It's time to re-think mental health services for children in care, and those adopted from care

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Abstract
Much of what is written in this special issue points to the need for a clinical workforce that has much greater knowledge and skills for working with children with a history of alternate care, including those who are subsequently adopted. Standard child clinical conceptualization, assessment methods, and formulations miss the mark for these vulnerable populations in a number of critical ways. The present paper proposes 10 principles to guide the design of mental health services for children in care, and those adopted from care. Effective specialization in child welfare work by clinical child psychologists, psychotherapists and psychiatrists, requires: (i) specialized knowledge and skills; (ii) a shift from traditional clinical practice to a *clinical psychosocial-developmental* scope of practice; and (iii) a strong advocacy role. To support such specialized practice, service design should be guided by: (iv) a primary–specialist care nexus, that includes universal, comprehensive assessments; (v) a shift from acute care to preventative, long-term engagement and monitoring; (vi) integration within the social care milieu; (vii) a shift from exclusion to active ownership of these client groups; (viii) normalization strategies; and (ix) alignment of services for these client groups. Finally, it is argued that mental health service provision for these children is strengthened by policy that promotes (x) "whole of government" accountability for their mental health needs.

Keywords
child and adolescent mental health services, children adopted from care, looked after children, mental health service models, out-of-home care

At any given time, perhaps a million children in the western world either reside in legally-mandated alternate care, or have been adopted from such care. A substantially larger population encounters alternate care at some time in their childhood. Many jurisdictions have witnessed a doubling of the prevalence of children in care over the last decade, which in 2005 averaged around 5 per 1000 children across western, Anglophone nations (Holzer & Bromfield, 2008). This increase is largely accounted for by a corresponding acceleration in the detection of child maltreatment.

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Variations in national rates of children in care partially reflect the provision of long-term solutions such as return to birth parents, adoption from care, and/or special guardianship orders. They also reflect shifting thresholds of concern, particularly as agencies are subjected to public outcries when children who are formally safeguarded by the state die through lack of proper supervision or services. A child who enters care in England, and is subsequently adopted, is counted as exiting the care system. In Australasia, adoption from care is more difficult to achieve, and is thus uncommon. There, early-placed children who are not restored to parental care are typically raised in quasi-adoptive foster or kinship placements, without change of legal status. A surprisingly large number of early-placed children are retained in long-term care in England as well, as a part of more general permanency policy (Biehal, Ellison, Baker, & Sinclair, 2009; Schofield & Ward, 2008). These children are more likely to endure greater systemic threats to their "felt security" than children adopted from care, such as the realization of their carers' lack of custody rights, and the state's intrusion throughout their childhood (Nutt, 2006). Otherwise these groups have comparable developmental pathways, invoking similar risk for attachment- and trauma-related mental health difficulties. "Age at entry into care" predicts both the incidence of clinically-significant mental health difficulties and placement breakdown (Rushton & Dance, 2006; Tarren-Sweeney, 2008b), while there is evidence that placement breakdowns account for further deterioration in children's mental health, independent of other factors (Barber, Delfabbro, & Cooper, 2001). A pattern of spiralling deterioration in mental health and social functioning, serial placement breakdowns and increasingly unstable living arrangements is more commonly observed among children who arrive in care in middle childhood or later, following chronic exposure to abuse and emotional deprivation. Fewer such children are adopted from care.

Surveys have consistently found that a child in care is more likely than not to have psychological difficulties of sufficient scale or severity to require mental health services, regardless of their location (Tarren-Sweeney, 2008a). Around half of children in care are reported as having clinically significant mental health difficulties, while up to one quarter more have difficulties approaching clinical significance. More is known about the scale and severity of their mental health problems, than of their nature, characteristics or underlying mechanisms. However, recent findings suggest that a sizeable proportion manifest complex psychopathology, characterized by attachment difficulties, relationship insecurity, problematic sexual behaviour, trauma-related anxiety, inattention/hyperactivity, and conduct problems and defiance (Tarren-Sweeney, 2008a). Children in care also endure poorer physical health, higher prevalence of learning and language difficulties, and poorer educational outcomes than other children (Crawford, 2006). Although children adopted from care enjoy greater placement stability than those who remain in care, studies carried out in England suggest as many as 60 per cent of children manifest mental health difficulties six years after being adopted from care (Rushton, 2004; Selwyn, Sturgess, Quinton, & Baxter, 2006).

