ORIGINAL ARTICLE
THEORETICAL RESEARCH

What interventions can CAMHS provide for young people involved with Oranga Tamariki? A review of the literature

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ABSTRACT

INTRODUCTION: Many care-experienced young people face significant mental health challenges. However, this group is not well served by child and adolescent mental health services. In this first of a two-part series, we present the evidence for effective mental health interventions for care-experienced young people to inform clinical decision-making and improve mental health service delivery. This precedes a second review of principles for working effectively with care-experienced young people.

METHODS: This is a narrative review of the literature regarding mental health interventions for young people involved with child welfare. It is based on international reviews of mental health interventions with the addition of relevant research from Aotearoa New Zealand, especially with Māori young people.

FINDINGS: Appropriate mental health interventions include Trauma-Focused Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Wraparound, and assertive outreach approaches, as well as systemic interventions that work with the whole care system around a young person. Application of each of these interventions to meet the specific needs of care-experienced youth in Aotearoa New Zealand is discussed. The findings are also relevant to other jurisdictions with overrepresentation of Indigenous young people involved with child welfare services.

CONCLUSION: Individual and systemic interventions are recommended that can support holistic mental health care. There is little integration of cultural considerations and anti-discriminatory practice within the existing literature, despite many of these young people coming from marginalised communities. The authors argue that mental health interventions must be culturally appropriate to meet the needs of care-experienced young people.

Keywords: Mental health; child welfare; therapy; adolescents; care-experienced

AOTEAROA NEW ZEALAND SOCIAL WORK *36(2)*, 68–83.

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In this article, we present a review of the literature on appropriate mental health interventions for young people involved with Oranga Tamariki, the child protection agency in Aotearoa New Zealand. This review prioritises research with Māori, the Indigenous people of Aotearoa New Zealand. However, the findings may be applicable across jurisdictions, particularly with care-experienced young people from marginalised groups.

In Aotearoa New Zealand, young people involved with Oranga Tamariki face multiple barriers in accessing quality support from child and adolescent mental health services (CAMHS) despite experiencing high levels of mental health difficulties (Oranga Tamariki, 2023). In response to these issues, there has been an interagency commitment to improve mental health services for care-experienced young people (Oranga Tamariki, 2022). To further support this goal of improved CAMHS care for this population, we present the evidence for effective CAMHS interventions for care-experienced young people to answer the research question "What are effective mental health interventions for care-experienced young people?"

This is the first of two literature reviews on CAMHS care. This first article focuses on the range of interventions available for care-experienced young people. The second article focuses on principles that can guide clinical practice with this population, regardless of treatment modality (Appleby et al., 2024). It is our intention that both articles are read together to inform CAMHS clinicians about the *what* and the *how* of effective mental health care for young people involved with Oranga Tamariki or other child welfare systems.

In these articles, we have used a wide definition of "care-experienced" that includes young people who are involved with Oranga Tamariki or other child welfare services. This broad interpretation acknowledges the experience that these young people bring, is shorthand for the more cumbersome phrase "young people who have been involved with Oranga Tamariki", and can be applied in international contexts. We also acknowledge the added layers of trauma for those young people who have been in state care.

Background

Te Hiringa Mahara—the New Zealand Mental Health and Wellbeing Commission (2023)—recently released their report into the wellbeing of young people in Aotearoa New Zealand. The Commission identified that there are decreasing positive mental health outcomes and increasing distress for young people, and their wellbeing is impacted by racism, discrimination, whānau wellbeing, and uncertainty about the future. There has already been recognition that young people in general are underserved by CAMHS in Aotearoa New Zealand, with further lack of responsive service provision for Māori and those involved with Oranga Tamariki (Thabrew et al., 2017). This occurs despite young people involved with Oranga Tamariki being twice as likely to have depressive symptoms and four times as likely to have attempted suicide within the last year compared to the general youth population (Fleming et al., 2021). A recent report into the mental health and wellbeing needs of children and young people involved with Oranga Tamariki (2023) found that these young people are often excluded from CAMHS support. CAMHS teams have not been set up to meet the mental health needs of care-experienced young people, many of whom have experienced trauma.

