Exploring Innovations in Transition to Adulthood (EXIT Study)

Innovations in mental health and well-being work with care leavers

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Report, May 2024

Introduction

The mental health of care leavers has been an explicit public policy concern for UK government for at least a decade. It precedes, and is accompanied by, a wider concern with the mental health of all young people. That concern was heightened by the UK's experience of pandemic lockdown restrictions and consequent isolation in 2020-2021. Our concern here is much narrower. It is with care leavers being supported by leaving care teams, with an age range of 16 to 25 years of age.

In recent years, there has been a flurry of publications highlighting mental health issues facing young care leavers (e.g. Department for Education and Department of Health, 2015; Juliette, et. al. 2023; NLCBF and Drive Forward, 2021). These and other sources have provided a wealth of advice on the need to improve support to care leavers in this area (e.g. Transformation Partners 2023). Moreover, there are intergenerational aspects of such issues that make tackling them particularly important (see: Parsons, School and Fitzsimons, 2021).

This report is a result of research conducted as part of a wider 'Innovations in Transition to Adulthood (EXIT) Study. The EXIT Study has sought to "Support the development, implementation and diffusion of meaningful innovation for YPLA (Young People Looked After) as they negotiate the transition from care to adulthood" (Exit Project, ESRC Full Bid, February 2019). It is intended to complement data found in broader project innovations in work with care leavers (see Johnson et. al., 2024).

The concept of innovation in the local government sector

As noted in the EXIT Project's Scoping Review (2020), the concept of innovation is "an abstract term and there is no universally accepted definition". (p.3). In the case of local authorities, it is likely to be, "about processes – creating change in relationships between service providers and their users" (p.3). In the course of our interviews, we often had to explain the meaning of innovation to our interviewees. We did so by

elaborating on the definition of innovation used elsewhere in the EXIT project. This definition is that innovation is:

> The process by which new practices, organisational arrangements, service initiatives, or new technologies/interventions were intentionally created, introduced, sustained and scaled up for generating public value through improved organisational performance and/or service user outcomes and experience. (EXIT Project Scoping Report, 2020: 4).

Once interviewees had a clear grasp of the concept, they were often able to frame a range of activities with it.

Acknowledgements
We'd like to thank the following for help and advice with this work: Professor Graeme Currie, Terry Galloway, Hannah McCowen, Doug Simkiss and interviewees in the following local areas: Cornwall, Kent, Brighton and Hove, Neath Port Talbot, Greater Manchester, Norfolk, Nottinghamshire and Clackmannanshire.

Background

The Care Leavers Association has been part of the EXIT project since its inception. One reason for our involvement was our longstanding interest in the mental health issues faced by care leavers of all ages, reinforced by our health research project, conducted between 2014-2017. That project was funded the UK's Department of Health and we conducted research amongst care leavers across the life course. We received questionnaire responses from over 400 care leavers and found that mental health issues, either related to the care experienced or not addressed during it, were causing many care leavers life-long problems (Braden, et.al., 2017).

As part of research, we also worked with members of the 10 National Health Service (NHS) Clinical Commissioning Groups we were working with and undertook an online survey with health and related professions (who provided 215 respondents). The top five issues affecting care leavers that professionals reported were: mental health, general physical health, drug and alcohol issues, sexual health, access to services. They also identified key areas of need: mental health, transitions (between services), general support, housing, access to services. Some of these issues come up repeatedly in the interviews we conducted for this report.

Other research confirms the wide range of problems we found. For example, it is increasingly recognised that there is a significantly higher risk of early mortality for those raised in care. This is related to extensive social and economic disadvantage. As Sacker et. al. (2021) note, between 1971 and 2001 the risk of early mortality increased for those from a care background while remaining stable for those brought up in birth families. Much earlier, Meltzer et, al. (2008) had, using ONS longitudinal data on children in residential care between 1971 – 2001, found that those from such homes were three times more likely to have died than those from private households (mainly from accidents, violence, injury and poisoning). Those surviving to 2001 were more likely to be in rented accommodation, to have no qualifications and to be unemployed. These lifelong problems often begin with the failure to address the mental health struggles of younger care leavers.

Methodology

This was an exploratory study with several aims: 1) to contribute to the wider EXIT study findings on innovation within services for care leavers, 2) to seek a preliminary picture of the range of innovations and service offers on mental health support for care leavers, 3) to provide a knowledge base for campaigning for improved support in this area.

We were provided with funding for this work from the main EXIT project. We chose to conduct semi-structured interviews with a range of professionals involved in delivering mental health support for care leavers in England and, in one case each, Wales and Scotland. Finding interviewees was initially difficult. The pressures on local government are currently intense and many professionals had little time to be interviewed for our project. However, in December 2023 and January 2024 we sent two waves of emails, with detailed information about the project, to over 200 leaving care teams or similar professional groups working with care leavers.

Of those that responded, three reported that they'd only recently started mental health or wellbeing work with care leavers. For example, two local authorities had recently appointed, or were about to appoint, one or more people to engage in such work. By mutual agreement, we decided it was too soon for us to be able to conduct a useful interview. A further prospective interviewee had to defer the interview due to an imminent Ofsted inspection and there wasn't time to rearrange. In the pre-discussion we had with them, it was clear that their approach was primarily based around signposting to helpful web resources and other organisations. One is mindful, in this context, that some authorities may lack the financial resources to do much more than this.

To the interviewees, we sent an outline of the project and a consent form in advance. For half the interviews, there was also an exploratory discussion in advance. This was in order to assess who in an organisation should be interviewed and whether an interview would be worthwhile. This involved assessing whether an initiative was sufficiently innovative and significant. One potential interviewee was energised by the topic of care leavers in mental health but not convinced she was conducting innovative work. In the event, she did not take up the option of being interviewed.

At the start of each interview, we explained that our overarching purpose was to discuss mental health innovations for young people leaving care, including a focus on examples of such innovations and the enabling and hindering factors associated with sustaining and scaling-up innovations. There were two subsidiary aims: 1) to gather views and experiences of mental health innovations for young people looked after who are transitioning to adulthood, 2) to explore the process of innovation.

With more time and resources, we might have chosen a coding approach to analysing our interview data (e.g. Lofland and Lofland, 1995). It is an approach with which the main author is familiar from earlier research on the views of looked after children and care leavers (Lynes and Goddard, 1995). However, in that case a far larger sample size rendered coding both more necessary and more useful. So did the far greater specificity of the questions.