While specialized mental health services for child welfare populations have been established in some countries, no western jurisdiction has yet developed an integrated model of clinical practice that adequately addresses the parameters set out in this special issue. What has been realized to date has been largely piecemeal, initiated in the main by a small number of visionary clinicians. There are positive signs of some governments working in the right direction, as seen for example with England's "Every Child Matters" programme (Department for Children, Schools and Families and Department of Health, 2009), and the development of inter-government health and education services for children in care in New South Wales as part of the "Keep Them Safe" initiative (New South Wales Government, 2010). Notwithstanding such progress, it can be argued that governments have generally underestimated the extent of change required, as evidenced by attempts to make existing service systems and professional practice models fit the needs of children in care. A recent review of

CAMHS services in England (Department for Children, Schools and Families and Department of Health, 2008) proposed a need for targeted mental health services for "looked-after children", without considering whether such services are ideally developed within a CAMHS system. It contained no discussion on whether such services might be better placed elsewhere within the National Health Service (NHS), or outside of the NHS altogether (such as within the Department for Children, Schools and Families), except in relation to the commissioning of services by Children's Trusts.

Why should we re-think mental health services for children in (and adopted from) care?

The present paper sets out to address some of the challenges identified in this special issue, particularly those raised by John Simmonds, Margaret DeJong, and Kim Golding. Its focus is limited to western jurisdictions in which foster and kinship care are the predominant forms of care. The most visible shortcoming in the provision of mental health services for children in care, as well as those adopted from care (Sturgess & Selwyn, 2007), is insufficient capacity. This is despite these populations having high rates of service use relative to other disadvantaged children (Bellamy, Traube, & Gopalan, 2010; Sturgess & Selwyn, 2007). The prevalence of clinically significant mental health difficulties among these children is sufficiently high to warrant systematic assessment of their mental health service needs. In this issue, John Simmonds (2010) outlines a population-based screening and assessment protocol designed by a committee of delegates at a US "Best Practices for Mental Health in Child Welfare" conference (Romanelli et al., 2009). These guidelines seem reasonable and well considered. Yet, it is unlikely that any state or country could sustain a "whole of population" approach to detection and management of mental health difficulties among children in care without a large expansion of service capacity, regardless of whether the work is done by specialist alternate care teams, or generic child mental health services. It is known for example, that US children in care presently receive a disproportionate share of Medicaid public mental health services, relative to other disadvantaged child populations with high prevalence of mental health difficulties (Leslie et al., 2005), including maltreated children who remain in parental care.

Beyond questions of scale and capacity, it is apparent that publically-funded, "acute care" child and adolescent mental health services are poorly matched to the service needs of a disadvantaged child population presenting with complex attachment- and trauma-related psychopathology, and unstable living arrangements. Such children require greater continuity and certainty of care than acute care services are designed to provide. This requirement seems particularly ill-matched to acute care services that function within a "managed care" environment (Leslie, Kelleher, Burns, Landsverk, & Rolls, 2003), or which are required to achieve high client turnover.