Rangatahi Māori (Māori young people) are disproportionately represented in the numbers of young people in care, and in mental health need (Oranga Tamariki, 2023). The Human Rights Commission (2022) has recognised the impacts of white supremacy, racism, and colonisation on Māori. The Ministry of Health (2020) developed a Māori Health Action Plan which recognises that Māori mental health is a priority in Aotearoa New Zealand. The Plan aims to reduce health inequities for Māori by valuing and promoting Māori solutions, including Kaupapa Māori (by Māori, for Māori) services (Ministry of Health, 2020).

In their review of Māori models of health, Wilson et al. (2021) discussed how whakapapa (genealogy), whenua (land) and whānau (family) are the foundations of connectedness for Māori

and the basis for clinicians engaging in whakawhanaungatanga (the process of connecting with someone) with Māori. They highlighted that a Māori-centred model of relational care must include consideration of the sociopolitical context for Māori. In the *Meihana Model,* clinicians consider ngā hau e whā (the four winds of Tawhirimātea)—how colonisation, racism, migration, and marginalisation impact Māori (Pitama et al., 2017). These four factors are integrated into mental health formulation, alongside individual and whānau factors. Connection is especially important for rangatahi Māori when engaging with clinical services. Hamley et al. (2023) suggested that clinical services consider how to engage with rangatahi Māori creatively and informally outside of usual forms of service engagement. This involves stepping out of dominant views of time, such as individual assessments within a 60-minute appointment time, to a Māori worldview of the interconnectedness of people, places and events within time and whakapapa.

In Aotearoa New Zealand, CAMHS clinicians have seen increased demand for services without commensurate resourcing, and many do not think that CAMHS is still fit-for-purpose (Every-Palmer et al., 2022). Most CAMHS teams are now using the Choice and Partnership Approach (York & Kingsbury, 2009). This model advocates for efficient use of resources while also promoting principles of service user self-determination and participation. However, there is critique that the model commodifies CAMHS delivery, co-opts the language of empowerment to discharge young people from CAMHS, and these "individually based biomedical pathologizing approaches fit well with a neoliberal agenda but fail to engage with the social and political context of people's lives" (Johnstone et al., 2022, p. 224).

Care-experienced young people have complex mental health presentations in the context of traumatic relational disruption in their families and with services. These young people experience high rates of placement disruption and homelessness (Vreeland et al., 2020). They are more likely to be Māori, to have a disability (Oranga Tamariki, 2023), to experience discrimination (Bernard et al., 2021), and to experience difficulties accessing CAMHS (Garcia et al., 2015). Tarren-Sweeney (2021) argued that standard mental health interventions are less effective for these young people due to the high degree of clinical and social complexity they experience, and that they should be identified as a priority group and given treatment tailored to their needs.

Much of the existing literature about mental health interventions for this population is based on interventions for younger children with a focus on parenting interventions. However, the purpose of this review is to explore effective mental health interventions for the older care-experienced adolescents who may not have caregivers actively involved in their mental health care. This article provides an overview of the evidence base for a range of mental health interventions for adolescents, with discussion of how each intervention can be adapted for care-experienced young people.

Structuring the literature

This is a review of the literature on effective mental health interventions for care-experienced young people. It focuses on the adolescent age range of 13-18 years old, which is aligned with the upper age range for CAMHS in Aotearoa New Zealand. For the purposes of this review, the scope of the term care-experienced is wide and includes the full spectrum of involvement with child welfare services, including those who remain with their families, those in family and non-kin placements, and residential and foster care. The interventions that are presented do not comprise an exhaustive list of all mental health interventions for care-experienced young people. Instead, there is a discussion on the application and adaptation

in Aotearoa New Zealand of the more commonly cited interventions.

There are two general approaches within the literature about mental health practice with this population. One body of research centres on implementing and assessing clinical interventions, which is the primary focus of this article. Another body of research emphasises the relational and collaborative skills employed by CAMHS clinicians in various interventions with traumatised young people. These skills are the focus of a second review (Appleby et al., 2024).

This article builds on 10 published international reviews of interventions with care-experienced young people. Following identification of the five main intervention types, additional research is presented about the application of these interventions with care-experienced young people, and where available, research from Aotearoa New Zealand is included. It is notable that none of the 10 reviews focused specifically on the adolescent age range, as they included interventions for children, parents, and adolescents. Additionally, none of the published reviews include research with Māori. This article appears to be the first review that is adolescent-specific, presenting the interventions suitable for care-experienced adolescents, while also prioritising local research, particularly with rangatahi Māori.

