ORANGA TAMARIKI
Ministry for Children

EVIDENCE CENTRE
TE POKAPŪ TAUNAKITANGA

Evidence Brief: Mental health and wellbeing needs of children and young people

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Acknowledgements

The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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Executive summary

This evidence brief details what is known about the best practice responses to meeting the mental health and wellbeing needs of children and young people receiving assistance, or who are in the care and protection or youth justice systems. This report provides insights across:

- assessment and identification;
- approaches to addressing complexities and concerns with children in care and protection, or youth justice systems; and
- Indigenous research.

The learnings from the literature may inform Oranga Tamariki's strategic discussions about actions that could be taken by and across the sector to support the mental health and wellbeing needs of children and young people in a care and protection or youth justice environment.

Assessment and identification models are typically formal processes with mixed views on how accessible they are

Models of assessment and identification are typically formal processes that formulate management plans based on factors such as personal history, mental state, recorded problems and symptoms. This is mandated in some jurisdictions, but the effectiveness of such an approach is unclear. Moreover, there are mixed views on the accessibility of formal assessments, as this is not always a timely process. This is exacerbated for disabled youth in care. In general, young people and their carers are not active in seeking support for mental health, or the child/young person relies on carers to do so. However, some newer models of assessment that move away from this status quo are emerging, especially in Aotearoa.

Approaches to addressing complexities and concerns with children in care, protection, or youth justice systems include person-centred care and early intervention

Modalities of care that centre tamariki and rangatahi are increasingly common in the OECD including in Aotearoa. This includes models such as wraparound care, which both centres the child and attempts to coordinate responses and services at an agency, community, family, and other service level. Common interventions include therapeutic, behavioural, and emotional interventions, but the effectiveness of such approaches is still somewhat uncertain.

Early intervention for children and young people in care who have issues or concerns about their mental health is paramount. When young people on the verge of adulthood are experiencing issues, there must be continuity of care from child to adult mental health services. There is a major gap in appropriate support and interventions for children and young people, but increasingly, youth-specific services that fill this gap are emerging in Europe, the United Kingdom, North America, and Aotearoa.

Best practice approaches include:

- Providing wraparound multi-layered interventions and early intervention initiatives.
- Providing ongoing professional development and therapeutic training and support for carers.
- Multi-agency collaboration in the form of normalised and standardised information sharing across relevant agencies, multi-agency supports, cooperation and both professional and agency and operational and systemic levels.
- Expediting access and ensuring quality of mental health services by having a health clinician at care facilities, ensuring priority status for children in referral to particular services and ensuring health professionals have all available medical records for initial health assessments.
- Providing children and young people with active involvement in decisions and conversations about their mental health needs, quality, stable placement and targeted mental health services.

Insights from Indigenous research

Western ways of understanding mental health and mental health service provision present ongoing challenges for Indigenous and marginalised populations, and are typically inconsistent with comparable Indigenous models. Research emphasises the need to integrate culturally safe concepts and models of health into service provision, including in Child and Adolescent Mental Health Services (CAMHS). Some examples of Indigenous models of health are in use in Aotearoa at the moment (Te Whare Tapa Whā, Te Pae Mahutonga, Fonofale, Fa'afaletui, for example). Best practice approaches in this space include:

- Providing informal and formal referral pathways to culturally appropriate CAMHS ensuring a system approach that is cohesive, multisectoral and can provide support services across the life of the child/young person. This includes services that enhance Māori identity and link them to cultural- and clinical-based CAMHS support.
- Working in partnership with parents, whānau, and community leaders in the CAMHS process.
- Models/approaches to care should be co-designed or co-constructed with Indigenous communities, and allow rangatahi to feedback on the quality of CAMHS, so they are involved and have agency in the process.
- Having strengthened support for Indigenous families who deal with ongoing impacts of colonisation, language and culture loss, and removal from land.
- Ensuring CAMHS and practitioners/clinicians have an operational understanding of Indigenous practices, customs and ceremonies. This includes

for example, having tikanga and kaupapa Māori embedded in service delivery and fusing Indigenous conceptions and understandings of treating mental distress with Western models of assessment and treatment.

Introduction

Oranga Tamariki commissioned this literature review to explore what is known about the best practice responses to meeting the mental health and wellbeing needs of children and young people receiving assistance, or who are in the care and protection or youth justice systems. Indeed, mental distress amongst children in care is widespread in Western and developed countries (see OECD 2018, 4), with more than fifty per cent requiring mental health services and intervention. As has been observed, "Looked after children have complex and multiple social care, educational and developmental needs, which compound their mental health" (Anderson, Vostanis, & Spencer, 2004 in Vostanis 2010, 557–58). This review offers some insights into current thinking in this space.

The purpose of the review is to:

- Inform Oranga Tamariki's strategic discussions about actions that could be taken by and across the sector, to build an approach for providing for the mental health and wellbeing needs of children and young people in a care and protection or youth justice environment.
- Explore how other international agencies have addressed the issue.

Research questions and report outline

The review draws on a range of mental health and wellbeing insights for tamariki and rangatahi. The following focus areas were adapted into research questions to guide the review, and this report is structured chronologically in response to each question:

1. How is assessment and identification made for children and young people receiving assistance, or in care and protection or youth justice systems?
2. For children and young people receiving assistance, or in care and protection or youth justice systems, what are typical approaches to addressing complexities and concerns related to the child (e.g., family), especially in instances where multiple agencies are involved?
3. What system frameworks, services, and supports are found in OECD countries that experience similar challenges?
4. In this context, what insights can be drawn for best practice from other jurisdictions with comparable Indigenous populations?

Please note, as questions two and three thematically overlap, they have been combined into a single section. Questions 1 and 4 remain standalone sections.