In this case, the well-known problems with coding – such as losing context through fragmentation of the data (see; Coffey and Atkinson, 1996) – are relevant. The same problems would also have applied if we'd used a more specific framework approach to our data (e.g. Gale et. al., 2013). We were frequently dealing with long, narrative accounts that flowed back and forth as our interviewees knitted together responses that provided the context and organisational dynamics for their work. Some accounts had less relationship to the interview questions than others. To capture the full sense of what we were being told and meet the objectives of the project, it made more sense to adopt a form of light thematic analysis. By this we mean noting the commonalities between interviews that shed light on the process and dynamics of innovation in this field and that, broadly, built on the answers to the questions we had set out before the interviews.

It was clear that there were particularly strong themes evident across a number of interviews. For this reason, we have structured our discussion of the interviews in line with our questions (which are provided in Appendix One and were sent to interviewees in advance). In searching for connections and trends, we focussed on such phenomena as repetitions, similarities and differences between interviews and the use of theories (see Ryan and Bernard, 2003). Although the main researcher identified these themes in the course of his analysis of the full data set, the co-researcher and one other individual had access to the full set of interview responses (through the provision of a table setting out all those responses) and were therefore able to confirm or challenge his interpretation of the main themes and other findings.

Interviews

The two main researchers carried out 14 interviews in total. Both were care experienced, with close co-ordination between them (eight interviews conducted by one researcher, six by the other). Each interview was conducted using the same script of core questions (see appendix), with follow-up questions varying. The following table sets out details which will make the subsequent discussion clearer.

Interviewee	***Organisation***	***Level***
1	Local authority and NGO combined	Post funded by local government. Direct work with care leavers.
2	Local authority	Senior Professional: Commissioning and Contracts
3	NGO	CEO
4	Local authority	Team manager; leaving care service
5	Local authority - Health	Clinical Psychologist: Lead for Adolescents
6 & 7	NGO	CEO and team leader
8	Local government	Team manager (temporary)
9	Local government	Team Leader, Mental Health Nurse
10	Local government	Assistant Director: Family Help and High Needs
11	Local government	Mental Health Social Worker
12	Local government	Mental health professional

13	Local government	Leaving Care Team Leader
14	NGO	CEO

The Interviewees
By its nature, our recruitment process provided interviewees who were enthusiastic about their work and generally saw themselves as positive ambassadors for innovative practice. Some had much more experience of driving innovation than others. Some of the less experienced were more likely to focus on barriers that more experienced colleagues were able to deal with more successfully. Needless to say, the level of seniority played a significant role here. For example, more senior interviewees found it easier to gain collaboration from external partners. They saw barriers, but were more able to overcome them.

The interviews were semi-structured and not all interviewees found it easy to keep to the structure. This meant that not all questions were answered. Most interviews lasted between 30 minutes and three-quarters of an hour but some ran for over an hour. The following structure follows the order of our topic list, but not necessarily the order in which each person answered the questions.

We began by explaining the broad purpose of the EXIT project and the narrower purpose of our interviews within that project, answering any questions about the project (many of which had already been answered in preparatory discussions, with about half the interviewees, a week or two before the interview proper).

Role and Experience
We had a good range of practitioners operating at different levels of organisational delivery. Each interview began by discussing the participant's role in their organisation. After that, we sought to identify their background and their experience and involvement in innovations for young people leaving care. There were three possible levels of involvement:

- Strategic and/or operational delivery of services for care leavers
- Involvement in policy-making and advocacy to inform policy
- Evaluation of projects that aim to improve outcomes for care leavers

These levels were used to help ourselves and our interviewees to categorise their organisational position. Some respondents found it easy to identify themselves as working within only one of these areas, while others covered more than one. This was partly to do with the nature of their role and partly related the nature of the organisation, particularly its size. For example, Interviewee 14, heading a small NGO, was forced by circumstance to operate at all three levels. In any case, it was fairly clear that boundaries were often deliberately fluid. For example, some senior leaders chose to remain involved in ad hoc direct work with young people. Equally, some direct case workers were involved in wide discussions on policy.

We originally sought to ask about involvement in specific projects and/or policies in the last 10 years, but his applied to only a couple of our respondents. Most projects had been developed far more recently.

It's also worth noting that for two of our local areas we had more than one interview; for one area we had three interviews and for another area we had four. This gave us a much stronger sense of the range of work in these areas. We come back to these

areas at the end. We did seek to interview care leavers involved the development and delivery of this work, but this was not a significant feature in most authorities and we were not able to set up interviews with the few leads we had. Co-production was not a significant feature of these innovations.

The Meaning of Innovation

We wanted to explore what our interviews understood by the concept of innovation in the context of their services. This necessitated us explaining the concept as it was being used in the EXIT project. Not all interviewees found this easy to answer. As noted above, the concept is often poorly understood and defined. Those that understood the concept well gave fluid and varied answers that provided a good basis for understanding their subsequent discussion of developments.

Responses were inclined to differ based on level of responsibility. Face-to-face workers tended to focus on flexible work with young people, whereas senior leaders focussed on operational-level innovations. For example, on the former:

> *I think for me, the innovative practice is really working with the individual and working your practice around them. Having the theoretical background, having the structure behind you within the organisation, but being able to work around that so you can meet the needs of that individual. I think it's thinking outside the box as well, so looking at being up to date with new practices or just being prepared to experiment or to try different things and to really work the individual, I think that's the innovative practice for me. (Interviewee 1)*

Likewise our mental health nurse interviewee:

> *Yes, it's looking at how young people can be helped with either their mental health or just their day-to-day lives and any identified issues that they have. It's looking about what we can put in place or what other services can put in place, whether that's children and families, Leaving Care teams, mental health can put in place to help that particular group of young people because they have very specific needs often that are a result of them being brought up a lot of times in care. The innovations and looking at what can be implemented, it was about for us, and it's about me being [on] a learning curve, focusing on what could we identify the needs were for this particular group that other services might put in place that they would actually engage with and use? (Interviewee 9)*

And our mental health social worker:

> *I think it's about doing things differently. It's about looking at what we're being presented with and changing our approaches to reflect people's needs. (Interviewee 11).*

In contrast, one of our senior managers was focussed on the task of persuading colleagues to introduce system-wide change:

> *Actually being able to go to commissioners and say, "This is what you have. This is brilliant in terms of service provision, but where is the service for our young people?" Actually trying to help them understand and learn what is it that is so unique about care leavers and how does that need to be thought of differently, compared to other young people in society so that actually they have much more of an understanding. (Interviewee 5)*

That being said, it’s worth noting that Interviewee 5 also worked directly with young people from time to time, so was equally open to the idea that innovative practice was also “personally driven” and exhibited in direct work with young people.

