Therefore, mental health services should think carefully and proactively about their offer for children who are not in a stable placement, and avoid having this as

a reason for automatically rejecting or closing a case. In many cases this instability may be, at least partially, driven by their mental health symptoms and beliefs that the world is unsafe and people cannot be trusted. Services should consider whether there are other stable influences in the child's life that they could draw on, the young person's own strengths and resources, and strategies to support engagement where possible.

02 How to find out about the best evidenced interventions: The NICE Guidelines

There are different types of evidence and all evidence can have its place. The figure below explains different types of research evidence. When designing services, we want to consider the best-evidenced treatment approaches - these are the treatments that have been shown to give children the best chance of overcoming their mental health difficulties.

Your 'go-to' for best-evidenced mental health interventions for children (including children in care) are the NICE Guidelines. These guidelines provide research-driven recommendations about best-practice for assessment and therapies for a wide range of mental health conditions. When considering mental health provision for children in care, it is important to refer to the broader NICE Guidelines for mental health, and not solely rely on the NICE Guidelines for Looked After Children. Whilst the latter can be a useful resource, they are predominantly focused on relationships and stability and are not specific to addressing mental ill-health.

Beyond 'evidence-based' interventions, services may also discuss 'evidence-informed' interventions. Evidence-informed usually refers to interventions that use core common components of best-evidenced treatments. Sometimes this is necessary if commissioning does not allow full best-evidenced treatments to be used (e.g., if there are restrictions on the number of sessions).

Wherever possible, all decision making should be underpinned by robust research evidence and supported by young people's feedback and clinical experience.

You can find out more about treatment options for specific mental health needs here.

Strength of research evidence

Case studies provide useful clinical insights into specific interventions used with one or a small group of children.

We can use these to understand strategies for delivering effective treatments, but cannot draw conclusions on whether a treatment 'works'.

Uncontrolled trials (sometimes called pre-post designs) use validated measures to show how symptoms change before and after an intervention, without a comparison.

We cannot tell if any change was from the specific intervention or something else.

Controlled trials compare children in an intervention to a group who did not receive the intervention.

We will not know if improvements are due to the intervention or to differences between the two child groups (e.g., one group having fewer complex needs or being more engaged).

Randomised controlled trials (RCTs) assign children randomly to receive either the intervention or a control or comparison condition.

We can be more confident that the results are because of the intervention and not other factors. The best method for testing if and how an intervention works.

Meta-anaylses put the results of different studies together.

We can be even more confident of the results across studies. These are the gold standard of research evidence and often underpin national and international treatment guidelines..

weaker evidence → strong evidence

03 Young people's feedback and clinical expertise

Young people's feedback

Alongside having evidence-based interventions at the core of a service, it is also crucial that regular feedback is heard and actioned from young people, caregivers, and professionals. Beyond treatment options, stakeholder views can also be essential for considering pathways into and through services, and accessibility and inclusivity issues.

While it is vital to listen to young people about what helps or doesn't, services should not be built on a few individual voices alone. Their feedback should be integrated with clinical experience through a co-production approach, helping to adapt and refine evidence-based interventions and broader service structures for better accessibility and engagement.

Clinical experience and expertise

Alongside robust research evidence and young people's feedback, decision-makers and service leadership must also consider clinical and practitioner experience. These will give key insights into what the service needs, both from the perspective of working with care-experienced young people and also working with the wider system (e.g. other professionals).

04 How do you know if the service is working?

The only way to know if a service is working is to ensure service evaluation is embedded as part of routine practice. Routinely collecting, storing, and analysing service data should be prioritised as a core part of any evidence-based mental health service, and can enable answers and reflections on key issues, such as:

- The numbers of children moving through each stage of a service.
- Whether certain groups of children are systematically not able to access the service.
- Whether interventions are leading to improvements in children's mental health symptoms and supporting them to reach their goals.
- Whether particular approaches are more or less successful for engaging young people.

Service evaluation is not there to judge a service or frontline professionals. But if used supportively, can be key to ensuring services can reflect, refine, and improve their offer.

Adapting and innovating within the evidence base

Care-experienced children do often present to mental health services with multiple mental health needs (sometimes known as co-morbidities) or other complexities (such as risk, safeguarding concerns or unstable accommodation). This isn't a reason not to at least offer best-evidenced support. But it might be a reason to expect more is needed than just a standard programme. In these cases, services will want to consider how they can thoughtfully adapt interventions to the unique needs and contexts of children in care whilst remaining grounded in research evidence and the core elements of the treatment that drive effectiveness. Adapting an intervention for

the needs of the individual child is part of good clinical practice for any young person.

The interventions outlined in the NICE guidelines are generally designed to be flexible and can be delivered in ways that are acceptable and accessible to the child or young person. This would mean changing aspects of delivery but keeping their roots in the evidence base. In the same way that although a medicine might benefit from being flavoured, packaged and delivered to make it acceptable to a child, it will still need the active ingredient for it to be effective.

Adaptations might consider:

- **Sessions** – the number of sessions offered, the length, frequency and pace of sessions.
- **Mode of delivery** – be flexible to use talking, drawing, play or movement as adaptations to make the therapy accessible and engaging to the young person.
- **Accessibility** – Adopt suitable communication tools, visual aids and sensory resources and use interpreters where needed.
- **Personalised and child centred approaches** – draw on the child's strengths, interests and values so that sessions feel meaningful to them.
- **Caregiver role** – think about how adult caregivers might be included most effectively.

Even best evidenced treatments don't work all the time for every child, but they should be the starting point for services. Any innovative approaches should draw from the evidence base as well as incorporating insights from young person and clinical or practitioner experience.

If a service prioritises collecting routine service data, then they will be able to explore in a data-driven way, whether adaptations to their offer are effective (and for who) for their population base.

Summary

Commissioners and decision-makers should be confident in talking to their mental health services about whether and how they are delivering best-evidenced mental health support. 'Best evidenced' does not mean therapists rigidly stick to reading a manual – but it does mean services provide treatments that we know give children (including care-experienced children) the best chance to overcome their mental health difficulties and lead a more fulfilling and happy life.

Of course, as for any child or young person, interventions will require some adapting to meet the needs of the individual child. This may include intersectional needs, like race or ethnicity, gender identity, sexuality, and neurodivergence. This requires thought and consideration so that the core evidence base (or 'key ingredients') still underpins any personalised approaches.

Shaping Futures Together

www.uktraumacouncil.org

UK TRAUMA COUNCIL

An Anna Freud project

UCL

NIHR | National Institute for Health and Care Research

This work was made possible through funding from the NIHR Applied Research Collaboration, with funding from ARC West, ARC North Thames, ARC South West Peninsula, and ARC North East and North Cumbria. The views expressed in this resource do not necessarily reflect the views of the NIHR or the Department of Health and Social Care