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Experiences From Treatment for Anxiety and Depression Among Youth in Foster Care: A Qualitative Study

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ABSTRACT

Youth in foster care are at high risk of internalizing problems. However, research is scarce regarding their experiences of mental health treatment. This knowledge is important if mental health services are to meet their needs. Through qualitative interviews, we explored the experiences of youth in foster care ($N = 9$, aged 16–18 years) having been treated for anxiety and depression. Systematic text condensation was used to analyse the transcribed interviews. The youth reported different paths to accessing treatment. They conveyed the need for therapists to build trust and demonstrate genuine care by advocating for them. They valued learning strategies to manage their symptoms and reported that to adopt these strategies, introspection and psychoeducation were necessary. Finally, they emphasized the importance of the treatment setting (e.g., outdoors versus in a traditional office setting). Findings indicate that it was arbitrary as to who helped the youth access treatment. Moreover, for youth to feel they benefitted from the treatment, certain features of the youth–therapist relationship and treatment content proved central. The findings are relevant for clinicians and policymakers within child welfare and youth's mental health services.

1 | Introduction

Children and youth in foster care have high risk of mental health disorders as well as high level of comorbidity (Ford et al. 2007; Lehmann et al. 2013; McMillen et al. 2005; Turney and Wildeman 2016). In general, internalizing disorders (e.g., depression and anxiety) are among the most commonly reported mental health disorders in children and adolescents (Polanczyk et al. 2015). Recent research has found higher levels of internalizing problems among youth in foster care, compared to youth in the general population (Bronsard et al. 2016; Moussavi, Wergeland, et al. 2021).

Mental health treatments specifically for youth in foster care are lacking (Tarren-Sweeney 2021). Interventions are identified as general programmes for the foster family (Bergström et al. 2020), as well as interventions targeting externalizing disorders, such as Treatment Foster Care Oregon (TFCO; Chamberlain 2003) and multisystemic therapy (MST; Henggeler et al. 2009). To our knowledge, no studies on the treatment of internalizing disorders have been conducted among youth in foster care in Europe (Leve et al. 2012; Luke et al. 2014). A systematic review investigating mental health interventions for children in different care contexts in the United States found five interventions that prevented or reduced internalizing problems (Hambrick et al. 2016). Another systematic review, also from the United States, examined lifetime and past-year prevalence of internalizing problems in youth in foster care who were transitioning to adulthood but did not specify types of disorders (Havlicek,

Garcia, and Smith 2013). These US-based findings may have limited generalizability to a Scandinavian setting, where the child welfare services (CWS) and mental health services are organized differently (Gilbert, Parton, and Skivenes 2011). To better meet the needs of youth in foster care with internalizing problems, more knowledge on the mental health treatment available to them is essential.

A starting point could be to explore the experiences of youth who have received treatment for internalizing problems. They may have unique treatment experiences, as they have a different background than most youth in the general population receiving treatment. User experiences have become more common quality indicators utilized as a part of health care research (Anhang et al. 2014) and required for the evaluation of health systems and the delivery of services (The Organisation for Economic Co-operation and Development [OECD] Health Ministers 2017). The UN Convention on the Rights of the Child states the child's right to participate, to express their opinions and to be listened to in issues affecting them (General Assembly Resolution 1989). Further, Norwegian law grants service users the right to influence their health care (Lovdata 2001). This is particularly relevant for youth in foster care, who may have more complex mental health profiles than their peers (Dubois-Comtois et al. 2021; Turney and Wildeman 2016).

1.1 | The Norwegian Child Welfare and Youth's Mental Health Services

The Norwegian mental health services are organized within the municipal primary health care services (e.g., the general practitioner and school/health services), for those with mild to moderate symptoms, whereas the specialist health services (i.e., child and adolescent mental health services; CAMHS) offer services to those with moderate to serious symptoms. Health care services in Norway are publicly financed, with limited use of private mental health care. Despite their increased risk, there is no established routine as to where and when youth placed in foster homes should receive mental health assessments. To identify service needs and provide timely access to mental health services, attempts have been made to strengthen the service provision and cooperation between the mental health services and the CWS for youth in alternate care (Helsedirektoratet/Barne- ungdoms- og familiedirektoratet 2017). The Norwegian government has recently approved a proposal for an interdisciplinary health assessment of children in alternate care (Norwegian Directorate for Children, Youth and Family Affairs 2022; Lovdata 2023, § 4-3a). This proposal argues that children and youth in foster care are at high risk of not receiving the mental health treatment they need.