The two voluntary organisations tended to see themselves as occupying the time-honoured position of the voluntary sector as innovators. Thus the CEO of one responded as follows:

> *Innovations that I've seen in the last 10 years? Well, if we're talking about mental health within the local authority, it was our work and our young people's campaigning that led to-- they said, and I'm sure there's an element of truth in this, innovating (sic) a psychologist in [the] Sixteen Plus service. (Interviewee 7)*

In contrast, one of our NGO CEOs saw their work as not especially innovative but as a simple response to learning what works and what doesn't in developing co-production techniques:

> *I would say we don't do a lot of innovation because co-production, and being user led and user involvement and peer involvement is inbuilt into our DNA. That's not something that's been new to us, and we've tried to do differently. We haven't innovated in that way… Being a user-led organisation, one of the things that we do is that we talk to care leavers of all ages and we listen and we have focus groups and we have meetings and we have surveys and we assess, what are the main issues affecting care leavers.*
>
> *… If we can get an NHS Trust to deliver a mental health and well-being service to care leavers, maybe the way they do it is not innovative, but actually doing it because it hasn't been done before is innovative. (Interviewee 14)*

What is Working Well and What are the Areas for Development?

This was a fairly open-ended question which, understandably, generated some lengthy responses. There was some overlap, here, with the later responses regarding the barriers and enablers for innovation.

A number of interviewees cited the flexibility of their role as a significant positive. New roles often allowed workers to define their own approach to their task and develop their own priorities. The main benefits, for workers at grassroots level, arose from working with individual young people. For example:

> *I think what's worked well is the flexibility. I haven't got any set parameters, so depending on the need of the young person. Like I said, I've got that space to be able to see them once a week. I can see them in their home because in the community it's very much dependent on that young person and also as well say if they-- because going with the young people we work with, if they cancel last minute, I've got the flexibility to still see them like a couple of days later or the next week. I think that works really, really well. (Interviewee 1)*

For this interviewee, the same benefits of a flexible timetable also applied to working with other professionals.

Another interviewee also found that the flexibility of developing a new initiative was particularly beneficial in work with clients:

> *What has worked well is that more recently, we've been giving a little tiny bit of money to a young person or to a couple of young people who've really wanted to access a playgroup with their children. We've been giving them bus tickets, but also giving them a little bit of money so when they get to the playgroup, they can have a cup of tea or coffee so they don't look no different to the other mums that are there. They've said previously, "We can't go because I can't afford the cup of tea when I get there and the biscuit because I've got to put the money into other things." For me, it's those little things. (Interviewee 8)*

At a more senior level, innovation applied to developing new processes that opened up fresh conversations. Recognition of a fresh need seemed to produce paradigm shifts that led to creative thinking and the development of new processes:

> *The other thing that worked really well, that again I think is innovative, is rather than what we could have done as the Council was written a job description and a person specification for a wellbeing specialist, gone through all of our various processes and that would have took umpteen period of times. What we did with […] was we said this is broadly what we're looking*

at and she came back with the suggestion that I think could sit within a refined remit but the clinical nurse specialist or the wellbeing worker.
What we were able to do was match what we were looking for to some existing job roles and job descriptions within the Trust, which saved I think a significant amount of money going through an internal procurement process and a repeating reinventing a professional wheel if you like that's already out there and doing a role. (Interviewee 2)

For some workers at a senior level, the key to an innovation working well was relationships with fellow professionals. Since that was their means of influence, that became the focus of their attention:

Okay. I think the things that are working well is that in order to do this work effectively, you have to have good relationships with the people who you work with. I feel I have that. I think although the team has grown massively, and there's some people who I still need to do that, the core of the team have a really good understanding of what psychology is…I was kept very separate for quite a long time.
I feel like that's worked really well. I feel very embedded in my team, having really strong relationships with managers so that they had an understanding. Being able to support them when they had difficult days so that they could be more psychologically minded, but also more psychologically available for their workers was really, really important. I feel like that's worked really well.

Rationale for the Initiative

Here, there was some overlap with the answers to other questions. However, there was also a sense amongst several interviewees that the rationale for their initiative lay in a simple recognition of unmet need. Part of this was rooted in a growing awareness of the problems being caused by the age categories embedded in the leaving care process:

…these young people they get to 18 and then it just all drops away. I think it drops away or the level of support they would have had before 18, it drastically reduces post-18… and a lot of them get a real shock of like, I've just messed up my accommodation and then there's only so many times before it goes, no you've lost it, like we're not going to keep on housing you… I think they saw there was more need for that more intensive work with the young people to try and prevent crises from happening. (Interviewee 1)

This developing understanding could also be precipitated by active analysis of the problem. In this same local area, the CEO of an NGO that worked closely with the local authority had conducted research eight years ago which:

…found what so many papers and policies have since found. That actually, care leaving services were very, very good at that point in time in meeting practical needs, but actually not very good at meeting emotional needs. The young people's voices were very strong around that. (Interviewee 5).

Interestingly, in one local area different interviewees all took different views of innovation (Interviewees 1, 5, 6 and 7 were all from the same area). We were provided with multiple rationales for innovation, depending on the perspective of the interviewee. In the case of Interviewee 7 the rationale went back 20 years, to personal experiences involving young people that she was the foster carer for. Through the development of the NGO which this individual led, this had evolved, over the two decades, into a communal, peer-mentoring and networking approach which brought care leavers together to support each other:

I think the rationale is really around enabling those young people to move forward with a larger community and support network into their adulthood… I have met young people who 18, 19 that have never met another young person in care and it's quite profound when they come into a group the impact that that has.