Methodology

Following discussions with Oranga Tamariki, our team undertook a scan and analysis of relevant literature across academic and general research platforms, based on agreed search terms (see Table 1 below).

Table 1: Search terms

Search term 1	Search term 2	Search term 3	Search term 4
Mental health needs	Rangatahi	Social model	Te Ao Māori
Support approaches	Young people	Social work	Kaupapa Māori
Care and protection	Tamariki	Education	Strengths-based model
Wellbeing	Children	Disability	Rights-based model
Need		Mental health	Indigenous model
Youth justice		Psychology	Kānaka Maoli/Kānaka ʻŌiwi
Assessment/ needs assessment			Aboriginal and Torres Strait Islander
System supports			Native American

The title and abstracts of initial returns were reviewed for relevance to the key research areas. The references used in articles or reports that passed this initial review, as well as lists of documents that had cited these articles or reports (generated by the databases searched), were also checked for any further relevant information sources.

A total of 62 documents – including research articles, government strategies, and reports – were reviewed, forming the basis of this report.

Assessment and identification

This section responds to, and addresses, the following question:

1. How is assessment and identification made for children and young people receiving assistance, or in care and protection or youth justice systems?

Models of assessment and identification

Mental health assessments are a central activity and high priority when determining what assistance someone experiencing mental distress requires. Formal mental health assessments generally focus on "recording or presenting problems, personal history, current symptoms, mental state, and identifying risk factors. This typically leads to a formulation, diagnosis, and a treatment or management plan" (Wand et al. 2020, 172).

In some jurisdictions, children/youth in care must undergo an annual statutory health assessment, which can serve as method of assessment and identification of potential mental distress (Hill and Watkins 2003). While statutory assessments can be an opportunity to assess and identify mental distress, evidence suggests they are often seen as a procedural "freedom from infection check" and serve the interests of a carer rather than the child, or as a paperwork hurdle (Hill and Watkins 2003). For statutory assessments to be effective in assessing and identifying mental health needs for youth in care, they must be health promoting rather than disease screening, and delivered by health professionals who have skills in recognising and addressing diverse health needs (Hill and Watkins 2003).

Literature generally supports early intervention (including in the case of assessment and identification) for youth in care (Herwig 2022). Adverse outcomes have the potential to be significantly reduced for youth in care when there is "intensive and direct psychological input at an early stage" (Herwig 2022, 54). Evidence suggests that referring youth in care along with carers for psychoeducation and to support groups with peers in similar situations can all support early assessment and identification of mental distress (Herwig 2022).

The role of carers in help-seeking on behalf of youth in their care

Evidence shows that young people and their carers do not regularly engage in seeking help for mental distress (Powell, Huxley, and Townsend 2021). Young people and their carers are often concerned about stigmatisation, confidentiality, the inaccessibility of services, limited opportunities to be involved in decision making, and a perception that service providers will not understand their circumstances (Powell, Huxley, and Townsend 2021). Young people thus often seek out informal support via family and friends, and often with peers who are perceived to relate to what they are going through. This means that some youth in care experience mental distress that is neither identified nor assessed at all by professional mental health services, due to negative perceptions felt by youth and carer alike (Powell, Huxley, and Townsend 2021).

Nevertheless, youth in care are generally reliant on carers to help-seek on their behalf (Powell, Huxley, and Townsend 2021; York and Jones 2017). Whether or not a youth in care has their experience of mental distress identified and consequently assessed often relies on the actions of their carer (Powell, Huxley, and Townsend 2021; York

and Jones 2017). Some literature discusses the fact that, by nature, carers have intrinsic knowledge about children in their care that needs to be acknowledged and utilised by mental health service providers to support identification and assessment (York and Jones 2017). On the other hand, some evidence suggests that carers need further support and training to understand when and how to escalate mental distress experienced by children in their care to support assessment processes (Powell, Huxley, and Townsend 2021).

Accessibility of formal assessments

There is evidence that there is generally good access to mental health services following the referral of youth in care, but barriers exist in the system when more specialist mental health services are needed (York and Jones 2017). The biggest barrier cited is delays in the delivery of services, particularly between the onset and recognition of problems (York and Jones 2017). This suggests that assessment and identification for youth in care is not always made in a timely or proactive manner; however, this is similarly experienced across mental health services for the general population as well. Literature searched did not describe general assessments used beyond the definitions provided; however, further, targeted research in this space may yield more insights.

Evidence suggests that assessment and identification of assistance required for youth in care who are referred to mental health services can be inconsistent, particularly across different characteristics of referral (Rao, Ali, and Vostanis 2010). This is attributed to the fact that "the distinction between mental health needs, problems and disorders is not always clearly defined" (Rao, Ali, and Vostanis 2010, 58). This results in considerable service variation around assessment, identification and consequential mental health assistance; while youth in care who had indication of a likely disorder are accepted for specialist care, there is much less consistency around assessment decisions for youth with behavioural and attachment problems, and in the absence of a likely disorder (Rao, Ali, and Vostanis 2010).

Disabled youth in care

Assessment and identification for children with intellectual disabilities who have experienced abuse, neglect and trauma is challenging, and can become complicated further when a social worker or health practitioner does not have a good level of knowledge or skill in working with children with disabilities (Simpson, Yeung, and Munford 2022). Navigating the nuances of disability and abuse is complex. Assessing and identifying these children/youth involves a great deal of communication and collaboration with parents or caregivers, as social workers or health practitioners may rely on those closer to the child to interpret them (Simpson, Yeung, and Munford 2022). Assessment and identification of mental distress for disabled youth thus relies on practitioners having knowledge and skills in relational practice, socio-ecological frameworks, human rights and social justice, and advocacy to develop and tailor assessments and interventions that are fit for purpose for children with intellectual disabilities.