Method

This is a narrative review of the literature on mental health interventions for care-experienced adolescents. The research question that guided the literature search was "What are effective mental health interventions for care-experienced young people?" A search for relevant articles was conducted through the following databases: the EBSCOhost suite of databases (Child Development and Adolescent Studies, CINAHL Plus, Humanities International Complete and MEDLINE), PsychINFO and Google Scholar. Search terms included synonyms for child welfare (child protection, welfare, looked after children, out of home care, foster care), mental health (wellbeing, psychological health, emotional health, CAMHS), effective (efficacious treatment, successful, positive, enabler, benefit) and interventions (treatment, therapy). The search range covered the years 2005 to 2023 and focused on peer-reviewed articles written in English.

From this search we found 10 reviews that consistently identified several interventions (Bergström et al., 2020; Craven & Lee, 2006; Evans et al., 2023; Hambrick et al., 2016; Landsverk et al., 2009; Lee et al., 2015; Leve et al., 2012; Racusin et al., 2005; Rayment et al., 2014; Tarren-Sweeney, 2021). Five of those publications were systematic reviews (Bergström et al., 2020; Craven & Lee, 2006; Evans et al., 2023; Hambrick et al., 2016; Leve et al., 2012). All the reviews focused on interventions with children and young people involved with child welfare services, and six reviews focused specifically on interventions for children and young people in foster care (Bergström et al., 2020; Craven & Lee, 2006; Hambrick et al., 2016; Landsverk et al., 2009; Leve et al., 2012; Racusin et al., 2005).

We then searched for literature on the application of those interventions with care-experienced young people and marginalised groups, and searched for research conducted in Aotearoa New Zealand, and specifically with Māori. The findings have been presented as a narrative review, prioritising research on implementation with Māori.

Findings

Existing reviews identify Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Dialectical Behavioural Therapy (DBT), Wraparound services, assertive outreach, and systemic interventions as effective CAMHS interventions for care-experienced young people (Bergström et al., 2020; Craven & Lee, 2006; Evans et al., 2023; Hambrick et al., 2016; Landsverk et al., 2009;

Lee et al., 2015; Leve et al., 2012; Racusin et al., 2005; Rayment et al., 2014; Tarren-Sweeney, 2021). Each of these interventions can be used with adolescents in a range of care settings, including where there is placement instability and lack of caregiver involvement. This article summarises each intervention and notes any implementation considerations with care-experienced young people. While the findings are tailored to Aotearoa New Zealand in particular, they are also broadly relevant to other jurisdictions, particularly settler colonial nations with significant overrepresentation of Indigenous children in state care.

Trauma-Focused Cognitive Behavioural Therapy

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is recommended as a first-line treatment for children with post-traumatic stress (Dittmann & Jensen, 2014). In Aotearoa New Zealand, CAMHS are not funded for young people whose needs are solely related to sexual abuse, however the Ministry of Health's (2017) service specifications outline that CAMHS should be available for all young people with psychological difficulties, including emotional and behavioural disturbances, many of whom have experienced trauma.

TF-CBT is based on cognitive and behavioural approaches. Cognitively, there is an emphasis on restructuring unhelpful thoughts following abuse, particularly around self-blame. From a behavioural perspective, TF-CBT posits that classical and operant learning lead to the development of trauma triggers and ensuing avoidance behaviour. Treatment involves psychoeducation about trauma responses, teaching coping skills to replace avoidance, gradual exposure to trauma triggers, and actively talking about the traumatic events (Allen & Kronenberg, 2014).

Young people find the construction of the trauma narrative and cognitive processing necessary in their recovery, despite the inherent challenges in engaging in that therapeutic work (Neelakantan et al., 2019). Many young people have achieved habituation to previous trauma triggers from the exposure work. While initial expectations of therapy were generally not positive, many young people found TF-CBT therapy helpful. Cohen et al. (2011) suggested that TF-CBT can still be used with young people experiencing ongoing trauma, with clinicians focusing on enhancing safety early in the treatment phase, assisting young people to differentiate between real danger and generalised trauma reminders, and effectively engaging parents and caregivers (if available) in their children's treatment.