> *I think there's a lot of stigma still, there's a huge amount of discrimination that young people are facing day in day out and we know that it is not easy for care leavers in England or more generally, they have a huge amount more barriers. (Interviewee 7)*

For Interviewee 9, there was a similar rationale. The perception of need was a grass-roots recognition of problems with existing services, but of much more recent provenance:

> *I think it's been a need that's been identified, especially by the team I've worked… It's one of those things where I find it interesting with the Leaving Care team that it's talked about a lot, but nothing's ever actioned… I suppose you could put it as an innovation, one of the things we've been trying to do and are still trying to do is have care leavers classed as a protective vulnerability within mental health, like you would with the veteran service. (Interview 10)*

For Interviewee 14, there was a similar process:

> *The rationale was to develop a framework that would empower young care leavers in relation to their mental health and well-being. We, as a user-led organization, we use empowerment models. It is about the person becoming more self-aware, having more understanding of what's going on for them, and what has gone on for them so that when there is a trauma response going on to something, they can become aware of it and they can take strategies to counter it.*

This programme had arisen as a result of perceived problems with a previous programme.

Precipitating Factors

Most respondents found precipitating factors for the innovation difficult to identify, not least because the origins of initiatives were often complex. Interviewee 1 claimed their work had arisen from a "gradual sense" of a need. However, having only been in post for two years, this interviewee had not been present for the two decades of build-up identified by the NGO CEO in the same local authority area (Interviewee 7). That same CEO cited the development of a young women's group, many years earlier, focussing on exploitation that had been disrupted by the preference of the young women to engage in more playful activities, indicating that the need for "play and… being together and… being in a place of safety". Subsequent external research had, the CEO reported, validated the approach of developing a "secure base model" for work with young people. There were similar experiences with Interviewee 14, leading to work needing to be altered to the pace and circumstances, even the location, best for the young people involved. This shows the importance of capturing the history of work that leads to innovation if we want to ensure that steps in the process are not lost or forgotten, particularly given frequent staff turnover within some organisations.

For Interviewee 8, there were two factors that led to the development of their work: a) an independent source of money that could be used in a discretionary way to meet individual pressing needs of young people (often quite small needs and small amounts of money), 2) recent links with an NGO specialising in promoting the voice of young people in care and care leavers.

Core Aims

One of the common themes of the core aims we were given was that these innovations were not time-limited. For example, there was no case were therapeutic support was offered for several weeks, as in standard NHS psychotherapeutic

support. Instead, initiatives invariably sought to offer support to young people for as long as both sides deemed it necessary. If there were limitations, this usually centred around commissioning issues that were outside the control of local authorities. For example, NHS secondments could not often be committed to, in funding terms, beyond a year. This could inevitably restrict the capacity for long-term planning.

When prompted, interviewees found it relatively easy to identify two or three core aims. In this, they were often focussing on their current work as well as the original aims of the innovation. For example, for Interviewee 1, their core aim was "to try to prevent homelessness". Aims subsidiary to this were providing skills that enabled long-term placement stability and supporting engagement with long-term statutory services.

These more practical aims were in contrast to those of Interviewee 5, who was a qualified mental health professional. As a clinical psychologist, she was, naturally enough, inclined to focus on her own goals rather than the wider development of which she was a part. These included *bringing:*

> *…a psychological understanding to the work with young people, so having a trauma lens, having an understanding, understanding people's journeys as to why they've come to this point… I think it's about bringing a trauma attachment and mental health lens to the understanding and to the work […with] young people and trying to understand that better." (Interview 5).*

Given that this individual had a pivotal role in local provision, they saw their goal of introducing a trauma lens into local work as operating on several different levels:

> *I do that on the ground when I meet with young people. I do that when I meet with workers to try and help them. I do that with managers in terms of thinking how do we make our service trauma-informed, how do we understand what young people's needs are? We do that with all aspects of the work that we do really. (Interviewee 5)*

Some interviewees wanted to distinguish between the overall aims of their organisation in this area and the more specific aims of daily work. For example, Interviewees 6 and 7 noted that core aims were specified:

> …according to our target outcomes wheel, which is helping care-experienced young people have a better life through positive relationships, support at times of transition and through having a voice." (Interview 7),

to which Interviewee 6 was able to follow up by noting that "one of our core aims is supporting young people to be able to ask for help when they when they need to" (Interviewee 6). This particular NGO repeatedly emphasised what they saw as the value of promoting supportive relationships between care leavers:

> That you're giving young people a chance to create their own community, I guess, because at some point they're adults… at some point they're 25 and we would be doing a disservice if they reach 25 and were unable to have the skills to meet other young people and go on and have a good life… and I guess one of our core aims is to do ourselves out of business. (Interviewee 6)

The core aim for Interviewee 8 was:

> *…to try and help the young people to access community resources… because isolation is quite a big issue for care leavers and the general population, especially with issues around poverty. A lot of our care leavers are only on universal credit and that doesn't get them anywhere, really. The little things that would really matter to help them break that cycle of isolation, they can't afford it…Getting them into the community so that they can find resources themselves because what we don't want is for them to be dependent on us, and then we disappear when they're 25. We're not doing them any service if we do that. (Interviewee 8)*

Interviewee 9, being a mental health nurse, was focussed on prioritising help in this area, particularly in relation to external mental health services. Professionals, as in this case, who had come into leaving care work from the health sector were more cognisant of available resources in that sector:

> *Yes, the core goals are trying to get care leavers protected status within mental health services. Also, trying to get possible therapeutic input or groups specific for care leavers with their particular issues. (Interviewee 9)*

It's important to note, however, that both this interviewee and Interviewee 5, both qualified mental health professionals, saw their role as also supporting leaving care colleagues. This included leaving care Personal Advisers and related professionals:

> *What we've been trying to do help with the team as well, who are working with care leavers, helping them keeping their boundaries so they can also protect their own mental health. (Interview 9).*

Another mental health specialist again pointed to the need to address how young people are treated by the health professions with which she was familiar:

> The aim is to make sure that the young people have got the mental health support that they need, and that comes under many umbrellas. The real biggie for me is the medical professions… diagnose things like personality disorders as soon as they hear the word trauma, rather than thinking that actually there might be something else going on. (Interviewee 11).

