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Care in Mind: Improving the Mental Health of Children and Young
People in State Care in Scotland

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Abstract

Some five thousand children and young people are in residential and foster care in Scotland. Many experience poor outcomes and concern about the quality of care has led to a number of government initiatives including the registration of care services and the social care workforce. Children and young people in state care experience a high level of mental health problems. Mental health services, however, have not served this vulnerable group well. The issue of the mental health of children and young people is now high on the government's agenda. A national needs assessment has set out an important agenda for the development of services. In addition, a number of innovative projects have focused on meeting the mental health needs of children and young people in state care. It is important that these developments lead to integrated and flexible mental health services in order to improve outcomes and well-being of children and young people in state care in Scotland.

Keywords: mental health, state care, children, young people, Scotland

Care in Mind: Addressing the Mental Health of Children and Young People in State Care in Scotland

Introduction

Over recent years, there has been a great deal of concern expressed about the poor outcomes of children and young people in state care in Scotland. Recently, a joint education and social work inspection of the education of looked after children identified a number of serious shortcomings. This led the Scottish Executive to commission a package of materials to help develop relevant knowledge and skills among teachers, social workers and carers and provide them with specific tools to enhance their practice (Hudson et al, 2003; Connelly et al., 2003; Ritchie, 2003; Connelly, 2003). There has been much less focus on the equally concerning issue of the poor health outcomes of looked after children and young people in general, and their mental health outcomes in particular. This is unfortunate in that research shows that the level of mental health problems among children and young people living in state care is much higher than that of children and young people in general.

That is not to say, however, that this issue has not been highlighted previously. Twenty years ago, a government working group produced a detailed report focused on the development of mental health services for children and young people in Scotland (Mapstone, 1983). The report was the first produced by an official UK agency which encompassed the wide variety of services involved in the mental health of children and young people. It highlighted the crucial need for inter-disciplinary cooperation and stated:

The failure to develop services in an inter-dependent way has resulted in disjointed and uneven development... not only are resources wasted when services are unco-ordinated, such lack of cohesion is harmful to children and their families. (Mapstone, 1983, p. 20)

The report set out detailed recommendations and an important agenda for the development of services, but these were not progressed in a coherent way. Twenty

years later, this situation, hopefully, is changing.

In October 2003, NHS Health Scotland held a national conference – *The Health of Looked After Children and Young People*, and the issue of mental health was a high priority at this conference. A number of projects have been established which focus on mental health issues of children and young people living in residential and foster care. Parallel developments have also taken place in relation to the health of all children and young people. In 2000, the Scottish Executive established the *Child Health Support Group*, a multi-disciplinary, expert advisory group, to co-ordinate and drive forward improvements in child health and the quality of child health services. In a revision of the group's remit and workplan in 2002, five key areas were identified for improvement and the first on this list was child and adolescent mental health. The Scottish Needs Assessment Programme which aims to ensure that needs assessment makes a measurable impact on health outcomes has also recently focused on the mental health of children and young people (Public Health Institute of Scotland, 2003).

In this paper, we will provide an overview of state care in Scotland and identify the particular issues relating to the mental health of children and young people in residential and foster care in Scotland. We will then outline the major policy developments occurring currently across health and social services which will impact on the development of services. Finally, we will describe some of the innovative projects which have focused on improving the mental health of children and young people in residential and foster care.

State Care in Scotland

Children and young people looked after in state care are among the most vulnerable in Scotland. Although the UN Convention on the Rights of the Child states that there should be special protection for children living away from home, a recent review highlighted the 'continuing failure of many local authorities as 'corporate parents' to provide these young people with the care and education they are entitled to by law' (Scottish Executive, 2001, p. 10). A number of scandals which have highlighted the abuse of children in care, particularly those in residential care, have been revealed

across the UK (Kendrick, 1997, 1998). These, in their turn, have led to a number of government reviews of issues relating to the safety of children in the public care (Utting, 1991; Skinner, 1992; Kent, 1997; Utting, 1997).

On 31 March 2002, 11,241 children and young people were looked after in Scotland; that is, local authorities had responsibilities under the Children (Scotland) Act 1995, to provide support and promote their welfare. More than half (56 per cent) are looked after at home or in the community with relatives or friends. Almost a third (30 per cent) are looked after and accommodated with foster carers, prospective adopters or in other community resources. The remaining fourteen per cent are in residential accommodation: local authority homes; voluntary sector homes; residential schools; secure accommodation or other residential provision (Scottish Executive, 2002a).