In Aotearoa New Zealand, Taylor (2019) adapted a manualised TF-CBT protocol for use with maltreated children through the addition of sensory modulation. Children with developmental trauma often have sensory processing difficulties in adolescence and beyond. While the adapted programme was helpful, Taylor (2019) noted significant issues with achieving caregiver involvement in the programme due to frequent placement changes and current experiences of abuse within placements.

Tania Cargo, a Māori Clinical Psychologist, developed the skateboard model of CBT for young people, representing the five-part model in a youth-friendly image (Mathieson et al., 2022). She also developed the waka ama (outrigger canoe) model of CBT for rangatahi Māori (Cargo, 2008). It uses the metaphor of a waka ama instead of a skateboard, with the paddlers representing the role of whānau in helping to steer the waka. While not specifically a TF-CBT model, these adaptations of CBT are helpful to apply when working with Māori care-experienced young people.

While TF-CBT can be helpful, it is most effective when a young person has some stability at home, even if that is just a stable care team (Rayment et al., 2014). There are critiques that CBT can be individualistic and ignores social oppression (Payne, 2014).

Hirini (1997), a Māori clinical psychologist, has also critiqued the cultural bias inherent in CBT assumptions about assertiveness training and what is considered *rational*. Therefore, when providing TF-CBT with care-experienced young people there should be a holistic approach that includes consideration of culture and oppression (Pitama et al., 2017). Clinicians should ensure Māori cultural responsivity with appropriate time for genuine engagement, inclusion of whānau, and use of relevant metaphors (Bennett et al., 2016).

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) was originally developed as a psychological treatment for adults with a diagnosis of Borderline Personality Disorder (BPD) (Linehan, 1993), and has been further developed for use with adolescents with multiple presenting issues (Rathus & Miller, 2013). DBT is based on a biosocial theory of personality, with the premise that emotional dysregulation develops in the context of invalidating environments in childhood, and posits a dialectical world view, where multiple truths exist concurrently (Linehan, 1993).

There is well-documented stigma towards people with a diagnosis of BPD, many of whom have experienced significant trauma (Veysey, 2014). Clinicians may see these people as manipulative, emotionally uncontained, and displaying intentional splitting behaviours, alternating between extreme idealisation and devaluation of clinicians to elicit care and avoid feelings of abandonment (Commons Treloar & Lewis, 2008). However, the DBT approach seeks to understand these difficulties, not as a fixed personality deficit, but as learned behaviours and survival techniques used with the intention of self-preservation and protection (Linehan et al., 2015). This has allowed for the behaviours previously seen as maladaptive to be reframed within a trauma-informed lens as adaptive within their context (Fonagy et al., 2017). This DBT approach can be helpful for CAMHS to understand care-experienced young people.

There has been some promising research into the adaptation of DBT with care-experienced young people in the UK. James et al. (2011) adapted DBT by holding meetings in the community, providing transport and meals, and including a residential 'outward-bound' weekend. Andrew et al. (2014) have also implemented a DBT programme for young people leaving care in the UK. For the therapists, adopting a dialectical approach towards the young people they worked with was invaluable. Andrew et al. (2014, p. 510) offered the following dilemmas in working with young people obliged to survive in an adult world as care leavers:

> … apparently competent AND emotionally vulnerable, acceptance of suffering AND recognition of a need for change, adult AND child, independent AND dependent, I get it AND I don't, this is difficult and change seems impossible AND you must change. While others are drawn into proving the young person does not want to change ("they keep doing this"; "they throw everything away"), and could change if only they wanted to, the dialectical position allows us to accept that all of these positions could be true.

This dialectical understanding of care leavers has been used by DBT therapists to work with the system surrounding the young people. Utilising this systemic support, DBT can be effective even when a young person does not experience placement stability, with the therapists working with the community of professionals surrounding the young person (Rayment et al., 2014).

Andrew et al. (2014) discussed the use of clinician self-disclosure in DBT with care-experienced young people. They suggested that insecure or unsafe care experiences can limit a person's capacity to understand

others' perspectives, or the ways in which their own behaviour affects others. In the DBT programme for care leavers, therapists engage in personal disclosure including about their own families, success, and failures. Andrew et al. (2013) argued that self-disclosure helps to develop the therapeutic relationship, provides modelling of coping with adversity, communicates genuineness, and helps young people to notice the way in which their behaviour affects others.