Enablers and Barriers

Those interviews that addressed this question found it relatively straightforward, though it was often easier for them to identify barriers than enablers. Again, though, this often reflected their position in the organisation; one's perception of barriers was related to one's degree of seniority. One theme that came up repeatedly was the high degree of choice workers involved in innovative projects appeared to have:

> *I think the flexibility has been a massive one to be able to get me to be able to do the work; the way that it's worked out. Working collaboratively and really closely with the personal advisors has been really, really helpful because it really allows that joined-up working and it means that I do more the emotional health and wellbeing side, and then if we've got issues with the housing, I work with the PA, who does more of that work. (Interviewee 1)*

For this worker, able to work with both the local NGO and local government but paid for by central government, their daily experience of work with young people was of being able to develop relationships flexibly, around the needs of the young person. There appeared to be a great deal of autonomy in how they delivered their support for young people.

The same was true for Interviewee 5. However, the greater seniority in her post offered stronger networks of support:

> *I think the thing that… enabled me to do what I've done is firstly being given funding to be in my post. I think that's made a big difference obviously. If that hadn't have happened, then actually I wouldn't be able to do my work. I think the other thing is having a really strong psychology team behind me. When it wasn't very easy in the beginning, I had a team to turn to say, "This is really tricky. The 16 Plus team are making this quite hard for me." (Interviewee 5).*

For this individual, their elite medical status was a particular enabler in terms of being taken seriously when advocating change. Although they didn't like using the power of status, they were prepared to do so when necessary. That status also had a more benign use in that it was seen to generate widespread respect amongst

fellow professionals on both the medical and the leaving service side. This was both fortunate and necessary, since the cross-over between mental health services and leaving care services produced initial barriers of trust:

> *I think initially, a massive barrier was trust. I think lack of trust of the workers. They really struggled with that. We laugh about this now looking back, just how anxious it made people feel having a psychologist join the team, and how long that took. It would have been very easy for me in the beginning to say, I don't think this is working, and to walk away from it. It took a long time (Interviewee 5).*

For our small NGO, the key trust issue was with young people rather than with other professionals. Here, the charity had an advantage through being user-led. Having fellow care leavers delivering its wellbeing programme was a strong asset (Interviewee 14).

For larger organisations, having staff seconded in, or transferred in, from health services could be a double-edged sword (Interviewee 4). On the one hand, it brought in a knowledge of health services that could be valuable. It also offered a fresh perspective, from outside existing social care paradigms. Health service workers, as already noted, frequently offered support to Personal Advisers as well as to young people. However, there were frequently concerns about time-limited funding for such developments.

On the subject of barriers, it was often noted to be other agencies that were major impediments (such as housing and mental health service providers, for Interviewee 1). Another barrier was the age-related transitions between services. Innovative approaches to work often stopped when they encountered the same agencies that previous approaches had already struggled with:

> *The barriers, and this has always been the case, is access to services especially mental health services, but also the same with housing, with benefits, with DWP is basically having to beat down doors or they literally have to be standing on a cliff edge to be seen and to be taken seriously. I think because one of the main barriers is if somebody has a PA or a key worker, and I'm guilty of this when I was in mental health services, they don't become as urgent because other services believe they're being overseen. (Interviewee 9)*

The same was true for Interviewee 11:

> *I can think of a lot of barriers. I can think of the lack of services for young people with autistic spectrum. They need that extra support, and we're able to provide that up until 25, and then trying to get adult services to pick that up can be very difficult. Yes, it's mainly around adult services, actually, not picking up. Not picking up at all. We might have a young person. I start by working with the rising 18, so 17.5. Some of them are in mental health provisions and trying to get adult services involved with enough time so that when they do turn 18, we've got another provision for them to go to that's reasonable, or the funding is in place to continue what they have.*

For one of the NGOs (Interviewee 3), short-term funding was “an absolute nightmare” that can be “really harmful” and was identified as a major barrier. Criticism in this regard was aimed at both local government and health service funding. One of our other NGOs (Interviewees 6 and 7) also identified this as an issue, but they appeared to have become adept at managing an array of different funding streams. However, voluntary sector funders could bring their own barriers, through a lack of understanding. Generously wanting to fund activities that the NGO knew were wasteful was one of them (Interviewee 7). Often, for this NGO, flexibly spending much smaller amounts of money was seen as more productive.

Another barrier was age-related and other transition difficulties from within local government. This particularly arose with mental health services:

> We do have some young people whose therapeutics needs haven't been met while they were under 18. Potentially, that could be because the young person hasn't wanted the therapy. I know over the years that some psychological assessments say that a young person won't be ready for therapy until they're in their 20s.
> For many years, it's been a blanket no. Over 18, the local authority won't provide any funding for therapy. (Interviewee 8)

Sometimes the difficulties with transitions were of a more prosaic nature, involved with simple problems of information not passing between child and adolescent services. This was something that could clearly exacerbate what was already going to be an artificially abrupt transition, an abruptness that has no parallel in the lives within birth families:

> I think what the barriers [to] a lot of things are, what hasn't necessarily been helpful is that it's a one size fits all, which it doesn't. There's a lot, you find a lot, what I find difficult is that a lot of the history of an individual may be lost when they come into an adult, go into an adult realm.
> The notes, say, for CAMHS are not available to adult mental health services and not necessarily transferred unless there's a transition plan. It's the same in regards to if they've had a social worker and they've been in foster care and then they're 18 and then they go on to supported housing or other kinds of care. There's doesn't seem to be any therapeutic or preparation work for that. There's a lot of young people who have had a lot of support and input pre-18 but post-18, they're all of a sudden expected to be an adult and have agency to access whatever they need and have an understanding of that. (Interviewee 9)

Outcomes: 1 – The Organisation

With regards to outcomes, it was often easier for respondents to note the changes to their organisations and the professionals who worked for them than it was to identify outcomes for care leavers. This was perhaps unsurprising for those initiatives that were relatively new, where outcomes for young people might take years to emerge. However, some of the more long-standing initiatives had at least sought to measure the potential gains for young people.