Thirdly, as outlined by DeJong (2010), there are big question marks for this population around the coherence and validity of clinical formulations based on standard conceptualizations of psychopathology, and using standard assessment data. In 1996, I reviewed 110 clinical assessment reports sourced from 50 psychological records of children in care, and other child welfare clients, as part of the development of a mental health checklist for children in care and related populations. Most of these reports were written by psychologists and psychiatrists working in specialist public health services, child welfare and alternate care agencies, and private practice. The reports revealed considerable diagnostic disagreement and uncertainty, as well as a tendency to frame complex psychopathology as a series of discrete, co-morbid disorders. From a practice perspective, the accumulation of multiple and conflicting diagnoses provides little clarity or guidance for children's social workers, teachers and carers (DeJong, 2010). Whereas a half of children in care have clinically significant mental health difficulties, cluster analyses of mental health scale scores of a survey sample of

347 Australian children in foster and kinship care (aged 4 to 11, 176 boys, 171 girls) identified 20 per cent of boys and 26 per cent of girls as having severe *and* complex mental disturbances that are not adequately conceptualized within DSM-IV and ICD-10 (Tarren-Sweeney, 2009).

Finally, amongst colleagues who provide clinical services for children in care and/or those adopted from care, there is reasonable consensus that standard psychological and pharmacological interventions appear less effective for these children. Yet, there are almost no research data describing the effectiveness of standard treatments for these children (Landsverk, Burns, Stambaugh, & Reutz, 2009), while the effectiveness of interventions designed specifically for adopted or in care populations remains somewhat uncertain. In this issue, Bellamy et al. (2010) report their findings of an analysis of the effects of standard out-patient mental health treatment for a national sample of 439 children in long-term foster care, drawn from the US National Survey of Child and Adolescent Well-being (NSCAW). Their analysis controlled for a number of known or likely confounders, while change was measured from baseline and 18-month follow-up Child Behavior Checklist (CBCL) scores. They found that outpatient treatment had no independent effect on changes to CBCL scores, suggesting that collectively, interventions that constitute standard outpatient treatment in the US may not be effective (at least over this timeframe). A useful next step in this area of research is to examine the effectiveness of specific types of intervention for children in care, as provided through generic outpatient services. The evidence supporting various "evidence-based" child psychological interventions is mostly limited to findings from clinical trials, in which treatment response has not been stratified by special population status. These findings may thus not generalize to children in care, and children adopted from care. For example, the mechanisms accounting for the characteristic inattention/over-activity of severely deprived children (Kreppner et al., 2001) may differ from those that account for other inattention/over-activity, in which case alternative treatments may be warranted. Generic treatment modalities are also mostly designed for discrete disorders rather than complex bio-psycho-social phenomena. Children in care are more likely to present with complex disorders (Tarren-Sweeney, 2008a) that are less likely to respond to psychological treatments developed for discrete disorders, such as depression (National Institute for Clinical Excellence (NICE), 2005).

Along similar lines, there has been little discussion about the potential for psychotherapy to harm children and young people in care. Fonagy and Bateman (2006) have speculated that traditional psychotherapies are harmful for some adults with Borderline Personality Disorder, due to iatrogenic mechanisms involving impaired mentalization capacity, and the activation of their attachment systems within a therapeutic alliance. If there is substance to this, then it seems plausible that the sizeable proportion of children in care who have complex attachment- and trauma-related difficulties could be similarly vulnerable to experiencing harmful effects from a number of common psychotherapies. These considerations highlight a need for research on mental health treatment for children in care, and those adopted from care, and a parallel need for better informed treatment planning for these children.

A way forward: 10 principles for guiding the design of mental health services for children in care (and those adopted from care)

In this section I propose a number of principles for guiding the design of mental health services for children in care, and for those adopted from care. These are meant to complement and extend on the body of ideas contained within existing clinical practice guidelines (Romanelli et al., 2009; Royal Australian & New Zealand College of Psychiatrists, 2008) and various government initiatives. They are also written as a partial response to the challenges raised in this issue by John

Simmonds, Kim Golding and Margaret DeJong, but leaving aside the design of psychosocial interventions for these special populations. The principles are summarized in Table 1, and arranged at three levels:

Level 1: Specialized practice
Level 2: Service models
Level 3: Civil society

These levels can be thought of as concentric spheres of influence on the lives of those children who receive services, the most proximal referring to clinicians and the parameters of specialized practice.