This aligns with Māori perspectives on whakawhanaungatanga (the process of establishing relationships). CAMHS clinicians can engage in whakawhanaungatanga with whānau Māori (Māori families) to build a trusting relationship (McClintock et al., 2016). This contrasts with the western notion of distanced professionalism that is not often well-received by Māori, with some whānau Māori requiring their CAMHS clinician to share about their own background before they will engage with CAMHS support (McClintock & McClintock, 2018). The result of whakawhanaungatanga processes is that client and practitioner can become whānau (family). From a Māori lens, this form of relational care is culturally and ethically appropriate (Eketone, 2021).

In Aotearoa New Zealand, Morton (2019) provided a DBT programme for young care-experienced boys aged 11-14 years old in a residential community home. Accessibility was enhanced to allow any of the boys in the community home to attend. Two of the three participants were Māori. Morton (2019) found that the programme was helpful, particularly the use of humour, role plays, and aiming skills at an achievable level. For example, learning to use the breath was taught first, before building to the more cognitively complex tasks of staying focused on a task in a social interaction. Morton (2019) noted the significant difficulties with retaining boys in the programme due to frequent placement movements (the programme was delivered within the home) and with high staff turnover. Additionally, Weenink (2019) has evaluated an adaptation of the DBT programme for use in a youth justice residence in Aotearoa New Zealand. The programme was amended for delivery within the constraints of the residence and the original skills manual was adapted to suit the needs of Māori young people, including the use of culturally appropriate art, proverbs, and metaphors. Feedback about the programme from the residential staff was positive, especially for those young people who could be supported by the youth justice staff to practise the DBT skills.

Fuchs et al. (2013) discussed the use of DBT with people from marginalised and underserved backgrounds. They suggested that the therapeutic stance within DBT sees people's experience and expression of distress located within their sociopolitical and historical context. A focus of DBT is to understand this context and validate the distress, before encouraging behavioural change. Fuchs et al. (2013) have suggested that this contextualised approach may be well received from people from marginalised backgrounds, particularly those who mistrust the mental health system. This also aligns with Māori assessment frameworks that emphasise the influence of sociopolitical context on current mental health (Pitama et al., 2017). DBT provides a dialectical framework to validate the lived reality of oppression of marginalised groups while also helping individuals to identify helpful actions that are within their control.

Wraparound

Wraparound is a model for working collaboratively with families where there are multiple problems and several services are involved (Bruns & Walker, 2008). Guiding principles include having family voice, engaging in collaboration, being community-based and culturally competent, providing individualised support, and clinicians making an unconditional commitment to serve young people and their families (Bruns & Walker, 2008). In Aotearoa New Zealand,

service specifications exist for CAMHS to provide Wraparound through individually tailored flexible packages of care for young people with complex needs (Ministry of Health, 2017), however it has not been widely used (Shailer et al., 2017). CAMHS teams can use Wraparound specifically with young people who are involved with Oranga Tamariki (Kirkwood, 2014; McNatty, 2017). A team forms around a young person and their family, including CAMHS clinicians and Oranga Tamariki social workers. The programme requires a high degree of collaboration and co-working between CAMHS and child welfare social workers.

The Wraparound process prioritises understanding of a young person's cultural context and ensures that processes are aligned with young people's cultural values and norms. Both Kirkwood (2014) and Tamihere (2015) have written about the close alignment of Wraparound principles with Māori values. Kirkwood (2014), a Māori social worker in CAMHS, has explored the connections between principles of voice and choice with whānau values; natural supports with whānau, hapū (sub-tribe) and iwi (tribe) networks; and the principle of collaboration with the concept of being mana-enhancing (recognising a person's intrinsic value). He has discussed the Wraparound engagement processes with whānau Māori, including whakawhanaungatanga, identifying strengths, instilling hope, and using te reo Māori (Māori language) and Māori metaphors. Tamihere (2015), a Māori clinical psychologist, has also compared Wraparound principles to Māori concepts of mana motuhake (self-determination), aroha (love), tautoko (support) and manaakitanga (care), promoting Wraparound as a culturally appropriate intervention with whānau Māori.

Wraparound programmes require adequate funding to offer flexible and responsive plans that include small caseloads for clinicians (Walter & Petr, 2011). When appropriately funded, Wraparound programmes have been found to contribute to significant improvements in mental health and wellbeing (Bruns & Walker, 2008) and to make a real difference for whānau who face many challenges (Kirkwood, 2014).