Alternatives to 'one size fits all' models of assessment and identification

Formal mental health assessments in Australia and Aotearoa, such as those described above, have not adapted to changes in contemporary thinking and practice. Some evidence suggests that assessments tend to remain focused on unhelpful criterion to support diagnosis (Wand et al. 2020). These indicators have since been reviewed and examined, with evidence suggesting many aspects of formal assessment such as repeated risk screening and items around "appearance" are unreliable tools that are unsupported by modern evidence and present little benefit to both patient and practitioner in assessing, identifying, and treating mental distress (Wand et al. 2020, 174). A lack of recording or reference to cultural contexts and issues can mean that mental health assessments are not culturally safe or appropriate (Rao, Ali, and Vostanis 2010). This is particularly prevalent in Aotearoa where Māori are overrepresented in care settings (Johnstone & Reid, 2000, Savage et al. 2021).

A number of alternative assessment models have been developed, particularly in respect to distancing themselves from Western psychiatric models of health. Models developed in Aotearoa appear repeatedly in the literature, and the search did not return examples of any alternative models of assessment from other jurisdictions. While none of these models have been designed specifically for youth in care, consensus in the literature tends towards the fact that formal assessments are not fit for purpose for youth in care – especially Indigenous youth – and each model has shown evidence of positive outcomes for young people who have been assessed in this way. These include:

- **Your Choice:** The *Your Choice* method of assessment and identification has shown potential to be an acceptable and effective way to reduce symptoms for youth with mild to moderate health concerns (Clark et al. 2014). This model of assessment included a single point of entry, a low threshold for referral acceptance, prompt intake and supported transition to CAHMS if needed. The process involved triage, engagement and facilitated access to a choice of free therapies with a collaborating multidisciplinary team of mental health service providers.

- **Te Ara Waiora a Tāne:** This Kaupapa Māori mental health assessment and intervention planning approach is collaborative, narrative-based and embedded in Te Ao Māori. The approach offers whānau Māori a "culturally appropriate, innovative and practical structure for joint understanding, goal setting an planning next steps in their mental health care" (Bush, Campbell, and Ransfield 2019, 339). The approach focuses on what whānau wants from mental health services, and the initial *Choice* appointment focuses on identifying shared goals and shared formulations, while following *Partnership* appointments continue joint work towards whānau goals (Bush, Campbell, and Ransfield 2019). Initial evaluations indicate that staff find this approach user friendly and helpful for whānau. However, further research is required to assess the views of Māori and whānau (Bush, Campbell, and Ransfield 2019).

- **Pōwhiri Asessment Tool (PAT):** PAT is a Māori mental health assessment model based on the metaphor of pōwhiri, using the elements of wero, karanga, hongi/hariru, mihimihi, koha, whānau, whanaungatanga, hākari/kai and wairua. PAT can be used as a way to link and understand assessment, and while it takes time and effort to attend a pōwhiri, a singular, focused, Westernised assessment is not always accommodating for tāngata whaiora, with some finding it overwhelming (Williams 2019). PAT is both culturally familiar and less threatening than formal assessment for tāngata whaiora. Moreover, the pōwhiri experience is supported by Te Whare Tapa Whā as the health framework, and the Western assessment model BATOMI (behaviour, affect, thought, orientation, memory/motivation, intellectual, function and insight) as the mental health status examination tool (Williams 2019).

Approaches to addressing complexities and concerns with children in care and protection or youth justice systems

This section responds to and addresses the following questions:

2. For children and young people receiving assistance, or in care and protection, or youth justice systems, what are typical approaches to addressing complexities and concerns related to the child (e.g., family), especially in instances where multiple agencies are involved?
3. What system frameworks, services, and supports are found in OECD countries that experience similar challenges?

Wraparound care

A common feature of the provision of care to children with complex issues, where multiple systems are involved (such as health care, welfare, youth justice, addictions), is the 'wraparound approach' (Winters and Metz 2009; Ferguson 2006, 92). The wraparound approach is a key intervention in the care of children and young people, where relevant services are 'wrapped around' the child and their whānau, tailored to individual children. This "…results in a unique set of community services and natural supports that are individualised for a child and family to achieve a positive set of outcomes" (Winters and Metz 2009, 138; see also Ferguson 2006, 93). A wraparound service is an "intensive, family-driven, and individualised team-based collaborative care planning process, which coordinates supports and services for youth and their families in a culturally relevant manner" (Shailer, Gammon, and de Terte 2013, 197). This involves significant planning, but seeks to centre the child and whānau, build on their strengths, embed ties to the community, and be culturally relevant (Winters and Metz 2009, 138–39; Ferguson 2006, 93).

In addition to this, wraparound approaches are outcome driven, and insist on a cross-agency response (Winters and Metz 2009, 138–39; Ferguson 2006, 93). In this manner, wraparound services focus on a coordinated, multidisciplinary and individualised service. This is supported by evidence as a promising model of care for rangatahi who present with multiple, complex and expansive mental health needs (Shailer, Gammon, and de Terte 2013). Wraparound models of care can address cultural challenges and limitations found in Western models of mental health service provision, as it has a particular focus on cultural competence and family voice and choice (Shailer, Gammon, and de Terte 2013). The theme of family voice and choice is consistent with Māori models of mental health care and support, which prioritise whānau as an inherent and integral part of mental health services (Shailer, Gammon, and de Terte 2013).

In the United Kingdom, for example, wraparound services for looked after children are standard. The aim is for cohesive delivery by multiple agencies in the "…the provision of early, holistic and flexible mental health services" (Herwig 2022, S54). Attention is also focussed on supporting the development of "healthy social relationships" with caregivers, peers, and teachers (Herwig 2022, S54; Jones et al. 2012, 20); and enhancing informal support networks provided by "family, friends and pets" (Herwig 2022, S54).