Level 1: Specialized practice

Much of what is written in this special issue points to the need for a clinical workforce that has a deeper knowledge and skill set for working with children with a history of alternate care or other child welfare involvement. Existing child clinical training – whether it is through clinical psychology, child psychotherapy, or child and adolescent psychiatry training schemes – does not adequately prepare trainees for understanding or working with these children. I propose that effective specialization in child welfare work by psychologists, psychotherapists and psychiatrists, requires: specialized knowledge and skills; a shift from traditional clinical practice to what might be termed *clinical/psychosocial-developmental* scope of practice; and a strong advocacy role.

(i) Specialized knowledge and skills. As outlined earlier in this paper, standard child clinical conceptualization, assessment methods and formulations miss the mark for these vulnerable populations in a number of critical ways. This is partly indicative of gaps in knowledge that have yet to be clarified through research. However, a lot has also been learned that is yet to be translated into standard clinical practice, including knowledge and skills that can increase clinicians' understanding of these children, and yield more accurate clinical formulations. In the main these have quite a specialized focus, requiring fairly detailed or intensive training. For this reason, it is more realistic to set our sights on developing specialized clinical workforces for child welfare work, than

Table 1. Summary of principles for guiding the design of mental health services for children in care (and those adopted from care)

Level 1: Specialized practice		
	(i)	Specialized knowledge and skills
	(ii)	Clinical/psychosocial-developmental scope of practice
	(iii)	Advocacy
Level 2: Service models		
	(iv)	Primary–specialist care nexus, and universal assessment
	(v)	Preventative, long-term engagement and monitoring
	(vi)	Integral part of social care milieu
	(vii)	Active ownership
	(viii)	Normalization strategies
	(ix)	Service alignment
Level 3: Civil society		
	(x)	Whole of government accountability

expanding the scope of standard clinical training. The development of specialized workforces requires both high quality training, and the maintenance of specialist practice standards through professional bodies.

What then should be the main characteristics of specialized clinical practice with these populations? First, it should be guided by appropriate conceptual frameworks for formulating complex attachment- and trauma-related disorders, and the bio-psycho-social mechanisms and developmental pathways that determine the mental health of children with a history of care and/or maltreatment. The significance of early social adversity and attachment conditions on these populations' neurological and psychological development, points to complex, time-sensitive etiological mechanisms. For these children more than others, it is essential that we incorporate new knowledge from developmental psychopathology research, and an ecological–transactional framework (e.g. Cicchetti, Toth, & Maughan, 2000) into clinical reasoning and case hypothesis generation.

In addition to ecological enquiry, specialized clinical practice requires an improved conceptualization of complex attachment- and trauma-related symptomatology manifested by these children (DeJong, 2010). While some work has been devoted to re-conceptualizing such difficulties (Crittenden, 1997; O'Connor & Zeanah, 2003; van der Kolk, 2005) it may be several decades before we attain an empirically validated classification of attachment- and trauma-related mental health difficulties that accommodates a high degree of symptom complexity. Until that eventuates, I believe that specialized clinical practice requires both an understanding of the particular limitations of present diagnostic classifications in relation to these forms of psychopathology, and some modification of clinical reasoning and formulation to work around these limitations. One "workaround" is employing a *profile approach* to the formulation of complex and severe symptomatology. Rather than diagnosing complex presentations as discrete, overlapping or interrelated co-morbid disorders, I would propose that for many children it is more valid to formulate such complexity as attachment-trauma symptom profiles. These are representations of continuous distributions of symptom types, severity, and complexity, which could be referenced to characteristic attachment-trauma symptom clusters identified through research.

A second characteristic of specialized clinical practice with these populations is knowledge and training in the application and interpretation of interview, psychometric and observational measures, which are appropriately matched to their particular life circumstances, as well as to the range of mental health difficulties that they manifest. While there are few available population-specific psychometric measures, experienced clinicians in this field tend to conduct quite specialized cross-informant interviews and observations. This aspect of specialized practice is likely to be strengthened over time, as further development and validation of purpose-specific assessment methods unfold.