Assertive outreach

Assertive outreach is an approach that has been used in adult mental health services for those who struggle to attend clinic-based appointments due to the severity of the mental health and/or social issues they experience. It has been adapted for youth services and involves clinicians having small caseloads of 8-10 clients, meeting clients in their communities instead of clinics, and providing after-hours support (Vijverberg et al., 2017). Assertive outreach includes individual, family, and system interventions (Ryall et al., 2008). Most of the CAMHS assertive outreach research has come from the Australian state of Victoria, where there has been specific funding for CAMHS assertive outreach teams since 1998 (Assan et al., 2008; Ryall et al., 2008). Assan et al. (2008), in their file audit from 2003-2004, found that there was a 100% retention rate of young people in their assertive outreach team, which they attributed to the flexible nature of the approach. Assertive outreach interventions have been found to reduce suicide risk and inpatient hospital admissions (Schley et al., 2008).

Several studies have indicated that assertive outreach is well suited for care-experienced young people. Schley et al. (2008) found that almost half of their assertive outreach clients were also involved with child welfare services in Australia, and that most of the clients had experienced traumatic childhoods. In Aotearoa New Zealand, there are service specifications for intensive clinical support, a mobile assertive outreach approach that also provides training and support with mental health issues for foster parents and other caregivers through Oranga Tamariki (Ministry of Health, 2017). However, there is a dearth of local research

on the implementation of any youth assertive outreach approaches.

Systemic interventions

In Aotearoa New Zealand, CAMHS are tasked with promoting inter-sector collaboration for all young people (Ministry of Health, 2017), but this is particularly important for care-experienced young people. Andrew et al. (2014) have detailed the importance of working systemically for young people with complex problems who are involved with multiple services, where often the "well intentioned systems that surround young people ... all too often also serve to reinforce maladaptive behaviours" (p. 511). When those young people feel unable to communicate with services, they may engage in risk behaviours to communicate their distress and influence decisions made about them and their care. Therefore, it is important that the whole system shares a common management plan and formulation of the issues. This helps reduce risky behaviour and provides a sense of containment for a young person where there are multiple services involved.

It is also possible for mental health services to provide support to the system around a young person who is not engaged with the service. Callaghan et al. (2004) presented models of care that incorporate avenues for clinicians to provide guidance to foster carers and child welfare staff without necessarily requiring any direct clinical input with the young person. This avoids the problems of over-assessment of vulnerable young people and recognises the significant impact that a young person's environment has upon their wellbeing. Social workers engaging in early consultancy with CAMHS could even assist with placement decisions and possibly decrease CAMHS referrals (Callaghan et al., 2004).

The THRIVE framework for system change (Wolpert et al., 2019) has been developed in the UK and includes provision for such systemic support. Within this framework are five categories of support for young people: thriving, getting advice and signposting, getting help, getting more help, and getting risk support. This last category is relevant to the discussion of systemic support in the absence of direct clinical work.

Wolpert et al. (2014, p. 9) described the 'getting risk support' category as "perhaps the most contentious aspect" of the model. It is aimed at young people who do not improve with traditional CAMHS input. The THRIVE model recognises that, for a minority of young people, there may not be any effective mental health treatment available, but they remain at risk to themselves or others. These young people tend to be the subject of much discussion between services. They may be understood as 'not ready' for treatment, may routinely go into crisis but are not able to make use of CAMHS support, struggle to attend appointments, and/or CAMHS has not been helpful for them. Within the THRIVE model, the CAMHS team remains involved and joins a multi-agency network to provide support and mental health advice to the system surrounding that young person.

Lidchi and Wiener (2020) and Lobatto (2021) have discussed the use of the THRIVE framework within specialist mental health services for care-experienced young people in the UK. Lobatto (2021) found that the intensive systemic support provided by the service led to increased placement stability for the young people, all of whom had a history of frequent unplanned placement changes. Lobatto (2021) described how the conflict within children's birth families can become replicated in other institutional systems surrounding a young person and explained how the specialist mental health team takes an "appreciative position" (p. 15) to honour all members of the system, creating a healthy community of care surrounding a young person.

There is scarce local research on interagency initiatives, despite agreement that improved collaboration is important (Oranga Tamariki, 2023; Whāraurau, 2021).