The number of children looked after away from home has fallen by about half in the last 25 years. The proportion of children in foster care and residential care has also changed significantly. Twice as many children and young people are in foster care today, the reverse of the situation in 1976. This has occurred for a variety of reasons. There has been a general, policy preference for children and young people to be cared for in family settings and for services to be directed towards supporting and helping the family as a unit to prevent the need for children to be received into state care (Directors of Social Work in Scotland, 1992). A recent review of child protection, however, found that some children remained in their family home, suffering harm, because professionals did not want to remove them into state care. Although they recognised the weaknesses of this approach, they had clear reasons for not removing children. These included the strong attachments children had to their family; the poor outcomes for looked after children; the lack of good quality residential and foster care placements; and residential provision not being able to meet the needs of the child (Scottish Executive, 2002b).

Foster care is seen as the preferable placement unless this is contrary to the child's best interests, and if return home is not a viable option the child should be provided with permanent substitute family care (Directors of Social Work in Scotland, 1992). This being said, there is also a recognition in Scotland of the important role of residential child care and the need to promote residential care as a positive choice

for some children and young people (Skinner, 1992). A recent manifestation of this has been the establishment of the Scottish Institute for Residential Child Care to ensure that residential child care staff throughout Scotland have access to the skills and knowledge they require to meet the needs of the children and young people in their care. Foster care is 'now dealing with some young people who were formerly thought to require residential care and who tend to be more testing in their behaviour' (Hill, 2002, p. 13). Specialist foster schemes have been developed which, for example, are providing alternatives to secure accommodation (Walker *et al.*, 2002). Similarly, residential care is now providing services for young people who present more serious and challenging behaviours.

Over a number of years, research has highlighted the poor outcomes for children leaving residential and foster care. The care experience of young people has often involved frequent moves between care placements and educational disruption (Kendrick, 1995; Triseliotis *et al.*, 1995; Dixon and Stein, 2002). A recent survey of care leavers in Scotland identified that the majority of care leavers had poor educational outcomes; over half were unemployed; and many of the young people had experienced mobility and homelessness (Dixon and Stein, 2002; 2003). The Residential Care Health Project (2004) highlights the health disadvantages of children and young people in residential child care.

Driven in no small part by the scandals and the recommendations made by the inquiries and reviews, there have been major developments in the UK: both directly focused on the 'special protection' of children living away from home; and more general developments which affect all areas of social care for vulnerable people (Kendrick, 1998; Kendrick and Smith, 2002).

The Care Commission has been established to register and inspect care services. National Standards have been issued which services must meet. The main principles underpinning the standards are: dignity, privacy, choice, safety, realising potential, equality and diversity. The Care Commission, will enforce these standards and it will be able to use legal sanctions if services fail to meet the standards. Ultimately, it will be able to cancel a service's registration. The social care workforce is also in the process of regulation and the Scottish Social Services Council will set standards of

conduct and practice for the workforce and publish codes of practice for social services workers and their employers; establish a register of individuals in specified groups; and regulate education and training.

Mental Health and Children and Young People in State Care

Children and young people who are looked after in state care will often have left their own homes in traumatic circumstances. They may have suffered physical, sexual, emotional abuse or neglect (Richardson & Lelliott, 2003). They may be involved in the misuse of alcohol or drugs or involved in offending. This can be compounded by instability and disruption in the care experience itself. It is not surprising then that they suffer from a range of mental health difficulties at a much higher level than the general population of young people.

In an early study of the psychiatric ill-health of young people in the care system, McCann et al. (1996) included all young people aged 13 – 17 in residential and foster care in Oxfordshire and compared them to a matched group of adolescents with no previous or current contact with the local authority. They found that the prevalence rate of psychiatric disorder of those in care was 67 per cent (96 per cent in residential units and 57 per cent in foster care) compared with 15 per cent in the comparison group (McCann et al., 1996). They concluded that one of the most worrying findings was that ‘a significant number of adolescents were suffering from severe, potentially treatable psychiatric disorders which had gone undetected’ (McCann et al, 1996, p. 1529). A more recent national survey in England, found that of a sample of 1,039 looked after children aged 5 – 17, 45 per cent were assessed as having a mental disorder, 37 per cent had clinically significant conduct disorders, 12 per cent were assessed as having emotional disorders – anxiety and depression – and 7 per cent were rated as hyperactive (Meltzer et al., 2003, p. 20).