With respect to organisations, there was a common sense of organisations being improved by the innovation. One needs to be cautious here, as there is clearly a risk of organisations taking an overly-positive view of changes through ‘marking their own homework’. There is also the selectivity involved in choosing to be interviewed by us on this topic. That said, there was a widespread sense of permanent positive change. For example:

> I think both [NGO] and the council have been quite pleased with the results and how the roles worked. I think they're trying to embed it as a full-time role within the council. That's quite a good outcome regarding that. (Interviewee 1)

Interviewee 5 tended to focus on the ideology of practice, rather than with changes at an organisational level; noting, for example, that “I think we have an organisation that is more trauma informed”. The same was true of Interviewee 7, who simply felt that their organisation was wiser as a result of steady learning over time, that they, “know what works” with respect to facilitating supportive relationships amongst care leavers. The increased growth of their NGO, through partnership working with the local authority, was seen as local authority vindication of this perception. For Interview 9, there was a similar focus on the culture and practice of the organisation,

that it had evolved innovative working and a greater willingness to explore “shared care and have joint meetings with mental health service[s] and housing”. For others, such as Interviewee 11, it was a case of being better able to monitor the numbers of care leavers with mental health problems. For the final interviewee, as one might expect of a small organisation, the impact of developing this area of work had been significant:

> It's made us much better at being data-driven, data-led. It's really helped us to be agile and responsive by having a delivery model and then looking at it and evaluating it and then talking to participants and making changes as we went along. Not just in the way we delivered it, but actually in the focus, we went from independent living to mental health. I think that looking at the data and being responsive has permeated throughout the organization now, which I think is good. (Interviewee 14)

We can see, here, that evaluation of the innovations and methods used is less based on evaluative outcomes or measures than on a sense of historical knowledge regarding traditional ways of working. Such traditional working practices can be viewed, with hindsight, as a barrier to expansion due to their inability to capture and replicate key components of practice in future iterations or in different areas. The same problem arises if the historical leads leave the organisation. A data-driven approach leaves more historical knowledge within the organisation, regardless of personnel changes.

Outcomes: 2 – Professionals in Frontline Practice

With professionals, there was often a sense of workers being both challenged and helped by the introduction of mental health issues into their work with care leavers. For Interviewee 14, for example, there was a clear sense that workers involved had to learn new skills while at the same time recognising their professional limitations:

> I think you would have to say something about the emotional toil it took on each worker to deliver. We did have to have external supervision going on with them because, yes, because you're carrying a load, really. That is a challenge. We're not therapists, we're not mental health workers, we're not clinically trained. There is a line. Which is easy to draw until you're sitting in front of somebody, and they're dumping stuff on you. That's a challenge. It definitely took a toll on the workers.

For Interviewee 2, as for some of the other interviewees, a key outcome for professionals arose from the flexibility that these innovations often brought to professional timetables and commitments. This flexibility gave them the opportunity to take some workload from others and to identify issues “a lot quicker than they might have been previously… before it gets to crisis point”. For Interviewee 5, the change went further than more effective forestalling of crisis situations:

> …two things happened for the workers. One is that I think their practice is much more trauma informed, much more mental health focused. I would say that the practice of workers is no longer based on practical skills alone. They very much go and see their young people and think about their emotional well-being and how they can make a difference.

Beyond this, there were perceived changes in language, risk assessment and engagement patterns with young people. Perhaps as importantly, workers were claimed to be more aware of their own well-being while conducting their professional duties. This was to the extent of using the new mental health professional to assist with their own workplace mental health struggles. Generally speaking, however, this professional level was the outcomes area where interviewees had the least to say.

Outcomes: 3 – Care Leavers

In some cases, assessment of the outcomes for care leavers was anecdotal rather than measured. However, in at least one case (Interviewee 3), an NGO had

conducted an extensive evaluation of its work in 2021, which included its psychological well-being service of designated workers and fast-track trauma counselling. In each of these two service offerings, well over one hundred care leavers had been supported.

For workers engaged in direct practice, or close to direct practice, such as Interviewees 1 and 9, it was easier to identify cases where they had made, or witnessed, a direct impact in the lives of individual young people, such as helping young people to keep accommodation or to engage with GPs and mental health services. As noted earlier, sometimes this perceived ability to make a difference came from the relative flexibility that new workers in innovative practices had:

> I think those that we work closely with, we are able to offer that support that we need, even if it is just picking them up, taking them to their therapy, waiting for them in the waiting room. When they come out, we can have a debrief from the therapy and keeping that going so that they're able to access the therapy that they're given. Initially, in the first stages, until they feel comfortable and then we can duck out. We have that time, we have that ability to manage our diaries. (Interviewee 11)

Those at a higher level, such as one of our NGO CEOs, tended to think of pursuing broader outcome measures. In this case, for Interview 6, that meant possibly pursuing a longitudinal study, which was made possible by being engaged in work on mental health and wellbeing for several years. Others felt that assessing outcomes was "a bit tricky because unless we're doing questionnaires and things like that, validative or quantitative stuff, it's quite hard." (Interviewee 8). For Interviewee 14, however, there was a more precise edge to measuring outcomes:

> We… used well-being assessment criteria, which all showed positive indications at the end. We took baseline studies at the beginning. We took assessments at the end and they were all up… We know in general, yes. (Interviewee 14)

How has the Project Evolved?

Here, we wanted some sense of how projects had developed over time. For this, therefore, we presented our interviewees with a range of possibilities that might apply to the initiative they were involved with:

- Has it ceased or will it cease?
- Has it been sustained?
- Has it been scaled up over time?
- Has it spread beyond the initial site to elsewhere in the locality?
- Has it spread outside the locality?

No one reported that an initiative had ceased or was going to, though some had concerns about future funding. Despite the difficult funding position within local government at present, there was a sense that the argument for a mental health aspect to leaving care provision had largely been won within these organisations, in the sense that it would not be withdrawn (e.g. Interviewee 9). In short, all these initiatives had been sustained. There were sometimes, though, such as for Interviewee 1, future funding issues beyond the next year or two.

In a couple of cases, the work was being scaled up. It helped that senior figures were able to argue for this and that there was a critical mass of involved individuals, crossing the NGO, local authority and health sectors, to push for such scaling up. For Interviewee 5, it was more a case of development and learning over the course of eight years, with some areas of work expanding and others closing. However, this

was within a general context of steady expansion. This involved developing links and influence with other agencies in the region, such as those in youth justice.

A minority of respondents were able to identify the development of the initiative beyond their organisations, either locally or nationally. Being an NGO with a regional profile (Interviewee 3) clearly helped with this. The same organisation also had a profile in national networks. National influence stemmed from both visibility in the sector and direct connections with national government. Local influence was sometimes due to the work of an organisation being, by its nature, embedded across several local authority areas. Another NGOs (Interviewees 6 and 7) also had links beyond the local area and was active within national leaving care organisations. One NGO (Interviewee 14) noted having had their ideas repeatedly, and without permission, taken up and delivered by other organisations, who "basically nicked it and did it themselves". In such cases, we can assume the key components of overcoming initial barriers and other areas of historical knowledge are lost in the transfer process due to the lack of collaboration and knowledge-sharing.