The Norwegian CWS is responsible for children where measures must be considered to ensure their safety and development (Lovdata 2023, § 1-1). The focus of the Norwegian CWS is family-service oriented, and thus, the primary emphasis is home-based supervision and providing support for the family. If the child is exposed to maltreatment or neglect, foster care is the preferred and the most frequently used placement option in Norway (Backe-Hansen et al. 2019; Kjelsaas et al. 2020). Although youth in foster care have encountered adverse life events, it is important to underline their strengths and resilience in overcoming challenges and continuing developmental growth.

1.2 | Access and Utilization

Recent research on youth in foster care suggests that different types of maltreatment (e.g., neglect or physical, emotional or sexual abuse) have a cumulative effect and specific associations with various internalizing symptoms (e.g., panic/agoraphobia, generalized anxiety and depression symptoms; Moussavi, Breivik, et al. 2021). Given the increased risk of earlier maltreatment among youth in foster care, it is important to assess each youth's mental health status and to ensure the availability of timely services. This is also relevant when aiming to understand how youth in foster care access mental health services and how they perceive the treatment they receive. Importantly, research has found that the majority of youth in foster care who have mental health problems is not in contact with CAMHS (Larsen et al. 2018). Assessing access to and use of mental health services among youth in foster care is important, as mental health problems in childhood often reoccur and may last into adulthood.

Prior research has identified facilitators of access to and utilization of mental health services for youth. Based on the experiences of former youth in care ($N = 60$), one study found that facilitators of mental health service use could be professionals or family members who helped and motivated them to continue or access services (Munson et al. 2011; Munson and Lox 2012). Among the identified factors related to service use were the youth's emotions, insight into their mental health needs and mistrust of health care personnel. The researchers stress the importance of fostering and maintaining trust to keep the youth engaged in the services. Furthermore, other factors found to influence the health care utilization of youth in foster care are entry to care, stability and disruption of the foster care placement (Beal et al. 2022). However, due to lack of or inaccurate information, it is often unclear whether the health care utilization is according to the needs of the youth (Beal et al. 2022; Raghavan, Brown, and Allaire 2017).

Research has also examined barriers to access to and utilization of mental health services. A review by Aguirre et al. (2020) found that stigma and negative beliefs toward mental health services and professionals impeded help-seeking behaviour among youth (aged 10–19) with internalizing symptoms and general symptoms of mental illness. Mental health stigma among adolescents is complex, especially considering their developmental phase. Stigma encompasses a range of aspect, such as perceptions of and knowledge about mental health and treatment; identity development, including ethnicity, culture and gender; and public and individual self-stigmas (DeLuca 2020; Kranke et al. 2011). Research has also found that adolescents with more internalizing symptoms are less likely to seek help (Sawyer et al. 2012). Furthermore, research indicates that youth who have experienced cumulative adverse childhood experiences are less likely to access and receive quality mental health care services (Schweer-Collins and Lanier 2021). We lack similar knowledge about barriers to treatment among youth in foster care and their caretakers.

Adults function as 'gatekeepers' or 'gateway providers' in terms of youth's access to health services, and thus, they can inhibit or facilitate access to mental health services (Stiffman, Pescosolido, and Cabassa 2004). A review identified parents' perceived barriers and facilitators to accessing psychological treatment for their youth (Reardon et al. 2017). Four themes were identified: parents' perceptions of the services and treatments; parents' mental health literacy; parents' knowledge about the help-seeking process; and family circumstances (e.g., responsibility for and commitment to following up with the child). These findings highlight the complexity of factors that influence whether parents seek mental health services for their children or adolescents. However, the review did not focus on youth in foster care.

1.3 | Objectives

This study aimed to explore the experiences of youth in foster care regarding their access to mental health treatment for internalizing symptoms, as well as their experiences of the treatment they received.