About two-thirds of children living in residential care were assessed as having a mental disorder, compared with half of those living independently, and about four in ten of those placed with foster carers or with their natural parents (Meltzer et al., 2003, p. 25)

A number of Scottish research studies also reflect the high levels of mental ill-health among looked after and accommodated children and young people. Dimigen et al. (1999) focused on children entering the care system. Information was collected on 70 children aged between 5 and 12 years within six weeks of admission to care. Just over a third (36 per cent) showed very elevated levels of conduct disorder. A similar proportion showed very elevated levels of depression and depression was more common among those in residential care than in foster care. Again Dimigen et al. concluded that a considerable proportion of young children entering care have a serious psychiatric disorder but they are not being referred for psychiatric help. Minnis and Devine (2001) found that, in a sample of children aged between 5 and 12 and in foster care, 93 per cent had experienced some kind of abuse or neglect; 77 per cent had been sexually abused.

According to both foster carers and teachers, over 60 per cent of the children in the study had some degree of mental health problems. Around 50 per cent had problems with hyperactivity, 60 per cent had conduct problems and 50 per cent had problems with peer relations (Minnis & Devine, 2001, p. 45; see also Minnis & Del Priore, 2001)

Chetwynd and Robb (1999) surveyed young people aged 12 – 16 in Glasgow residential units. They received carer questionnaires on 46 young people and self-report questionnaires from 26 young people. Over half the young people (56.5 per cent) were rated ‘as experiencing levels of psychological problems commonly found in youngsters experiencing mental health difficulties’ (Chetwynd & Robb, 1999, p. 8). Almost half the young people rated themselves as experiencing significant psychological problems.

Ridley and McCluskey (2003) surveyed 96 young people aged between 14 – 24 living in residential child care or supported tenancies. The survey found significantly high levels of depressive mood and low self esteem. More females (33 per cent) than males (23 per cent) were highly depressed. Almost half of the young people (45 per cent) had self-harmed (Ridley and McCluskey, 2003). A parallel study surveyed 66 young people aged 14 years and older in foster care and found lower levels of depressive

symptoms: 30 per cent of females and 4 per cent of males (Scottish Health Feedback, 2003). This group of young people had high self-esteem, even compared to figures for the general teenage population. One in five (20 per cent) stated that they had deliberately self-harmed, again much lower than those in residential care (Scottish Health Feedback, 2003)

Blower et al. (2004) found that a majority of children and young people looked after by one local authority suffered from chronic and disabling mental health problems. While prevalence rates for psychiatric disorders were similar to those found in previous studies, they found no evidence of psychosis and surprisingly low rates of mood disorder or post-traumatic symptomatology.

The Residential Care Health Project (2004) carried out comprehensive health assessments on 105 children and young people aged between 6 and 17 years in residential units in three local authorities. This included a mental health assessment which found that “the majority of the assessed young people were experiencing psychological distress and emotional behavioural difficulties...” (Residential Care Health Project, 2004, p. 24). These included: impaired interaction with peers (70 per cent); low self esteem (66 per cent); impaired interaction with adults (63 per cent); impairment of mood (29 per cent); history of self harm (25 per cent); difficulties with attention and concentration (19 per cent); anxiety (12 per cent); and parasuicide attempt (10 per cent) (Residential Care Health Project, 2004, p. 25). One fifth of the children and young people were currently being seen by child and adolescent mental health services and a further fifth were referred by the project; half of these urgently.

Research, then, has consistently shown high levels of mental health problems among children and young people in residential and foster care.

Mental Health: A New Government Priority in Scotland

Despite the ‘Crossing the Boundaries’ report (Mapstone, 1983), mental health has not, until recently, been a priority for government. Child and Adolescent Mental Health Services (CAMHS) have been poorly funded and little strategic planning has occurred to identify and meet need. This situation is, however, changing in the context of

studies which highlight the prevalence of mental ill-health such as depression in Scotland. Scotland's suicide rate for males is one of the highest in Europe and is rising. Suicide is now the most common form of death for young men (Philp et al., 2002). The Scottish Executive has established a number of initiatives designed to improve mental health and these relate to: the whole population; children and young people; and vulnerable groups of children, such as those in state care.