In other cases, such as Interviewee 2, it was more a case of being embedded in a regional network where ideas were shared, as well as some of "the barriers and challenges in terms of trying to make sure that we are successful in our individual bid commitments [on Staying Close initiatives] whilst developing that regional commitment with an intention to work collaboratively". It was mutual exchange, rather than one-way influence. In this case, though, it included the development of a training pack that had been delivered externally. Another organisation (Interviewee 11) also identified having an influence in other authorities through training.

One further area of influence is worth noting. Several interviewees said that having responsibility for care leavers living outside the local authority area that was still responsible for them meant that they at least interacted regularly with agencies outside their area. This, though, was a relatively passive form of potential influence.

Final Thoughts

We also offered our interviewees the opportunity to offer general comments. A few did so, but most felt they'd managed to say as much as they needed to in the main body of the interview. It was noticeable that several were keen to share their innovative practices through this research project and beyond it. One NGO interviewee chose to emphasise the importance of being a stable centre to which young people could return. Another argued that achieving protected status for care leavers, under the Equality Act 2010, would help to ensure better access to GP and mental health services. A couple (Interviewees 2 and 11) chose to highlight the importance of developing trauma-informed care.

Finally, it is worth stressing that all interviewees were keen to know what was going on in other areas. There was a clear sense of some working in isolation. However, two areas had very wide connections that spread way beyond their local area. This meant that they were either involved in, or well aware of, regional developments.

Discussion

There are several ways of describing what we found. The simplest is to consider these innovations across two dimensions. The first is time. It was clear that some authorities and NGOs had been working in what they saw as an innovative way with respect to the mental health of care leavers for many years. At the most extreme end, this was two decades. One might question whether this was therefore an innovation, but it was also true that the organisation appeared to have developed its thinking and practice incrementally during that time. They had created new iterations of their innovation in order to better suit the needs of those they were serving. Others had only recently appointed staff or begun initiatives in the past two years or so. As noted at the start, some potential interviewees were excluded because they were only just beginning such work.

The second dimension for describing the innovations we considered are what we might call ‘hard’ and ‘soft’ developments. The former refers to the de facto merging of services through the secondment or appointment of specialist and qualified professionals from the mental health sector into local government leaving care teams or services. The latter refers to alterations in practice, including greater informal engagement with health services but without structural or personnel change. The former, unlike the latter, required high-level managerial initiatives and agreements.

A further point is the extent to which our NGO participants saw themselves as occupying the time-honoured role of the voluntary sector in developing innovations through greater flexibility. The 20th century history of the voluntary sector in childcare tells us that such innovatory qualities cannot be taken for granted, in that large voluntary sector organisations can become ossified as size produces defensiveness and rigidity. In this case, however, it was clear that local voluntary sector actors had far more practical flexibility than many local government workers. To some degree, though, central government and the health sector could provide similar gains in flexibility when they introduced new mental health workers or funding into leaving care provision. The tensions between health and social work cultures were not entirely absent from these initiatives, but the professional interrelationships at lover levels were presented in overwhelmingly positive terms.

One feature in several initiatives was the greater degree of flexibility in workloads that new initiatives offered. There was not an obvious split here between statutory and voluntary sectors, even though the latter often had more organisational flexibility. In practice, workers introduced into leaving care teams seemed to have more control over their workloads and practice than, for example, the long-established Personal Advisers many were working with and supporting. They valued this flexibility. For example, supporting Personal Advisers alongside young people had been an active choice by at least two interviewees. Innovation, for these workers, meant that they effectively worked out their future role in practice. Hence their greater choice. This, of course, could benefit care leavers as well as staff.

Finally, the development of ‘trauma informed’ interventions with young people (and, indeed, adults) has become an increasingly common subject of debate throughout the social care sector in the past decade. Ascribing influence to the role of ideas in changing professional practice is notoriously difficult, but it is clear that the concept

of ‘trauma-informed’ practice influenced the value many workers placed on the initiatives they were involved in.

The language of policies needing to be ‘trauma-informed’ or ‘trauma-responsive’ was common with some workers, with the word ‘trauma’ and these related terms being used no less than 84 times across the course of the 14 interviews. Typical of a wider language of discussion of this topic is Interviewee Three:

> *When you look at complex trauma and the best way of approaching that, and given that most of, if not all of our young people have experienced complex trauma, they've had repeated types of trauma in their lives, safety, and stabilization is the foundation, really, for any sort of therapeutic work that you're doing, particularly with young people who still have quite a lot of chaos or trauma going on in their lives.*

The authorities with multiple interviewees

Here, we want to give an overall impression in relation those authorities that provided us with multiple interviews, capturing elements of the provision than can be lost in the detail of individual interviewees and individual professional practice.

Authority One:
This area provided two interviewees, a mental health practitioner seconded from an NHS mental health trust to work part-time within a local authority leaving care team, and the manager of said team. The innovative provision consisted of targeted mental health support for young people with a case open to the local authority leaving care service, delivered by a mental health practitioner seconded part-time to the leaving care service from a local NHS trust. The provision sought to be highly need-responsive and tailored and, as such, was organised according to three tiers of support intensity.

The increased leaving care mental health provision was claimed, by the interviewees, to have been an invaluable asset to both the leaving care team staff and the young people. Staff were said to have believed that the increased access to mental health support for young people and guidance in the form of clinical supervision enhanced the service offer.

There were outstanding issues that needed to be resolved which were viewed as impacting the maintenance and sustainability of the innovation. The enhanced leaving care mental health provision was delivered primarily by a single mental health practitioner and it was felt that an additional mental health professional, to share caseload and discuss complex cases with, would have been helpful.

The enhanced mental health provision for care leavers is funded under joint commissioning arrangements that which have thus far offered only short-term security for the sustainability of the innovation. Priorities for evaluation and monitoring of effectiveness sometimes differed considerably between the ICB and the local authority.