2 | Methods

2.1 | Design and Procedure

This study had a qualitative design comprising interviews with youth in foster care. Inclusion criteria were youth (a) of any sex, (b) who had lived in a foster family for a minimum of 6 months, (c) currently resided in Norway, (d) between 16 and 18 years old, (e) who had experienced symptoms of anxiety and/or depression (i.e., internalizing symptoms) and (f) who had experienced internalizing symptoms between 0 and 3 years prior to inclusion in the study and having received treatment from primary health care or CAMHS. Exclusion criteria included having been hospitalized for psychiatric problems within the previous year.

Youth were recruited through extended network ($n = 2$) and user and private organizations ($n = 7$) for children within CWS. Information about the study was given to the organizations that forwarded information to youth, who could either contact the project leader themselves or make contact through the user organization. In addition, an information ad was shared on social media, so that youth could reach out to the project leader ($n = 0$). A total of nine youth was included. See the flowchart in Figure 1 for additional information on the recruitment process. All youth received a gift card of 300 NOK (approximately 35 USD) as compensation for their time.

To plan and assess the number of informants, we employed a model of information power as proposed by Malterud (2017). This model suggests five factors to consider when planning the number of informants in qualitative studies. The first factor is a narrow study aim. The second is to have a specific sample. Both factors indicate that we needed a limited sample (i.e., youth in foster care who had received treatment for internalizing symptoms). The third factor concerns theoretical framework, in which we used psychological theories from developmental psychopathology. In this perspective, the youth's development is shaped by an interaction of risk and protective factors (often referred to as the socioecological transaction model; Bronfenbrenner 1986). The fourth factor is that the dialogue is considered to be strong, which also indicates a need for a more limited sample. A strong dialogue involves focused and clear communication between the interviewer and the participants, among others influenced by the interviewer's experience and competence with the topic of interest (Malterud, Siersma, and Guassora 2016). Finally, Malterud (2017) recommends having a strategic sample representing both sex and geographical location. Based on these factors, we decided that interviewing 10 youth in foster care was sufficient to explore the research question.

The semistructured interviews were conducted individually with five youth. A conjoint interview was carried out with two youth. However, in this interview, the accounts of one participant

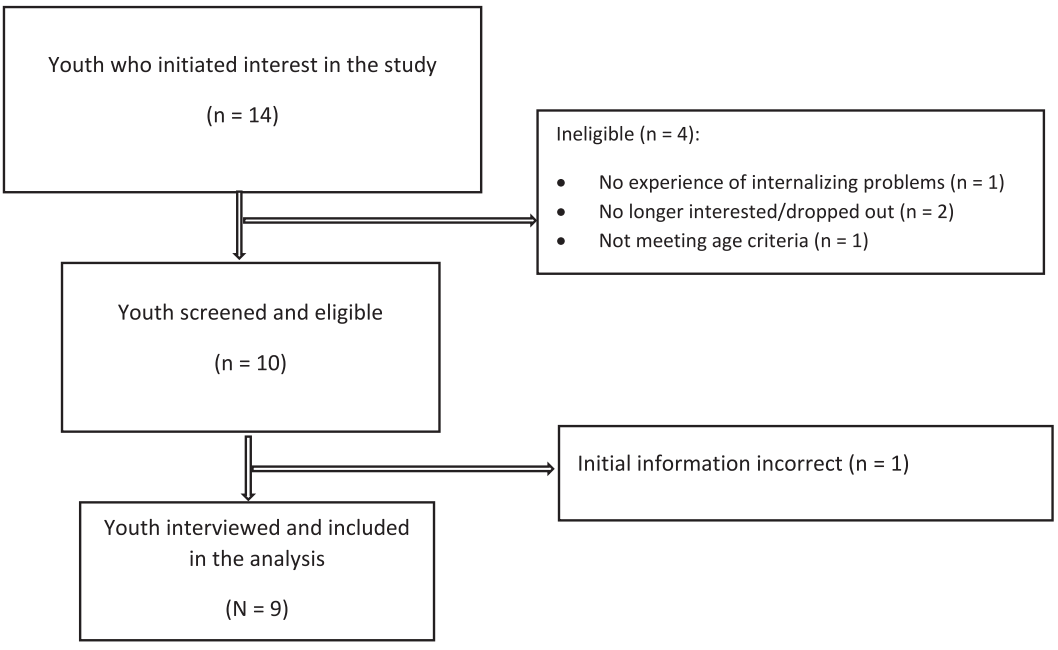

FIGURE 1 | Flowchart for information on the recruitment process.

were not included in the study as s/he did not fulfil the inclusion criteria. Lastly, one conjoint interview was conducted with three youth, according to their own wishes. Responses from all three were included in the study.