The Mental Health and Well-Being Support Group was established in 2000 to ensure that the NHS and local authorities are working together and planning to provide the best services, and to identify good practice. Following this, a *National Programme For Improving The Mental Health And Well Being Of The Scottish Population* was set up in 2001 with the main themes of: increasing public awareness; eliminating stigma and discrimination; reducing the rate of suicide; promoting recovery; and reducing inequalities (Well? Mental Health and Well Being website). In 2002, the 'see me' campaign was launched to challenge stigma and discrimination around mental ill-health in Scotland and to promote a more positive public perception of people with mental health difficulties (see me Scotland website).

While these developments have covered all age-groups, children and young people have been identified as priority groups. As part of the Scottish Needs Assessment Programme (SNAP), a multi-disciplinary group of professionals undertook an analysis of child and adolescent mental health needs in Scotland (Public Health Institute of Scotland, 2003). The report of the group identified three core themes. The first highlighted the importance of recognising the right of children and young people to be heard and their ability to be helpful in developing strategies and practice designed to improve child and adolescent mental health. Secondly, the report highlighted the need to 'mainstream' mental health, so that young people who are experiencing difficulties are not marginalised or excluded. Finally, the report stressed the importance of an integrated approach to promotion, prevention and care in relation to the mental health of children and young people.

The report identified serious concern about the level of resources in child and adolescent mental health services. There were problems with staff recruitment,

particularly with psychiatrists, nurses and clinical psychologists.

Overall there are many examples of innovative practice, but they are patchy and unco-ordinated, services are overstretched and struggling to cover all the bases and there is huge variation in the services to families (Public Health Institute of Scotland, 2003, p. 60).

Similarly, availability of residential or in-patient hospital units was highly variable. Two inpatient hospital units for children or adolescents were closed during the needs assessment, leaving only one unit for children and three for adolescents across the whole of Scotland (Public Health Institute for Scotland, 2003, pp. 21-2). There is no secure psychiatric provision for this age group in Scotland. While the numbers who may need this kind of service are low, the consequence of the lack of appropriate facilities is significant for those involved. The Scottish Executive is currently considering the need for secure mental health provision. The needs assessment report called for a national strategy to address specialist needs such as these (Public Health Institute of Scotland, 2003, p. 83).

A survey of frontline professionals who work with children or young people but who do not work in specialist mental health services was carried out. This included residential workers and foster carers. Only one in five reported any training in child and adolescent mental health (Public Health Institute of Scotland, 2003, p. 61). All the groups surveyed wanted increased training in mental health.

The report recognised the importance of developing creative and innovative ways to ensure that everyone (including children and their families) is able to work together to meet the challenges of safeguarding and caring for the mental health of young people. It, therefore, recommended a strategic approach to workforce development to increase capacity as well as a re-shaping and re-focusing of services. Any future child and adolescent mental health service should not only provide a treatment service for children in need but should also have a much larger commitment to consultancy, liaison and training with colleagues in other services for children (Public Health Institute of Scotland, 2003, p. 77).

The government has also highlighted these priorities in the Partnership for Care health white paper (Scottish Executive, 2003). In the section on workforce planning and development, there is a clear commitment to young people with mental health problems; they will be the first to benefit from a national approach to integrated work force development:

Our first priority will be mental health workers for child and adolescent services. This initiative will identify core competencies for staff, provide new opportunities for joint training and enable staff in partner organisations to combine more effectively in multi-disciplinary teams to provide improved, sustainable services (Scottish Executive, 2003, p. 48)

The needs assessment report urged continuous service evolution ‘informed by rolling needs assessment, which seeks excluded groups and unmet needs’ (Public Health Institute of Scotland, 2003, p. 78). The groups that the report specifically identified as meeting this category include looked after and accommodated children, as well as children with learning difficulties, those involved in substance abuse and those who are offending. The report acknowledged that these groups of children and young people have not been well served by mental health services.

The *Child Health Support Group* was established by the Scottish Executive in 2000. This multi-disciplinary, expert advisory group is co-ordinating and driving forward improvements in child health and the quality of child health services (Child Health Support Group, 2003). Improving mental health services and early intervention for young people is high on the group’s agenda.