A third characteristic pertains to the *comprehensiveness* of clinical assessments. Specialized practice with these populations requires more detailed assessment of attachment- and trauma-related problems, and a wider developmental and contextual focus than that typically employed in mental health clinical assessments. In essence, specialized assessments of these children requires a shift from a relatively narrow, "mechanical" focus on identifying children's symptoms and disorders, to seeking a comprehensive understanding of children's felt experience, their relationships, family/placement processes, and systemic and care-related influences on children's lives. John Simmonds' case scenario contained in this present issue (Simmonds, 2010) highlights the critical importance for extending clinical assessments beyond the individual child, to include assessment of the adoptive/ foster/kinship family system, and how these systems are influenced by child welfare systemic factors. Clinicians need to enquire about motivations for caregiving and systemic influences on carer roles (Dozier, Grasso, Lindheim, & Lewis, 2007), carer attachment styles

(Schofield & Beek, 2005), and carer "felt security" regarding the permanence of their relationships with the subject child. This is because the primary therapeutic agent for children in care, and those adopted from care, is their substitute family (Schofield & Beek, 2005).

(ii) Clinical/psychosocial-developmental scope of practice.   The characteristics of specialized clinical practice set out above translate firstly, as increased expertise in the assessment and formulation of attachment- and trauma-related psychopathology among child welfare populations. Secondly, it involves a shift beyond the traditional boundaries of clinical practice to include much greater focus on: the nature of family life that sustains and promotes the development of children who have experienced chronic social adversity; children's felt experiences and world view; child welfare systemic influences; and more detailed consideration of children's developmental histories, with particular reference to attachment and trauma theories. Together this represents a *clinical psychosocial-developmental* scope of practice that is specific to the development and well-being of child welfare clients, and most particularly to children who are in (or have exited from) alternate care. Clinical/psychosocial-developmental practice is thus as much focused on the minutia of context, as it is with identifying and treating mental health difficulties. It requires the clinician to have a good understanding of the age-sensitive psychosocial effects of such things as loss, entry into impermanent care, placement changes, restoration to parental care, length and types of court orders, sibling co-placement, birth family contact, and adoption from care by existing carers versus strangers. It also directs clinicians to enquire about the nature and quality of care that children receive in their present placements, and to learn (where possible) about children's care experiences in previous placements. I believe these factors collectively have greater proximal influence on children's development than do individual clinical interventions. Clinical/psychosocial-developmental practice thus seeks to facilitate therapeutic change and prevent the onset of additional psychopathology, by influencing decisions made by social care agencies, courts and carers. This consultation role is as central to our work as formulation of treatment plans. Clinical/psychosocial-developmental practice also sets out to provide a better platform for conducting psychosocial interventions within the adoptive/foster/kinship family, than standard child clinical practice.

(iii) Advocacy.   In this section I present a case for *advocacy* being a central component of specialized clinical practice with these children, and most particularly for children and young people with unstable care arrangements. Children in care, and those who have exited care, are some of the most disadvantaged child populations in the western world. Most children enter care following prolonged exposure to harm, during which time there is abject failure of parental responsibility. Once placed in care, many decisions and events that have a bearing on the children's well-being are controlled by adults other than their carers. Conversely, foster and kinship carers may be constrained from exercising parental decision-making on such everyday matters as school enrolment, going away on holidays, and having children over for sleepovers. In an ideal world, a child would have one social worker and one set of carers advocating together on his or her behalf, throughout their time in care. Many children who enter care, however, fall well short of gaining this level of support. For some, decisions made for them are compromised by distortions in judgement or empathy, a product of over-burdened or distressed social care agencies. Children in care increasingly encounter high turnover of social workers, resulting in decisions being made by people who have little knowledge of them or their life circumstances. In some jurisdictions, sizeable numbers of children in care have no social worker at all – the so-called unallocated cases. An even more critical factor affecting children's advocacy is placement stability. If a child is raised in a stable adoptive, foster or kinship placement, their carers are better positioned to advocate actively on their behalf.