An interview guide was developed including the following topics: a brief description of the problems for which the youth had sought help and how the youth understood these problems; how anxiety and depressive symptoms affected their everyday life; how the youth accessed mental health services and what type of help they received; their experience of a 'typical' treatment session; helpful and nonhelpful experiences/tools during treatment; and how this might have affected their coping. The interview guide was used flexibly throughout the interview process, to accommodate new topics that surfaced in relation to the youth's treatment experiences. At the end of each interview, the interviewer asked about the youth's experiences with the interview process.

The interviews were conducted in person, at a place selected by the youth: for example, in the foster home ($n = 1$), at the interviewer's workplace ($n = 1$), in a park ($n = 1$) and in an activity facility (e.g., a recreational cabin in the mountains or countryside; $n = 6$). All interviews were conducted, audio recorded and transcribed verbatim by the first author. The youth met the interviewer once, and this meeting consisted of two parts. The first part comprised a brief oral screening, developed for this study, examining whether the youth were eligible for participation. The youth reported their demographics, placement history and type of health care (physical or psychological) they had received. They were then asked to write in detail all mental health treatments they had received, for any condition, as well as the treatment focus and methods: This could be medical treatment, crisis intervention or individual or group psychological therapy. Furthermore, the youth were asked how they perceived the terms 'anxiety' and 'depression', to determine whether their understandings corresponded with the clinical meaning of these terms. If a youth was evaluated as not eligible for the study, the meeting would end. If eligible, the youth gave their written informed consent to continue to the second part: the semistructured interview. All youth but one were included after completing the screening.

The first author (YM), a clinical psychologist, conducted the screenings and interviews from July to August 2020. Each interview lasted between 60 and 90 min. The last author (SM), an academic physiotherapist with extensive experience in qualitative methods, was involved throughout the analysis process. The other authors (BSMH, GJW, and SL) are academics and specialists in children and youth clinical psychology or psychiatry. BSMH entered the analytical process during the creation of the superior themes. GJW and SL were involved with the project after the analysis was completed. The transcriptions were imported to and organized in the software program NVivo 12 (NVivo 2020).

2.2 | Analysis—Systematic Text Condensation (STC)

The analysis was conducted via STC, a thematic cross-case analysis strategy developed by Malterud (2012). This process entails four steps and aims to illustrate participants' experiences through their direct descriptions. In the first step, the first and last authors acquired an overview of the youth's experiences. After individually reading through the transcriptions, they listed six to eight possible themes that had caught their attention. These were discussed, merged and labelled as five temporary themes. In the second step, meaning units were extracted from these themes and categorized into codes. Overlap between themes indicated imprecise themes, eliminating two themes. Through an iterative process, three main code groups were created. Meaning units were decontextualized from their original context but still represented the content of their code group. In the third step, the first, second, and last authors developed subcategories for the three code groups. Within each subcategory, an artificial quote—a condensate—was created to represent the collective opinions of the participants regarding that specific theme. The second author was involved in this step to ensure that other perspectives were considered and to make any necessary modifications to the code groups. In the fourth and last step, the condensates were synthesized into final descriptions and themes capturing the youth's experiences of treatment for internalizing problems. These are presented as the results. To ensure that these final themes were still aligned with the youth's initial expressions, the first, second, and last authors read through the transcriptions; in this way, they were able to assess whether the themes stayed true to the original context they were taken from.

The interviewer (YM) and co-researcher (SM) documented their preconceptions prior to the interviews. These preconceptions were then utilized during the analysis to prevent bias and ensure that the findings were not influenced by anticipated results.

2.3 | Ethical Considerations

The Regional Committee for Medical and Health Research Ethics, Western Norway, approved the study (REK Vest ID, no: 7225). In accordance with the Norwegian ethical requirements, only individuals capable of giving consent were included. Youth aged 16 to 18 years provided written informed consent on their own behalf. The data were encrypted and saved on a safe server, following the Norwegian Research Centre's (NORCE) guidelines. Data were anonymized at the end of the project. To ensure that the research questions, methods and procedures were meaningful, we collaborated with the user organizations Norwegian Foster Care Association (NFF) and the Norwegian Organization for Children in Care (LFB) in the initial planning of the study.