Discussion

This review was undertaken to answer the question "What are effective mental health interventions for care-experienced young people?" There is a large evidence base around parenting and family approaches to address mental health issues for younger children. However, for older adolescents, particularly those without consistent carer support, the research base points to TF-CBT, DBT, Wraparound, assertive outreach approaches, and working with the care system surrounding a young person. Interventions should be tailored for care-experienced young people, considering their relational and learning styles and Māori models of connecting that may require adjustments to current CAMHS timeframes.

Care-experienced young people are more likely to be Māori or to belong to cultural minority groups (Oranga Tamariki, 2022) and experience multiple layers of personal and institutional racism, including within mental health services (Bernard et al., 2021). Colonial healthcare systems create barriers for Māori to access mental health services (Latimer et al., 2022), and distrust of government-funded health and welfare systems contributes to lower attempted access to mental health services and deferral of service involvement until the point of crisis. (Elder & Tapsell, 2013). These young people may present at CAMHS with mistrust of clinicians, along with attachment difficulties and communication deficits (Tarren-Sweeney, 2021).

However, care-experienced young people are also survivors and have developed skills to protect themselves from further trauma. A trauma-informed approach is required that sees young people as relational beings in the context of their families, even when in a placement away from them (Bush et al., 2009), is culturally sound and sensitive to their learning styles (Slayter, 2016) and literacy needs (Weenink, 2019). If, as Tarren-Sweeney and Vetere (2014) suggested, the mainstream CAMHS model is not designed to meet the needs of care-experienced young people, it is even less equipped to respond effectively to Māori care-experienced young people. CAMHS need to be attuned to the mental health needs of this group and adapt approaches to respond appropriately.

There is a clear overrepresentation of Māori and other Indigenous young people in state care who also experience mental health difficulties (Oranga Tamariki, 2023). However, there is little discussion in the literature about how mental health interventions for this group adapt to cultural values or experiences of racism and oppression. For example, Fuchs et al. (2013) have discussed DBT approaches to people's institutional mistrust as a result of racism, but those considerations are not evident in the literature on interventions with care-experienced young people. Indigenous mental health research and practice have not been well integrated into the research base about mental health interventions for those young people involved with child welfare.

Effective interventions for care-experienced young people should be available in culturally appropriate and flexible service structures. Tarren-Sweeney and Vetere (2014) proposed a "shift from acute care to preventative, long-term engagement ... a shift from exclusion to active ownership of these client groups" (p. 407). All the interventions presented in this article require funding structures that support flexibility and collaboration. Adapting interventions to suit the learning style, cultural, relational, and attachment needs of care-experienced young people necessitates extended time for therapeutic planning and engagement. Wraparound and assertive outreach programmes depend on clinicians having small caseloads and intensive involvement.

Time is required for clinicians to engage in multi-agency collaboration. The THRIVE model takes this a step further by mental health services investing time into multi-agency discussion for young people who are not 'service users' themselves. This approach offers a new model of care that is appropriate for care-experienced young people. The outcomes of such responsive mental health care could have cascading long-term benefits for young people and whānau wellbeing, relationships, and community contribution.

Limitations

This review summarises the mental health interventions recommended for care-experienced young people and considers application within the Aotearoa New Zealand context. However, there are limitations in the current body of research. Clinical research may exclude care-experienced young people due to their mental health and social complexities. Clinical trials of therapies are less applicable to this population, especially when outcomes are not stratified by special population status (Tarren-Sweeney & Vetere, 2014). There is a significant gap in the literature about culturally appropriate and effective mental health interventions with care-experienced young people, particularly those who experience placement disruption and have no caregiver input into treatment.

Research into effective mental health interventions for care-experienced young people in Aotearoa New Zealand is missing. This should be informed by the care-experienced community. While many of the interventions reviewed in this article have included adaptations for Māori, it would be more helpful for Kaupapa Māori research to explore what is most supportive for the mental health of care-experienced rangatahi Māori.

The scope of this review is limited to general clinical interventions for care-experienced young people, rather than a focus on diagnosis-specific interventions for this population. It is also limited to interventions targeted at a young person, their family and wider support system. It does not include macro-level interventions targeting the social determinants of mental health for this population, such as preventative community work, interventions to reduce societal and institutional discrimination, child protection policies that enhance placement stability and promote wellbeing, and governmental policies aimed at reducing poverty and homelessness.