This is because long-term carers tend to have greater knowledge of their children's needs, more established connections with services, and different commitment to children in their long-term care. Children's need for advocacy is not restricted to decision-making within the social care milieu. As described earlier in this paper, children in care and adopted children can have difficulty accessing mental health and related treatment services, especially if they have complex and severe difficulties that seem resistant to therapeutic change.

Clinicians who specialize in working with children in care should therefore see it as their role to ask "To what extent is this child or young person alone in the world?" Aside from identifying which people are advocating for a child's needs, specialized clinical practice generates alternative perspectives on what children's needs might be, which can then be used to challenge dominant or prevailing views. At a most human level we need also ask the question "What would I want for this child, if he or she was *my* child or grandchild?"

Level 2: Service models

This section sets out principles for development of mental health services that support clinical/psychosocial-developmental practice, and which address specific service needs of children in care and those adopted from care.

(iv) Primary–specialist care nexus, and universal assessment.   The prevalence, scale and complexity of mental health difficulties experienced by these populations are so great, that delineation between primary and specialist levels of care for these children is blurred. They require universal, comprehensive clinical/psychosocial-developmental assessments following entry into care or adoption. These assessments identify risks and casework-related issues that may contribute to future mental health difficulties, or detract from their development or well-being in other ways. This applies as much to children who enter care with few mental health difficulties. Universal, comprehensive assessment by specialist clinicians following entry into care is thus preferable to mental health screening, because it is designed for prevention of future difficulties as much as detection of present ones. Furthermore, mental health screening alone does not identify critical influences on children's development that have a bearing on other psychosocial-developmental outcomes (that could be remedied if detected early enough). Beyond initial assessment, there remains a need for a primary care (i.e. population-wide) approach to provision of specialist mental health services, equating to a primary–specialist care nexus.

(v) Preventative, long-term engagement and monitoring.   Complex attachment- and trauma-related difficulties tend to follow a long developmental course. They are rarely manifested as acute mental health states. In general, the older a child is before they first receive reparative, sensitive care, the more "trait like" and enduring become their difficulties. Two important goals of mental health interventions with these populations, is to facilitate the development of close relationships, and sustain children's placements. Part of the equation for achieving this is providing carers with reliable access to clinical advice and support, so they can be sustained through their most challenging times. Such children and their carers often require ongoing or recurring involvement with mental health services. In these circumstances, continuity of assessment and treatment are important contributors to treatment outcomes. These needs are ill-matched to the predominant "acute care" focus of publicly funded child and adolescent mental health services. Instead, specialized mental health services for these populations should be designed and funded for preventative, long-term engagement and monitoring.

(vi) Integral part of social care milieu.   In this issue, Kim Golding (2010) makes the case for integration between specialist clinical services for adopted and in care children, and social care agencies, citing her experience of multi-agency working in Worcestershire, and an emerging consensus among UK researchers in this field. Two other papers describe public clinical services that have some level of integration with social care agencies, in Sydney (Chambers, Saunders, New, Williams, & Stachurska, 2010) and Glasgow (Minnis, Bryce, Phin, & Wilson, 2010). Golding (2010) describes a number of benefits from service integration, including: an enriched understanding of cases gained through multi-disciplinary problem-solving; the opportunity to carry out coordinated, multi-faceted interventions across different agencies that address a range of related impairments (including mental health); and increased understanding by clinicians of the social context of children's mental health.

Given the present paper's focus on the development of a clinical specialization in child welfare work, it is worth re-emphasizing the significance of service integration to clinical/psychosocial-developmental practice – namely that such practice *requires* close engagement between mental health and social care services. This is because it provides clinicians greater opportunity to understand the context of their clients' lives. Social care workplaces are typically intense, stressful, and sometimes chaotic. Many services attempt to juggle the competing demands and culture of alternate care and child protection teams in the same location. One needs to appreciate the nature of such work to understand how decision-making serves, and occasionally fails children in care. Clinicians who work outside the social care milieu often struggle to comprehend the logic of casework decisions, without understanding the constraints imposed on agencies (for example, a lack of suitable foster placements). Social workers are also often hampered by competing policy guidelines that have very real implications for children's well-being, for example "developmental" versus "natural justice" principles guiding the restoration of children to their birth families. A second reason is that integration facilitates social workers' access to clinical consultation on individual casework. This is very important, given the preventative focus of clinical/psychosocial-developmental practice.