The Child Health Support Group’s aim in this area is to promote development in child and adolescent mental health and support a strategic approach to development of specialist child and adolescent mental health services in Scotland. The major focus of our work to champion these vital services is implementation of the recommendations made by the SNAP Team in their report on child and adolescent mental health in Scotland (Child Health

Support Group, 2003, p. 27).

The Development of Services for Children and Young People in State Care

One third of child and adolescent mental health services reported that they have a specialist service for looked after children and young people (Public Health Institute of Scotland, 2003, p. 59). In identifying the mental health needs of children and young people in residential and foster care, one factor has emerged as highly significant, and has greatly influenced the mode of operation of new services. Not only do children in state care have extremely high rates of psychiatric disorder but they also have great difficulty *accessing* those child and adolescent mental health services which do exist (Arcelus et al., 1999; Lewis, 2000; Callaghan et al., 2003). In some cases, the young people themselves may have resisted referral because of the stigma associated with psychiatric services, however research has indicated that long waiting times and referral procedures have deterred social workers who would often want to refer young people at times of crisis (Richardson & Lelliott, 2003). Blower et al. (2004) reported waiting times of up to year and that young people were suspicious of what they viewed as inaccessible and irrelevant mental health professionals.

The lack of consistent adults to act as advocates for young people and frequent changes of placement experienced by so many young people in the care system also act as barriers to access of services (Callaghan et al., 2003; Philips, 1997; Residential Child Care Health Project, 2004; Richardson & Lelliott, 2003; van Beinum et al, 2002). Child and adolescent mental health professionals have, on occasions, been very reluctant to accept referral of young people when they have been 'in crisis' or who expressed their emotional distress through challenging behaviour. There has also been the assumption that their involvement with children should be as brief as possible. Looked after children and young people have experienced such disruption in their relationships with adults that effective intervention with them often requires a more long-term commitment.

The general message of the needs assessment report is welcome to professionals working with looked after children as it indicates a shift in focus and perspective that is more in tune with the type of needs that these children have. In this section of the

paper, we describe some of these new service developments and some of the key lessons being learned.

The Greater Glasgow Health Board has been at the forefront of developments in this field and has recently set up a Mental Health service for looked after and accommodated children and young people. The service consists of a psychiatrist, a psycho-therapist, three psychologists, a family therapist and three psychiatric nurses, along with administrative support. This new service has been built upon the foundation of two pilot projects, Open Door and LACES, which ran between 1999 and 2003. The former operated in East Dunbartonshire, a small local authority on the edge of Glasgow city, and the latter which served the 'East Sector' of Glasgow city itself. Open Door (Scottish Health Feedback 2003b, van Beinum et al., 2002) mainly worked with children and staff in residential units while LACES worked with children under the age of twelve, the majority of whom were placed with foster carers. In the same period, the Acorn Project was set up in the West Dunbartonshire local authority area under the auspices of Lomond and Argyll NHS Primary Care Trust, part of the Argyll and Clyde Health Board area. The Acorn project consisted of a mental health professional and a social worker and also aimed to serve the needs of children and young people in residential and foster care. Meanwhile in Ayrshire, the LEAP Project had been established with a diverse team of nurses and youth workers to provide an 'emotional well-being service' for looked after children and young people in three social work areas.

In 1999, in the North Lanarkshire local authority area the Public Health department of the local Health Board (Lanarkshire Health Board) felt they had to respond following the suicide of two young people who had recently been discharged from residential care. A short-lived service, the Youth Emotional Wellbeing service, consisting of a single psychiatric nurse was established. The nurse frequently visited children and young people placed in the five residential homes operated by the authority, providing a range of services to young people and consultancy to staff (Milligan, 2001).

Another important development has been the establishment of the Residential Care Health Project which was established to address the health inequalities faced by

children and young people accommodated in residential units in Edinburgh, East Lothian and Midlothian (Grant et al, 2002; Residential Care Health Project, 2004). The project aimed to work with social work and education colleagues in order to establish a holistic approach to the provision of health care and health promotion for these young people. At first there were no mental health staff in the team but upon undertaking their first visits to the residential units and asking what the main health problems were they rapidly found out that mental or emotional problems were a high priority for the care staff (Grant, 2001). The team then added a psychiatric nurse to their complement. The work of the project mental health practitioner developed in the areas of: consultation with staff about young people; liaison between the residential units and child and adolescent mental health services; direct work with young people; training; and helping the project staff to understand residential unit staff's difficulties in working with very troubled young people (Residential Care Health Project, 2004). The mental health component of the project has now evolved into the much more fully staffed CONNECT service which Lothian Health Board has established to provide a service to all looked after and accommodated children.