Implications for practice and policy

Many care-experienced young people have mental health needs that would benefit from clinical service input. Their presentations are often complex, affected by their experiences of abuse and neglect, institutional mistrust, placement instability, and challenging relational styles. Effective CAMHS interventions require innovative and flexible funding structures that allow time for prolonged engagement, intensive involvement, adapted approaches, and multi-agency collaboration. This is particularly evident when considering how CAMHS may be able to support the system around a young person with complex issues. While clinicians may not provide direct clinical input to the young person, the provision of mental health support and advice to child welfare social workers and other professionals could be effective in developing a trauma-informed and developmentally sensitive understanding of a young person. This shared understanding can assist with managing risk and enhancing placement stability, both of which are significant contributors to mental wellbeing for care-experienced young people.

It is important that mental health services are culturally appropriate in both access to services and the interventions offered. For Māori, this includes a holistic approach incorporating whānau and spirituality (Durie, 1994), connections between people,

land and time (Hamley et al., 2023), and consideration of how colonisation, racism, migration and marginalisation impact Māori mental health (Pitama et al., 2017). Clinicians should consider how these experiences impact the engagement and intervention processes for young people and create culturally safe pathways into services.

Recommendations

- At a policy level, there should be clarification about the relationship between experiences of trauma and access to CAMHS support. If CAMHS teams will accept referrals for care-experienced young people whose mental health is impacted by trauma, TF-CBT should be made available.
- CAMHS teams to continue to offer DBT. Entry criteria about parental involvement could be more flexible to ensure that care-experienced young people are not excluded from participating.
- Wraparound teams to be established and supported with ringfenced funding to provide a specialist service for care-experienced young people with mental health needs. These teams should be informed by an assertive outreach approach to working with young people. Kirkwood (2014) provided a good description of an effective Wraparound team that operated in the Waitematā district. The findings of this literature review support the re-establishment and development of such teams to provide appropriate support for care-experienced young people.
- CAMHS teams should consider implementation of the THRIVE framework to offer mental health consultation to Oranga Tamariki and other professionals even when not directly clinically working with a young person.
- CAMHS clinicians to be supported to engage in training on: 1) working with whānau Māori; 2) trauma-informed care; and 3) interagency liaison. These trainings to be complemented with reflective discussion on the application with care-experienced young people.

Conclusion

Care-experienced young people often present with significant mental health difficulties alongside traumatic histories of abuse and experiences of discrimination. Despite the high mental health need, there has been little research into effective clinical intervention for this group. This is particularly evident for older adolescents without caregiver involvement in their treatment and those who experience frequent placement disruption or homelessness. This review summarises the research base for mental health interventions for care-experienced young people to support the Oranga Tamariki (2022) Action Plan to improve mental health services for this population.

While it is ideal to have caregiver input in mental health interventions, it is still possible for care-experienced young people to participate in TF-CBT or DBT in the absence of caregiver input. These approaches validate the experience of trauma and societal discrimination while also providing young people skills to navigate their emotional responses to difficult environments. Wraparound and assertive outreach are approaches that support individual interventions in a therapeutic context of responsivity, meeting a young person where they are, physically and emotionally. Both approaches recognise that time is required to build a therapeutic relationship with the young person and to work with their surrounding system. There is a focus on flexibility and responsivity to enhance engagement and outcomes. These approaches are differentiated from standard mental health services as they require intensive resourcing, including reduced clinician caseloads.

Systemic interventions are critically important with care-experienced young people, especially those involved with multiple services and engaging in high-risk behaviour. CAMHS can provide systemic approaches in the absence of caregiver involvement, even for young people who are not receiving direct clinical input. Therapeutic readiness does not have to be a prerequisite for mental health service involvement as there is scope for clinicians to provide support to the wider system. The THRIVE model (Wolpert et al., 2019) is an innovative conceptual approach for youth mental health services, offering support to the system surrounding care-experienced young people who have not benefited from traditional mental health services.

There have been challenges for CAMHS teams to provide effective services for care-experienced young people. However, the Oranga Tamariki (2022) Action Plan provides a rationale for CAMHS to improve services for this population. This article outlines some appropriate interventions that can be provided by CAMHS to support the mental health needs of care-experienced young people and work towards more equitable mental health care.

Received: 5 July 2023

Accepted: 2 April 2024

Published: 15 June 2024

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