In South Wales in the United Kingdom, the Multi-disciplinary Intervention Service — Torfaen (MIST) has been successful in moving young people looked after in out-of-authority residential care to local foster homes, achieving significant placement stability, reintegration with biological families where appropriate, and engagement of youth in meaningful therapeutic interventions (Street, Hill, and Welham 2009). However, literature draws attention to the fact that wraparound services like MIST rely on an attachment model of care. This can have underlying ethical issues, as it may not be appropriate to offer an attachment-based model of support when support is often time limited, and the worker or carer may cease the relationship due to limits of care programmes (Street, Hill, and Welham 2009). This is of particular concern where the young person in question may have no other significant relationship to rely on. On the other hand, literature suggests that there may be significant costs for young people when risk-averse mental health services and responses dominate, and that young people are likely to benefit from services and carers that are intensive and adept at understanding and working with risk (J. Hill 2011).

‘Best endeavours’: interagency collaboration

Wraparound approaches are embedded in some jurisdictions. A study into mental health and developmental services for children in the New South Wales context highlighted the pivotal role of psychologists in service delivery, because the child welfare department in that jurisdiction has a dedicated specialist psychological service for children (Tarren-Sweeney 2010). This is one of several services offered by different agencies in New South Wales, where child and adolescent mental health services, paediatric, and education services are offered by health and education departments. New South Wales also has what is known as a ‘best endeavours’ provision in child welfare legislation, to prioritise a wraparound, multi-agency response for children in care. In practice, caseworkers submit such “‘best endeavour 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, in Tarren-Sweeney 2010, 492). This is an example of ‘inter-agency commissioning’, where policy is developed to ensure the collaboration of relevant agencies in the care of children and young people (Vostanis 2010, 555; see also Tarren-Sweeney in Lobatto 2021, 476).

Tamariki and rangatahi at the centre

Centring tamariki and rangatahi in service provision is critical for providing services to address complexities and concerns of children. The following are examples of the shift in policy toward person-centred care, an increasingly common approach in the OECD (OECD 2021, 10). In Northern Ireland, for instance, some providers develop health plans based on comprehensive health assessments, which detail actions to address the needs of the child in terms of care and medical requirements (McSherry, Fargas, and Walsh 2016, 164). There are a range of psychological and therapeutic services available for looked after children and young people in Northern Ireland, including crisis intervention, and services for drug and alcohol abuse. (McSherry, Fargas, and Walsh 2016, 165). However, as other research has insisted, it is not always clear that

children and young people are able to access the mental health care services they need, and many "appear to have difficulties in accessing the services they need" (McSherry, Fargas, and Walsh 2016, 168; see also OECD 2022, 3).

A similar example is found in the 'Your Choice' initiative, an Aotearoa-based kaupapa that oversaw the "process of triage, engagement, and facilitated access to a choice of free therapies" for youth, and especially Māori (Clark et al. 2014, 197). Referrals could be received from a variety of sources, such as health services, schools, community organisations, whānau, and young people themselves. The referral would then be reviewed and triaged, and a multi-disciplinary team would then suggest a suite of targeted services or 'therapy/care package' for the young person (Clark et al. 2014, 192). This was a collaborative and integrated approach that could "…more efficiently utilise existing primary care and secondary mental health resources" (Clark et al. 2014, 197).

A final example comes by way of research on wellbeing measures, which prioritise the voice of children in care. This includes, for example, ensuring children are "…involved in decision-making and having choice feature strongly in broader work on [their] well-being" (Wood and Selwyn 2017, 31; Bromley et al. 2020, 506). Similarly, children in care may wish to be involved in deciding upon placement moves, and contact arrangements and care plans, in exercising a level of agency that is fulfilling for them as young people (Wood and Selwyn 2017, 31; see also McSherry, Fargas, and Walsh 2016, 169).

Therapeutic interventions

Therapeutic interventions are also common approaches for children in care (Vostanis 2010, 559), and such services have shown positive results in Germany and the United Kingdom (Herring 2021; Vasileva and Petermann 2017). This may include, for example, therapeutic modalities based on "non-verbal modes such as art or play" (Vostanis 2010, 562). Studies show that children can engage willingly and therapies support them to feel valued, heard, and lessen the feeling of being stigmatised or marginalised (Herring 2021). While initial evidence from literature in this space is positive, further research is required to include feedback from a broader range of young people, particularly those from Black and ethnic minority backgrounds (Herring 2021; Luke et al. 2014).

Some research suggests targeted, short term therapeutic interventions produce or contribute to better outcomes, but other attachment-based models prefer longitudinal support and therapy for children in care "which aims to replicate secure caregiving" (Vostanis 2010, 559). Other interventions of a similar nature are attachment-based both for young children and their carers, as an opportunity for the professional development of carers' skills and practice (Herwig 2022, S54). This is informed by the notion that a relationship between children and at least one caregiver is necessary for optimal development. Such approaches combine both the child and carer, while individual therapy (as above) is a focus on individual children. While these are some of the therapeutic approaches used overseas for addressing complexities of children in care, their effectiveness remains to be seen (Vostanis 2010, 560).

Attachment theory

Frameworks of support informed by attachment theory[1] are considered useful for children in care, but literature emphasises that such approaches should be modified to best suit the "needs and characteristics of these children and young people, that is by accounting for their unstable and changing environment, difficulties with engagement, and complex psychopathology" (Edwards, 2007 & McColgan, 2007 in Vostanis 2010, 560). Similarly, as above, a focus on both the child and carer is important in support frameworks, where the carer is involved in the intervention itself for professional development, in which "psycho-education can be extremely beneficial" (Herwig 2022, s54). An emphasis on early intervention is similarly apparent in the literature (and equally in the Aotearoa context (McArdle and Lambie 2018, 239)), in an attempt to identify and address complexities before they develop or contribute to future complications or issues (Vostanis 2010, 561).