There are various ways of attaining close engagement between mental health and social care services, but each involves some level of integration of clinicians within the social care milieu. To my knowledge there has been no research comparing different integration models. In several Australian states and in New Zealand, statutory agencies operate in-house psychology/psychotherapy services for children who are in their care, as well as for child protection clients and their families. These are either co-located within regional clinical teams, providing services to a number of local offices (as mostly occurs in New Zealand), or work as sole practitioners in front-line social care offices (as mostly occurs in New South Wales). These services work in parallel with CAMHS and other health services i.e. their existence doesn't preclude children from accessing publicly funded health services. In many parts of the world, charitable children's agencies also operate in-house psychology/psychotherapy services, sometimes within larger multi-disciplinary health and education teams. A notable example is Casey Family Services in the United States. In Britain, where statutory agencies are much smaller than those in Australasia (operating within local, rather than state or national governments), integration more likely involves some co-location of specialist "looked after children" CAMHS teams and social care services, or similar multi-agency working through Children's Trusts. A third model sees social care liaison staff located within specialist alternate care CAMHS teams, which can be jointly funded by health and social services departments (Chambers et al., 2010). Finally, a degree of service integration could be attained using a "consultation-liaison" model, along similar lines to consultation-liaison psychiatry work in medical wards.

(vii) Active ownership.   Golding (2010) also describes a number of barriers to mental health services encountered by children and their alternate carers and adoptive parents. Many of these reflect a mismatch between the special circumstances of these populations, and the ways in which generic CAMHS services operate. In some instances, services employ intake criteria that actively block children's access to mental health services, for reasons including the absence of a mental health diagnosis (despite having evident mental health impairment), having the wrong kinds of diagnoses, not having stable placements, not having an identified exit placement, and not gaining access to inpatient care because they are already residing in residential care. It is possible that these situations are not always benign, but in some instances are designed to exclude children who fall into a "too hard basket". In addition to reforming referral criteria, these practices can be circumvented if specialist services actively seek to "own" responsibility for assisting our most challenging children in care.

(viii) Normalization strategies.   Balanced against the need for longer-term engagement, and continuity of care through childhood, is perhaps an added potential for causing harm to children or their families. Aside from questions about iatrogenic treatment effects raised earlier in this paper, we need to consider how long-term engagement with mental health services can become an "elephant" in children's lives – either by reducing their opportunity for a normalized upbringing (e.g. feeling uncomfortably different from other children), and/or causing distress or anxiety from children's negative perceptions (or experiences) of the service. These risks are not easily mitigated, not least because the training and sensitivities of individual clinicians are likely to have a greater influence on children's perceptions than service models. Notwithstanding this, different approaches to minimizing these risks could be implemented at the service level, depending on how much direct involvement is required between children and clinicians. Where there is need for sustained involvement with children, a useful starting point would be to consider what characteristics of long-term engagement could contribute to children perceiving the service as a source of comfort and reassurance, and as providing some continuity throughout their childhood (especially for those who encounter serial placement changes). For children whose difficulties do not require such direct contact with services, an "over the horizon" approach to long-term involvement is preferable, with a view to reducing the footprint of service provision on their lives (e.g. delivering interventions via carers, framing our direct contact with children in ways that deflect perceptions of abnormality).

(ix) Service alignment.   There are potential advantages in aligning specialized mental health services for children in care, those adopted from care, and those who return to parental care. Aligning services for these client groups provides greater opportunity for continuity of specialist service delivery through childhood, whether that be for children who proceed from care to adoption, return to their parents' care, or re-enter care following failed restoration or adoption. Secondly, these client groups have similar developmental pathways and mental health patterns. In this regard, children adopted from care have greater affinity with children remaining in care than with children adopted for other reasons. These client groups are thus similarly matched to the specialized clinical practice described in this paper. Thirdly, bearing in mind the high cost of maintaining publicly funded specialized mental health services, service alignment provides scope for economic efficiencies.