Interviewing about sensitive issues risks triggering difficult emotions, thoughts and/or symptoms. To prevent potential harm or a worsening of the youth's mental state, we considered this risk for each of the youth when assessing eligibility for participation in the study. We also requested that each youth provide the name and phone number of someone they trusted (i.e., their CWS caseworker; their general practitioner; someone in the school health services; or someone in their network, other than their biological or foster parent[s]). A procedure was established to provide assistance to any youth who required it following the

interview. However, this did not prove necessary. Moreover, all participants were invited to contact the interviewer after the interviews, but none did.

It was essential to create a safe space, with sufficient time and opportunity for the youth to express themselves. Semistructured individual interviews were deemed a suitable way to achieve this. It was also hoped that the interviewer's competence and experience as a clinical psychologist would help create an atmosphere of trust and safety.

No participants reported feeling emotionally upset during or after the interview. Most participants expressed that they felt unsure at the beginning of the interview but soon felt safe and that the interview turned out to be a good experience. Most participants reported that they had seldom been asked about their treatment experiences and that they felt valued and taken seriously throughout the interview.

3 | Results

First, we report on sample characteristics, and then we present the three major themes: various paths to access treatment; treatment experiences and the youth–therapist relationship; and treatment context and conditions. Each theme is presented with a concise analysis and relevant quotes.

3.1 | Sample

The mean age of the youth ($N = 9$; 5 girls and 4 boys) was 17 years. Most of the youth ($n = 6$) reported having been in the care of the CWS for more than 5 years. The majority was in foster care at the time of the interview. Most ($n = 6$) were not currently in treatment for anxiety or depression. Still, when asked whether they had ongoing internalizing symptoms, most of them reported persisting symptoms such as recurrent anxiousness and rumination over their future and their living arrangements. All youth had experiences with CAMHS at least once, from the age of approximately 12 years onwards. Half ($n = 5$) reported having been in contact with primary health care services at various times during their teenage years, but not necessarily due to internalizing problems. None of the youth reported having experiences from group therapy.

3.2 | Various Paths to Access Treatment

The youth reported various paths to accessing treatment for their internalizing problems. It appeared to be arbitrary as to who assisted them in accessing treatment. One youth described how a teacher was his access to further treatment:

> One of my teachers at school noticed that I wasn't like I always used to be. She asked me what was going on, and I told her about my fears and sadness. We had a good talk and planned how I could get further help.
>
> [William, 18 years old]

Other individuals who helped them access treatment included members of their biological family, foster parents, members of the health care service and workers within the CWS. Some participants also reported having accessed treatment through their own initiative. Most reported that their problems were initially observed by various adults in their lives. As one youth stated:

> My grandparents took me in after my parents could not take care of me. When I moved in, they told me I should see a psychologist because of all the things I had experienced. So, I started to go there to talk about what happened to me and my family.
>
> [Maya, 16 years old]

Access to treatment was often initiated once the problems had grown severe, as we see with Maya, who had experienced increasing difficulties over the years before being referred to treatment. Several of the youth revealed experiencing years of problems before treatment was accessed. This was reported regardless of the type of problems, for example, learning difficulties, untreated post-traumatic symptoms after aversive experiences.

3.3 | Treatment Experiences and the Youth–Therapist Relationship

3.3.1 | Caring and Building Trust

When a therapist assured confidentiality, particularly early on, the youth expressed that this fostered trust—in the therapist and the treatment setting. However, many of the youth reported being unaware of their therapist's duty of confidentiality. Consequently, this hindered them from being open and honest about different situations in the past, such as experiences related to their foster care placement. In the interviews, the youth mentioned having been betrayed by adults in their biological family, their foster family, the CWS and/or the health care system. Trusting others was described as complicated, as illustrated by one of the youth:

> I've felt betrayed by many, so I do not easily open up. One time, however, I decided to trust a therapist who seemed to be understanding, but when I later read what she had written about me, I realized so much was untrue and used against me in court.
>
> [Katherine, 16 years old]