Behavioural and emotional interventions

In the United Kingdom, a number of interventions are used to address the needs of children in care, across behavioural- and emotional-based programmes. They include:

- Direct interventions for young children such as Attachment and Biobehavioural Catch-up (ABC), Multidimensional Treatment Foster Care for Preschoolers (MTFC-P).
- Mixed interventions for young children such as Parent-Child Interaction Therapy (PCIT).
- Direct interventions for older children and adolescents such as Direct Attachment, Regulation and Competency (ARC), life story work and mentoring.
- Indirect interventions for older children and adolescents such as fostering attachments, fostering changes, Incredible Years Training (IY), Keeping Foster Parents Trained and Supported (KEEP), Multidimensional Treatment Foster Care for Adolescents (MTFC-A), and nurturing attachments.
- Mixed interventions for older children and adolescents such as Middle School Success (MSS).
- Direct interventions for older children and adolescents such as Animal-assisted therapy, arts therapy and Cognitively-Based Compassion Training (CBCT). (Luke et al. 2014).

[1] Attachment theory denotes how a child's early relationships with caregiver/s will inform how they develop relationships with others in future. As the Children's Court of New South Wales explains, the "…most important tenet [of attachment theory] is that an infant needs to establish a positive relationship with at least one primary caregiver for social and emotional development to occur normally, and that further relationships build on the patterns developed in these early experiences." See www.judcom.nsw.gov.au/publications/benchbks/children/cpm_allerton_attachment.html for more detail.

All of these interventions showed some levels of success; those that were most successful were those that "offered a structured programme of core components with some flexibility to meet individual needs", where they had a "joined-up approach from services with follow up support once the intervention had ended" (Luke et al. 2014, 104). While mixed-methods approaches appear to be the most successful, limitations with the research restrict the ability to decide which interventions or factors 'work', instead finding the set of common principles outlined above (Luke et al. 2014).

Early intervention

There is an ongoing push for early intervention of psychological services for children in care, and ensuring the continuity of this care as they develop and transition into young adults (Herwig 2022, S54; Vostanis 2010, 561; Singh and Tuomainen 2015, 360; OECD 2018, 4). Research underscores how early intervention is critical for youth experiencing complex issues, pushing for a "radical redesign with a seamless new pathway within a stigma free, youth friendly specialist model" (Singh and Tuomainen 2015, 360; see also OECD 2018, 4). Models of care in this manner are becoming increasingly common, where mental health care is considered akin to having a dental check-up (see Cocker and Scott 2006, 20), such as in Australia, North America, and parts of Europe (Singh and Tuomainen 2015, 360). Similar approaches are emerging in the Aotearoa context, such as through *Nōku Te Ao*, a public awareness campaign and programme that aims to increase social inclusion, and end discrimination towards people who experience mental distress.[2]

Continuity of care, and transitioning from youth to adult mental health services

In the United Kingdom and Canada, continuity of care from CAMHS to comparable services for adults (AMHS) is typically inconsistent (Abidi 2017, 388), where a "seamless transition [is] not the norm" (Singh and Tuomainen 2015, 358). The lack of continuity of care at such a critical time for rangatahi who may be experiencing other changing life factors (puberty; moving out of home; leaving school; cases of teen pregnancy) presents a high risk of disengagement and potential harm as a result (Vyas, Birchwood, and Singh 2015). Specifically, young people previously in CAMHS are often left without referrals or professional and clinical support, and even if they are referred, "…services are ill equipped to meet their needs" (Singh and Tuomainen 2015, 358). This is more broadly reflective of young people across the developed world disengaging, or not engaging well, with adult mental health services (Singh and Tuomainen 2015, 359). Literature emphasises that planning for continuity of care is critical, i.e., having frameworks for transition that are cohesive across: the child-adult boundary; are planned well in advance; are coordinated with services; involve both the young person and their family; include the young persons' preferences; and identify an appropriate provider before transitioning (Singh and Tuomainen 2015, 359; see also Abidi 2017, 391).

[2] See www.nokuteao.org.nz/whakapapa-history/.

This echoes earlier research which has underscored the need to ensure stability of placements for looked after children, with the hope of facilitating their engagement and involvement in education (Jones et al. 2012, 20). In Northern Ireland, comparable services are provided that help "[maintain] placement stability and avoiding placement breakdown" (McSherry, Fargas, and Walsh 2016, 166), in attempting to provide continuity of placement for children. Such approaches are augmented by ensuring foster carers are given appropriate training, and are involved in helping to provide placement stability for children (Jones et al. 2012, 20).

A gap in appropriate support and interventions for rangatahi presents a challenge across many jurisdictions

A critical gap highlighted in the literature is the need for mental health services and interventions that are appropriate for rangatahi (Stubbing and Gibson 2021; Vyas, Birchwood, and Singh 2015). It is well established across international literature that around three-quarters of a persons' lifetime experience with mental distress will have onset by the age of 24 (Stubbing and Gibson 2021). While those aged between 12 and 25 have the highest incidence and prevalence of mental distress across the general population, they also have the poorest mental health service access (Stubbing and Gibson 2021).

It is similarly acknowledged that the availability of the suite of services a wraparound approach (for instance) requires may not be readily available (Winters and Metz 2009, 146), echoing other literature which reiterates how the mental health needs of young people in care are often unmet (Jones et al. 2012, 3). What persists here is that "sizeable proportions" of this cohort are underserved and not provided the proper support and care they need (Tarren-Sweeney 2010, 481–82). A lack of coordination amongst relevant services similarly undermines the effectiveness of wraparound care (Winters and Metz 2009, 146). Young people electing not to engage with mental health services, as is sometimes the case with Pasifika and Māori youth, similarly impacts upon this (Bush et al. 2009, 138).