Balanced against these considerations are some potential drawbacks. The first relates to differences in the level of public funding provided for these groups of children. Where specialized services are funded entirely from health department budgets, then that funding is fairly transparent,

and unlikely to lead to differential levels of funding for the different client groups. However, where such services are partly funded by local authorities or children's trusts, there is perhaps greater scope for "misalignment" of service delivery, such that service access is partly determined by children's legal and care status, rather than their level of need. The second concern is that inequities could arise where there is pressure to accept referrals of children with unstable living arrangements or precarious placements, above other children with similar or greater impairment and distress – a situation that could tilt access away from adopted children.

Level 3: Civil society

The transfer of parental responsibilities from children's parents to the State involves the transfer of moral as well as legal responsibilities. This extends to ensuring that such children have as much opportunity to flourish, to attain happiness, and to form life-sustaining relationships, as we would wish for our own children or grandchildren. Where guardianship rights are later transferred to adoptive parents, the state is presented with another moral imperative – namely, to support those who inherit these parental responsibilities, and who in many instances are burdened with the challenge of raising children with long-term mental ill-health.

(x) Whole of government accountability.   In recent years, some governments have resolved that the "state as parent" is not limited to statutory child welfare agencies, but encompasses all parts of government that can affect the lives of children in care, and by inference, government-funded services. This multi-agency position has emerged partly out of the findings of judicial enquiries into child protection and alternate care systems (Secretary of State for Health & Secretary of State for the Home Department, 2003; Wood, 2008); partly as a consequence of emerging knowledge of ecological influences on children's development that are beyond the reach of child welfare agencies; and partly because of government recognition of the enormous social and economic costs of inter-generational transfer of severe social adversity.

Policies that emphasize a "whole of government" responsibility for children in care, which is not wholly relinquished when children are subsequently adopted from care, can help reverse the types of discriminatory exclusion practices described earlier in this paper (particularly in the health and education sectors). Aligned to this is a need to shift away from thinking of the problems of children in care as belonging exclusively to social care agencies. This principle is embodied in the previously mentioned "Every Child Matters" (Department for Children Schools and Families and Department of Health, 2009) and "Keep Them Safe" (New South Wales Government, 2010) initiatives, as well as in so-called "best endeavours" legislation introduced more than a decade ago in New South Wales. The latter provision enables social workers to submit "best endeavours" requests to other government agencies to provide services that " … promote and safeguard the safety, welfare and well-being of a child or young person" (Children and Young Persons (Care and Protection) Act (NSW), 1998). Agencies are legally required to make "best endeavours" to respond to such referrals.

Such legislation is really just the first step in establishing an effective multi-agency response to the mental health and psychosocial needs of these populations. Good policy is critical, but society's responsibility for these children is effectively borne (and interpreted) by individual workers, volunteers and carers. In a recent article, Paula Conway (2009) considers systemic failures in inter-agency working with alternate care and other child welfare clients, characterized by distrust of other agencies and staff, a lack of willingness to cooperate, inadequate communication, and blame shifting. Such dysfunctional working relationships are understandable when we consider that they develop among people responding to immensely stressful and distressing

situations as part of their everyday work, often without adequate psychological preparation. This can be partly resolved by bringing organizations and individuals together, allowing opportunities for personal connectedness, the communication of shared goals and values, and understanding other agencies' particular challenges and responsibilities. Conway observes, however, that effective relationships often fail to emerge even when opportunities for inter-agency connectedness are mandated through government policy. Bearing in mind the effects of frequent, peripheral exposure to traumatic events and traumatized people, governments need to consider how they can better prepare agencies and their employees for working with children in care and their carers, and with each other.

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