Authority Two
This area provided four interviewees. Two were from the NGO sector, one was a senior figure seconded from the local health authority and the fourth worked with both but was funded by central government as part of its 'levelling up' agenda. This latter appointment reflected the success and relative national profile of the local work being conducted.

It was clear that in this area there were positive relationships between the local authority and the NGO involved. It was also clear that the innovation on the local government side, of having a health worker introduced into the team, had been relatively recent. In contrast, the NGO interviewees felt that they had been working on care leaver mental health for many years – though it would be more accurate to describe their work as being focussed on well-being, since the language of mental health was largely absent from their discussion. Instead, the language largely focussed on promoting connection amongst young people, reducing isolation and providing a sense of community amongst care leavers.

As already noted, the interviews for this area of intervention provided different responses on the gestation, rationale and time-frame for developments. In other words, even within the same local authority area, accounts of the origins of an innovation differed markedly based on the perspective of the interviewee. This encourages a certain wariness around the rationales offered by our sole interviewees on other innovations in different local authorities.

Conclusions

One could characterise the nature of the innovations being described as either top-down or bottom up, but this tends to oversimplify and thus to mislead. It does, though, have some value in that it points to the capacity for individual workers, in some circumstances, to produce a knowledge-base that encourages fresh thinking and supports initiatives from the bottom. For top-down initiatives, it's also clear that at local authority and health service level a lot of discussion need to take place before significant initiatives, such as the appointment of specialist mental health staff, could be agreed. Bottom-up approaches to innovation thus tended to be more incremental.

Elsewhere in the EXIT project, emerging models of innovation have been of three kinds:

1. A relational model that includes an early recognition of need around mental health and wellbeing and the gradual adaption of practice to meet that need.
2. A responsive model that prioritises functional mental health and wellbeing and focusses on policy goals. This could include, for example, programmes linked to helping young people into employment by addressing mental health needs.
3. A restorative model that recognises differences between mental health and wellbeing and the different forms of support they require.

All these models, in different ways, require the building up of trust between young people and professionals and, in the best cases, strong elements of co-production. Changes in practice always produce challenges that routine responses to social

problems do not, simply due to the predictability of the latter. On a small scale, the innovations covered in this project often bore a striking resemblance to what Matt Ridley claims to be some of the core elements of innovation at a society-wide level. They are: gradual (in one case, over two decades), serendipitous (there were certainly elements of good fortune in some of these developments), involving trial and error (as some interviewees were perfectly willing to admit), a collective effort (there were no solitary innovators at work here; this was invariably a team process), working best under fragmented governance (it was notable that gaps between agencies, while producing barriers, often provided space for innovation that top-down governance frequently does not) (see Ridley, 2020, Chapter Eight).

The effectiveness of these innovations was not something that we were primarily focussed on. This is dealt with far more strongly elsewhere in the EXIT project (e.g. Johnson and Kerridge et. al.). However, since we asked about outcomes it was a topic brought up by many interviewees. Practices varied, but it was clear that all innovations had to seek to justify themselves by measuring effectiveness. There were a variety of methods, from the anecdotal to the quantitative. Interviewee reference to measuring outcomes sometimes echoed the three themes found in Johnson et. al. (2024): 1) tensions over top-level and economic outcomes; 2) variability amongst target populations (not all care leavers are facing the same pressures; for example, some of our interviewees operated in strongly urban environments whereas others were rural), 3) exploiting care leaver experiences (selective use of experiential and anecdotal data).

Finally, it would be as well to try to characterise the models we came across for work in this area:

- A specialist voluntary sector charity offering services to local authorities, incorporating mental health and wellbeing initiatives as part of their offer.
- Local authorities developing practice within their own leaving care teams.
- Local authorities working collaboratively with local voluntary sector agencies.
- Local authorities working collaboratively with local NHS provision, sometimes with seconded health workers within leaving care teams.
- A voluntary sector charity doing independent work in this area, with local authority support only in the recruitment of participants.

The selection of working model for service provision emerged as much from the logic of existing professional and agency relationships as from deliberate choice. The strongest element of choice was the logical one of local authorities choosing to link up with local health care provision to develop joint support for care leavers with a stronger focus on mental health and wellbeing.

Given our small sample, it would be wrong to suggest which models work best. The most we can do is point to some of the factors that are relevant to such decisions. The big structural factor here, because it involved differences in working cultures as well as in institutional structures, was between health and social services. At a professional level, the relationships were most constructive within secondment arrangements. This was perhaps unsurprising, as daily working relationships reduced barriers between health and leaving care workers and improved mutual understanding. More problems arose when professionals remained within separate structures. When this occurred, the lack of daily working relationships prevented the development of shared understanding and practices.

Overall, the key limitations on the effectiveness of innovative practice appeared to be the two most longstanding impediments to effective work with care leavers more generally; the structural barriers between organisations (health, education, housing and children's services) and the age-related transitions frequently operating between these same organisations (particularly mental health support).

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Appendix: Interview Topics

EXploring Innovations in Transitions to Adulthood (EXIT Study)

Stakeholder Interviews Topic Guide

Overarching aim of interview
To discuss mental health innovations for young people leaving care, including a focus on examples of such innovations and the enabling and hindering factors associated with sustaining and scaling-up innovations.

Purpose of interview

- To gather views and experiences of mental health innovations for young people looked after who are transitioning to adulthood
- To explore thoughts about the process of innovation

A. Descriptive – confirmation of role and experience

- What is your current role?
- What is your background and experience/involvement in innovations for young people leaving care who are transitioning to adulthood?
    - Strategic and/or operational delivery of services for care leavers
    - Involvement in policy-making and advocacy to inform policy
    - Evaluation of projects that aim to improve outcomes for care leavers
- Involvement in specific projects and/or policies in the last 10 years

B. Exploring the meaning of innovation

- What does innovation in this area mean to you?

C. Observations and reflections on innovation in research, policy and practice to support the mental health of care leavers in the last decade

- What is working well?
- What are the areas for development?

D. Drawing on the experiences outlined in A):

- We want to explore:

- The rationale for this initiative
- What precipitated its introduction?
- Its core aims
- What were the enablers?
- What were the barriers?
- What were the outcomes
  - Organisation
  - Professionals in Frontline Practice
  - Care leavers
- How did this project evolve?
  - Stop
  - Sustain
  - Scale
  - Spread within the locality
  - Spread outside the locality

E. Final thoughts