Moreover, the needs of children and young people in care often go unmet or undiagnosed by specialists (Jones et al. 2012, 3). This is exacerbated by having mental health policy frameworks that do not cohesively link into related domains such as social welfare and care, education, and employment (OECD 2022, 3; see also 2021, 10). Although, in Aotearoa, local government has signalled a multiagency approach (Ministry of Health, 2021). Indeed, as the OECD recently commented

> *When it comes to delivering an integrated, multi-sectoral approach systematic integration across mental health, education and employment approaches remains an exception, and not the norm. In all countries people with a mental distress were less likely to be employed, and had a lower level of education, than populations without mental distress* (OECD 2021, 10).

Filling the gaps

Several youth-specific services across different jurisdictions have emerged with the intention of filling this gap in care:

- Headspace (Australia)
- Jigsaw (Ireland)
- Maison des Adolescents (France)
- Youth Can IMPACT and ACCESS Open Minds (Canada)
- Youth One Stop Shop (New Zealand)[3]
- Other programmes across The Netherlands, the UK, Ireland and Canada (Stubbing and Gibson 2021).

The World Health Organization defines youth-friendly services as "accessible, acceptable, and appropriate to young people". This is supported by evidence from rangatahi in New Zealand who want mental health services to be "comfortable, accessible, welcoming, embedded in the community, holistic, adaptable, and youth focussed." (Stubbing and Gibson 2021, 2). Dedicated youth-based service pilots have been able to offer faster first contact, faster first assessments, reduced 'did not attend' proportions, high levels of user satisfaction and high levels of continued use of mental health maintenance techniques 12 months on from discharge (Vyas, Birchwood, and Singh 2015, 17). Early Intervention Services (EIS) for psychosis as well as early detection teams in care communities have proved successful in engaging rangatahi with services earlier, with less disabling symptoms; particularly as literature suggests rangatahi are reluctant to engage with primary care (such as GP referrals) when in need of mental health services (Stubbing and Gibson 2021; Vyas, Birchwood, and Singh 2015).

While evidence across numerous jurisdictions suggests consistent principles to take into account for youth-centred mental health services, the application of these principles in specific local contexts should be informed directly by the community in which the service is intended to reside (Stubbing and Gibson 2021).

Suggestions for future

Literature emphasises that there is little evidence on the effectiveness of current forms of intervention and supports provided to children in care (Vostanis 2010; Lobatto 2021, 474). However, several authors offer suggestions of what might be provided instead, drawn from recent clinical trials or research studies. These include:

[3] While Youth One Stop Shop is not a specific mental health service, many youth engaged in the service would not be able to access mental health care without it (Stubbing and Gibson 2021).

- Providing wraparound multi-layered intervention "…in which young people reside for a limited time period with a treatment foster family" (based on the *Treatment Foster Care Oregon for Adolescents*) (Lobatto 2021, 474).
- Echoing the call to provide ongoing professional development of carers, providing "lower-intensity training to existing foster carers", as well as therapeutic support and training for carers (Lobatto 2021, 474; Jones et al. 2012, 20).
- 'Attachment and biobehavioural catchup', an early-intervention initiative for maltreated toddlers and infants, to support and nurture the healthy development of relationships (Lobatto 2021, 474).
- Having a health clinician at care facilities to facilitate and expedite access to mental health services (Jones et al. 2012, 9).
- Ensuring health professionals receive all available medical records as they undertake initial health assessments, to mitigate against incorrect or incomplete mental health diagnoses of children (Jones et al. 2012, 9).
- Normalise/standardise information sharing across relevant agencies, and develop multi-agency supports that can reach into different aspects of the child's life (and therefore wellbeing) (Jones et al. 2012, 12).
- Ensuring children are given priority status in referral to particular services (McSherry, Fargas, and Walsh 2016, 169–70).
- Collaboration and cooperation at a professional and agency level, to encourage cohesiveness at an operational and systemic level (McSherry, Fargas, and Walsh 2016, 169–70).
- Ensuring children and young people are actively involved in decisions and conversations about their mental health needs (McSherry, Fargas, and Walsh 2016, 169–70; Wood and Selwyn 2017, 31).
- Providing quality placements that are stable, and ensure social workers and carers have appropriate training around mental health (McSherry, Fargas, and Walsh 2016, 169–70).
- Provide targeted mental health services for children (McSherry, Fargas, and Walsh 2016, 169–70).

Insights from Indigenous research

This section responds to and addresses the following question:

4. In this context, what insights can be drawn for best practice from other jurisdictions with comparable Indigenous populations?

Standardised, isolated and Western ways of understanding mental health and mental health service provision are a challenge for Indigenous and marginalised populations

Mental health services across different jurisdictions are generally acknowledging that standardised, Western models of mental health provision are not fit for purpose for all populations, and models of care are being developed and implemented to address these gaps (Anae et al. 2002). This is especially true for Indigenous peoples across the world.

Literature from Aotearoa highlights the need to integrate culturally safe and relevant concepts and models of health into mainstream service provision (Thakur et al. 2020). This is particularly important as Māori beliefs and values have been eroded as a result of colonisation (Thakur et al. 2020). Mental distress is also at the forefront for Indigenous peoples who are displaced or migrate between countries in reaction to a colonial world order; the mental health of Pacific peoples in New Zealand is of similar concern (Thakur et al. 2020).

Māori and Sāmoan frameworks of mental health share themes around the "holistic, multilevel, multi-faceted nature of mental health and well-being." (Anae et al. 2002, 21). Māori models of health such as Te Whare Tapa Whā and Te Pae Mahutonga recognise wellbeing as the result of a balance of a number of interrelated factors, such as wairua (spiritual), hinengaro (mental), tinana (physical), taiao (environmental), taha tikanga (cultural), and whānau, whakapapa and whenua (family and land) (Anae et al. 2002). Sāmoan models of health such as the Fonofale model and the Fa'afaletui model are rooted in the concept of the fale (a traditional Sāmoan house). Similarly to Te Whare Tapa Whā and Te Pae Mahutonga, these two models encompass physical, spiritual and mental dimensions and ground them in time, context and environment (Anae et al. 2002).