Given that most child and adolescent mental health services have operated with long waiting lists there was a perhaps understandable fear on behalf of some mental health professionals that if they opened up their services, or in some way prioritised the needs of children and young people in residential and foster care, they could be overwhelmed by demand. In the development of the new services, staff were clear that they had to operate in a different way from the normal 'clinic' model where therapists give out appointments and wait for the patients to come to them. It has been encouraging to note that the pilots have demonstrated that the mental health staff could engage with young people and their residential carers if they went to where the young people lived. By making visits the mental health staff have broken down barriers between themselves and the children and their carers. Sometimes direct work with young people has taken places in the residential units or foster homes, on other occasions staff have provided advice or consultancy to carers who have been having difficulty in dealing with a young person. This was exemplified in the 'Open Door' project where there was a central conviction 'that work carried out through those involved in directly caring for young people is at least as valuable, if not more

valuable, than direct clinical work with young people themselves...' (van Beinum et al., 2002, p. 18; see also Callaghan et al., 2003). Thus this project offered a wide range of services which included:

... assessments of individual young people and follow-up clinical work; consultations to care staff and social workers about individual young people; consultations to staff teams about whole unit issues; inputs to Looked After Children reviews, research and audits; and training seminars for front-line field and residential staff (van Beinum et al., 2002, p. 18).

The projects also act as a speedier and more trusted referral route to other psychiatric and specialist services.

Future Directions

This paper has shown that Scotland is in a situation of transition regarding professional awareness of the mental health needs of children looked after and accommodated by state authorities. The emergence of a number of new services focused on the mental health needs of this vulnerable group is evidence of this increased awareness, but nevertheless this new service provision has been ad hoc and patchy. In many parts of the country, social workers and residential care workers continue to find it very difficult to access existing, over-stretched, child and adolescent mental health services.

Where prevalence research has been carried out it confirms studies across the UK showing very high levels of psychiatric disorder. As with the rest of the UK, social work practice has for many years placed great emphasis on supporting families and not separating children from their parents unless absolutely necessary and following prolonged community-based interventions. Thus it is acknowledged that nearly all children admitted to residential and foster care have already suffered high levels of trauma and family disruption. In these circumstances, it is not surprising to discover a high level of emotional and psychological disturbance. Carers and social service personnel, however, have generally attempted to meet all the needs of these children and young people from within a somewhat limited 'care' perspective and specialist

child and adolescent mental health services have been difficult to access. It may also be true to say that social workers have been concerned not to consider a mental health diagnosis for fear of labelling a child.

What is now emerging, however, is a much greater awareness of mental health needs, and an openness to a mental *health* approach, as opposed to a focus on mental *illness*, among social work personnel. The training of direct care workers (residential or foster care) has also been identified as a central issue in improving the mental health of children looked after in residential and foster care (Chetwynd 1999; Polnay & Ward 2000; Public Health Institute of Scotland, 2003; Robinson et. al., 1999). The openness to, and indeed ‘hunger’ for, training should give comfort to mental health staff that they themselves do not need to take on all the responsibility for improving the emotional well-being of looked after children (Hatfield et al. 1996). As one social services manager involved in a pilot service put it, ‘we are not suggesting that there is a need for a psychiatrist at the foot of every child’s bed’! What is required is training and support for direct care staff. Consultancy services which involve shared discussion about the mental health needs of individual children and young people is emerging as a key feature of the new services. Residential workers frequently report how helpful it is to have the views of mental health staff, even when they are simply affirming the care practice that workers have been adopting in response to the needs of particular children and young people.

It appears that these new services are demonstrating that effective inter-professional and inter-agency working to improve the mental well-being of looked after children and young people is possible. They provide clear examples of the ‘joined-up working’ that government has been calling for in recent policy papers (Scottish Executive, 2001). It is crucial then, that the governmental priority given to improving the mental health of vulnerable children and young people, and the lessons learned from innovative mental health projects are harnessed to drive forward the development of integrated and flexible mental health services in order to improve the outcomes and well-being of all children and young people in state care in Scotland.

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