All nine youth expressed how their relationship with the therapist had influenced their perception of the treatment sessions. They emphasized the importance of the therapist's ability to tolerate diverse or negative emotions, like anger and sadness, or even silence. Moreover, concrete actions or initiatives from the therapist were helpful in establishing a safe relationship during the sessions. Such actions included going for a walk, meeting in another context than the office or playing a board game while talking. Kind gestures and concrete signs of caring were emphasized as important and could take place at the beginning of or throughout therapy. Examples included the therapist bringing ice cream for a session or driving the youth back to school after sessions. The youth underscored how these actions humanized

the therapist and allowed them to get to know the therapist. Through these actions and signs of caring, trust was steadily built, enabling them to gradually open up:

> The setting is so unnatural in the first place and I'm so self-conscious about what to say and not. It felt more natural with those who took me out for walks or a drive like it was a more normal situation. It helped to do something active rather than just sitting still and talking.
>
> [Jacob, 18 years old]

This quote illustrates how the therapy setting made the youth uncomfortable and that activities normalized the situation, making the youth feel more secure.

3.3.2 | Psychoeducation

Psychoeducation, where the youth learned about their own symptoms or disorder, was described as helpful. This enhanced their willingness to employ strategies like exposing themselves to their fears or anxieties (i.e., exposure therapy) or doing activities that were not always easy or tempting (i.e., behavioural activation):

> I've learned about a triangle that helps me remember that how I think affects how I feel and how I feel affects how I behave, and again—how I behave affects my thoughts and feelings. It also helped to learn that for my body and brain to function in the first place, I have to eat, sleep, and exercise—if I skip one of those things, the rest will not work.
>
> [Laura, 18 years old]

This youth is describing how she learned about the cognitive model to take care of her health. The quote also illustrates the importance of how knowledge about the disorder affects well-being and how to cope with the symptoms.

3.3.3 | Strategies to Manage Internalizing Symptoms

The youth learned to express themselves through creative tasks and to take care of their own mental and physical health through activities such as dancing, handball, football, jogging, drawing or music. Their relationship with and the actions of the therapist were crucial for the youth's ability to learn and apply concrete tools and strategies to manage symptoms of anxiety and depression. Strategies learned in treatment included how to ask for help, or actions to reduce tension, as well as techniques for distraction and relaxation. As illustrated by one youth:

> I learned that when I had many chaotic thoughts, it could help if I distracted myself with activities I enjoy. For example, when I notice that I get all these thoughts in my head, I draw colorful paintings or listen to music to relax.
>
> [Maya, 16 years old]

For this youth, learning that there are healthy ways to cope with difficult thoughts was helpful.

3.3.4 | Introspection

The therapist's ability to help the youth understand their inner self and to relate this to past experiences was described as having a significant impact on the youth's current life situation and well-being. The youth highlighted the value of introspection, where they sought to understand themselves better by analysing their emotions, thoughts and motivations. Psychoeducation was an important part of this introspection and entailed being educated in understanding the function and dynamics of anxiety and depression symptoms, PTSD, or other relevant mental illnesses.

> I do not easily trust people, but the therapist seemed so genuine and knowledgeable and helped me understand what was going on with me. She told me I was in a state of constant emergency, like a red alarm going off all the time, and that is why I shut down everything around me and I keep to myself. When I finally understood this and managed to talk about it all, she also helped me understand what I needed to work on, and that was helpful.
>
> [Katherine, 16 years old]

Here, Katherine is expressing her experience of personal and mental health insight through sessions with her therapist. Having a caring therapist who educated her about her mental disorder and its implications played a crucial role in her progress and willingness to take further steps in the treatment process.

3.3.5 | The Therapist Advocating for the Youth

The youth reported feeling respected, seen and valued when the therapist acted on their behalf, like an advocate, to solve problems in their everyday life outside of therapy. Examples include therapists who referred them for treatment for other mental or physical health problems, ensured that they received pedagogical support at school, intervened to solve problems in the foster home or helped them move due to difficult living situations in the foster home. Receiving this kind of support made the youth feel like they were being taken seriously. This was a feeling that was new to some of them, as they had grown up without adults who would take the necessary steps to improve their living conditions. One of the youth explained:

> I've spent my whole life in the same foster care—it's the only family I know. But bad things were happening there, and I did not dare to tell anyone. I even had the same social worker since I was three years old who came for her mandatory visits, but my foster parents were sitting in the same room. Finally, when I was 15 years old, I told a psychologist I had begun to trust what was going on at home. He called

> the CWS, asked many questions on my behalf, and stood up for me. They say we have a voice in the CWS, but I never experienced that until I met him—he was on my team. Eventually, I moved out and things have gotten better.
>
> [Jacob, 18 years old]

This quote exemplifies the importance of therapists who translate words into action and actively address the youth's concerns. This is particularly meaningful for youth who have grown up with caretakers who have failed to take responsibility or accurately identify problems.