Culturally appropriate interventions and care

Literature underscores the importance of providing culturally appropriate CAMHS and related interventions for Indigenous peoples (McClintock, Tauroa, and Mellsop 2016; McClintock et al. 2016; McClintock, Moeke-Maxwell, and Mellsop 2011; Twizeyemariya et al. 2017; *Toronto Star* 2020). While there is little research into how CAMHS can be modified to better suit Māori, some general insights include the need to address the cultural alienation exemplary in "mainstream services' clinical paradigms" (McClintock, Tauroa, and Mellsop 2016, 59). Similarly, the involvement of whānau in CAMHS delivery, and therapeutic methods in line with Te Whare Tapa Whā (whānau, hinengaro, tinana, wairua), should be incorporated into support frameworks for children in or requiring care in the development of culturally-responsive CAMHS (McClintock, Tauroa, and Mellsop 2016, 60; McClintock et al. 2016, 101).

An earlier study on developing a child, adolescent and family mental health service for Pasifika youth highlighted the importance of developing Pacific-based mental health services for this cohort, drawing on cultural expertise (such as from matai) to do so (Bush et al. 2009). The principle of vā, or the relational space between and amongst people and things, was critical, and as a core Sāmoan value, influenced the development of practice in this space (Bush et al. 2009, 142). Elsewhere, studies such as Te Tomokanga have investigated the appropriateness of CAMHS that is informed by kaupapa Māori or bicultural approaches, including a cultural framework underpinned by the metaphor of pōwhiri (McClintock, Moeke-Maxwell, and Mellsop 2011). As McClintock et al. explain, "…when aligned with the traditional pōwhiri process of engagement and participation, such a framework values respectful relationships, commitment and reciprocity. The challenge for CAMHS is therefore to provide a collaborative workforce with culturally appropriate responses to the needs of a diverse range of Māori whānau" (McClintock, Moeke-Maxwell, and Mellsop 2011, 388–89).

Insights for best practice

To conclude, research over the last decade or so offers some suggestions for best practice in working with Indigenous children and youth in the context of care (McClintock, Moeke-Maxwell, and Mellsop 2013; Twizeyemariya et al. 2017). These include:

- Review informal and formal referral pathways into CAMHS, to provide a broad suite of potential entry points (such as schools, whānau, health practitioners, etc). Culturally appropriate CAMHS should be provided from the assessment stage (McClintock, Moeke-Maxwell, and Mellsop 2011, 393–95; 2013, 128).
- Related to the above, having a cohesive, multisectoral approach "capable of modifying a complex set of risk factors and identifying and addressing emerging child psychological distress, starting early in life" (Twizeyemariya et al. 2017, 349). Such an integrated delivery model would provide support services across the life of the child/young person, that is, from clinical interventions through to other social services such as housing, income, and education (Twizeyemariya et al. 2017, 349–50). Importantly, such models/approaches must be co-designed or co-constructed with Indigenous communities (Twizeyemariya et al. 2017, 351).
- Strengthening support services for Indigenous families, who are saddled with the ongoing impacts of colonisation, language and culture loss, and removal from land (Twizeyemariya et al. 2017, 350).
- Ensuring CAMHS and practitioners/clinicians have an operational understanding of Indigenous practices, customs and ceremonies. This includes for example, having tikanga and kaupapa Māori embedded in service delivery (McClintock, Moeke-Maxwell, and Mellsop 2011, 394–95), or in the First Nation, Inuit and Métis context in Canada, having CAMHS that fuse "Indigenous knowledge and traditions with medical research, training and

healing models for caregivers serving Indigenous communities" (*Toronto Star* 2020, 1).

- Providing CAMHS that are culturally appropriate, enhance Māori identity, and link them to cultural- and clinical-based CAMHS support (McClintock, Moeke-Maxwell, and Mellsop 2011, 394–95). This includes providing CAMHS in whānau contexts, and familiar cultural contexts (through use of reo, whakapapa, karakia, etc) (McClintock, Moeke-Maxwell, and Mellsop 2013, 128).
- Involving and working in partnership with parents, whānau, and community leaders in the CAMHS process, and ensuring they are offered "appropriate cultural choices of care" (McClintock, Moeke-Maxwell, and Mellsop 2011, 394; 2013, 128; *Toronto Star* 2020, 1).
- Allowing rangatahi to feedback on the quality of CAMHS, so they are involved and have agency in the process, as well as being able to share experiences with other rangatahi in similar situations (McClintock, Moeke-Maxwell, and Mellsop 2013, 128–29).

Conclusion

Children in care often have complex mental health needs, and require significant support and intervention for this (Anderson, Vostanis, & Spencer, 2004 in Vostanis 2010, 557–58). This report provided insights into this, across assessment and identification; approaches to addressing complexities and concerns with children in care, protection, or youth systems; and Indigenous research. These are summarised below.

Assessment and identification

Models of assessment and identification are typically formal processes, a combination of recording problems, personal history, symptoms, and mental state, from where a management plan is formulated (Wand et al. 2020). This is mandated in some jurisdictions, but the effectiveness of such an approach is unclear. Moreover, there are mixed views on the accessibility of formal assessments, as this is not always a timely process; this is exacerbated for disabled youth in care. In general, young people and their carers are not active in seeking support for mental health, or the child/young person relies on carers to do so. However, some newer models of assessment that move away from this status quo are emerging, especially in Aotearoa.

Approaches to addressing complexities and concerns with children in care, protection, or youth systems

Overall, approaches to addressing complexities with children in care centres tamariki and rangatahi, a modality of person-centred care that is increasingly common in the OECD (OECD 2021, 10). Wraparound care is similarly a norm in providing services, an approach that centres the child, and attempts to coordinate responses and services at an agency, community, family, and other service level. Some jurisdictions, such as New South Wales, have interagency collaboration embedded in legislation. Common interventions include therapeutic, behavioural, and emotional interventions, but the effectiveness of such approaches is still somewhat unclear.

Research emphasises the importance of early intervention for mental health services and supports for children and young people in care, to address issues and concerns as soon as possible. Similarly, there is a push to ensure seamless continuity of care from child to adult mental health services, because at the moment there is an inconsistency between these two phases. Often this results in children being left without professional or clinical support (Singh and Tuomainen 2015, 358). But a persistent issue is providing appropriate support and interventions for rangatahi, a challenge present across many jurisdictions. Increasingly, however, youth-specific services that fill this gap are emerging in Europe, the United Kingdom, North America, and Aotearoa.

Suggestions for future development of best practice approaches include:

- Providing wraparound multi-layered intervention "…in which young people reside for a limited time period with a treatment foster family" (based on the *Treatment Foster Care Oregon for Adolescents*) (Lobatto 2021, 474).

- Providing ongoing professional development of carers, “lower-intensity training to existing foster carers”, as well as therapeutic support and training for carers (Lobatto 2021, 474; Jones et al. 2012, 20).
- ‘Attachment and biobehavioural catchup’, an early-intervention initiative for maltreated toddlers and infants, to support and nurture the healthy development of relationships (Lobatto 2021, 474).
- Having a health clinician at care facilities to facilitate and expedite access to mental health services (Jones et al. 2012, 9).
- Ensuring health professionals receive all available medical records as they undertake initial health assessments, to mitigate against incorrect or incomplete mental health diagnoses of children (Jones et al. 2012, 9).
- Normalising/standardising information sharing across relevant agencies, and developing multi-agency supports that can reach into different aspects of the child’s life (and therefore wellbeing) (Jones et al. 2012, 12).
- Ensuring children are given priority status in referral to particular services (McSherry, Fargas, and Walsh 2016, 169–70).
- Collaboration and cooperation at a professional and agency level, to encourage cohesiveness at an operational and systemic level (McSherry, Fargas, and Walsh 2016, 169–70).
- Ensuring children and young people are actively involved in decisions and conversations about their mental health needs (McSherry, Fargas, and Walsh 2016, 169–70; Wood and Selwyn 2017, 31).
- Providing quality placements that are stable, and ensure social workers and carers have appropriate training around mental health (McSherry, Fargas, and Walsh 2016, 169–70).
- Provide targeted mental health services for children (McSherry, Fargas, and Walsh 2016, 169–70).

Insights from Indigenous research

Overall, the typically standardised, isolated and Western ways of understanding mental health and mental health service provision are a challenge for Indigenous and marginalised populations. There is a strong emphasis on integrating culturally safe and relevant concepts and models of health into service provision, and some examples are in use in Aotearoa at the moment (Te Whare Tapa Whā, Te Pae Mahutonga, Fonofale, Fa’afaletui, for example). In this, there is a need to provide culturally-appropriate CAMHS. Some suggestions for best practice include:

- Review informal and formal referral pathways into CAMHS, to provide a broad suite of potential entry points (such as schools, whānau, health practitioners, etc). Culturally appropriate CAMHS should be provided from the assessment stage (McClintock, Moeke-Maxwell, and Mellsop 2011, 393–95; 2013, 128).

- Related to the above, having a cohesive, multisectoral approach "capable of modifying a complex set of risk factors and identifying and addressing emerging child psychological distress, starting early in life" (Twizeyemariya et al. 2017, 349). Such an integrated delivery model would provide support services across the life of the child/young person, that is, from clinical interventions through to other social services such as housing, income, and education (Twizeyemariya et al. 2017, 349–50). Importantly, such models/approaches must be co-designed or co-constructed with Indigenous communities (Twizeyemariya et al. 2017, 351).
- Strengthening support services for Indigenous families, who are saddled with the ongoing impacts of colonisation, language and culture loss, and removal from land (Twizeyemariya et al. 2017, 350).
- Ensuring CAMHS and practitioners/clinicians have an operational understanding of Indigenous practices, customs and ceremonies. This includes for example, having tikanga and kaupapa Māori embedded in service delivery (McClintock, Moeke-Maxwell, and Mellsop 2011, 394–95), or in the First Nation, Inuit and Métis context in Canada, having CAMHS that fuse "Indigenous knowledge and traditions with medical research, training and healing models for caregivers serving Indigenous communities" (*Toronto Star* 2020, 1).
- Providing CAMHS that are culturally appropriate, enhance Māori identity, and link them to cultural- and clinical-based CAMHS support (McClintock, Moeke-Maxwell, and Mellsop 2011, 394–95). This includes providing CAMHS in whānau contexts, and familiar cultural contexts (through use of reo, whakapapa, karakia, etc) (McClintock, Moeke-Maxwell, and Mellsop 2013, 128).
- Involving and working in partnership with parents, whānau, and community leaders in the CAMHS process, and ensuring they are offered "appropriate cultural choices of care" (McClintock, Moeke-Maxwell, and Mellsop 2011, 394; 2013, 128; *Toronto Star* 2020, 1).
- Allowing rangatahi to feedback on the quality of CAMHS, so they are involved and have agency in the process, as well as being able to share experiences with other rangatahi in similar situations (McClintock, Moeke-Maxwell, and Mellsop 2013, 128–29). There is evidence some local sites are developing mechanisms for feedback.

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