3.4 | Treatment Context and Conditions

Some of the youth experienced their foster home as unstable, highlighting the necessity of having a stable, safe base in order to benefit from psychological treatment. They emphasized that having an unstable foster home could hinder access to health care as well as recovery from symptoms. Examples of an unstable foster home were foster parents who frequently distrusted them and not being believed when expressing a need for help and treatment. It could also be that a complex situation regarding the foster home (e.g., conflicts between family members or uncertainty regarding the duration of stay) hindered the youth from receiving (further) help until the context had stabilized. Thus, instability, uncertainty and conflicts within the foster home were perceived as obstacles to receiving treatment or follow-up in CAMHS. The youth also described having foster parents be present in their treatment sessions was disturbing. This is exemplified by the following quote from two girls who had extensive experience with CAMHS and living in foster homes:

> I had a foster mother who made CAMHS believe that what was a problem to me wasn't a real problem. She told everyone I wanted attention. Every time I managed to get a psychologist or someone to listen to me, she would tell them I was lying. Eventually no one was listening to me. Because they were my 'pretend parents', I feel like CAMHS had to listen to them over me. My foster parents stood in my way of getting the help I needed.
>
> [Sophie, 18 years old]

> For a long time, my foster mother even joined all the therapy sessions, which made it hard for me to open up to the psychologist. Especially after I had been honest with her about how ill I was, and she told everyone that she could not continue to look after me. I felt so betrayed by my foster mother and CAMHS.
>
> [Laura, 17 years old]

In these quotes, we see how the conditions in the foster home and the relationship between the youth and the foster parents are critical, both for enabling treatment and for the youth to benefit from it.

The youth also emphasized several other aspects that are important in treatment, such as the frequency of meetings, prompt assistance and flexibility in the treatment context. Frequent meetings were depicted as helpful in creating stability in their relationship with the therapist—and in their overall life situation. However, flexibility in deciding *how* frequent the sessions should be was also valued, as it gave the youth a sense of involvement in and commitment to the therapy that was unforced. Flexibility in the treatment condition could manifest in various ways, such as allowing the youth to determine the duration of the session or giving them the freedom to choose the topics to be discussed. The frequent change of therapists was experienced as disruptive to the treatment process. It made it difficult for the youth to open up and establish a new connection with each new therapist. The constant turnover of therapists added to the existing instability in their lives, stemming from various sources—including disruptions in their foster home or placements, as well as restrictions around meeting their biological family. Instability was expressed as an especially important barrier for optimized treatment and services for the youth in foster care. As one informant articulated:

> I've had nine different caseworkers in the CWS, and too many different therapists. Once I start to trust and learn to open up, I've been moved into a new foster home, the therapists quit their jobs, or when I turned 18 years old, I was immediately moved to the adult psychiatric department.
>
> [Sophie, 18 years old]

The youth depicted many sides to instability, both within and outside the treatment context, and how this instability and inflexibility are not beneficial for their development in the treatment process.

4 | Discussion

In this study, we explored how youth in foster care accessed treatment for internalizing problems as well as their experiences of the treatment they received. The first theme, paths to accessing treatment, showed that there were many ways of accessing treatment, suggesting that getting into treatment may be somewhat arbitrary. In the second theme, the importance of experiencing the therapist as someone who is genuinely caring was necessary to build trust in the therapeutic relationship. Psychoeducation focusing on their reactions, emotions and thoughts, as well as learning strategies to deal with their internalizing problems, were further emphasized in the second theme. Certain youth expressed the importance of introspection, indicated curiosity about their well-being and a desire to comprehend their past. Therapists who stood up for them and acted on their behalf were highly valued. The youth also appreciated therapists who helped them solve practical problems in their everyday life. This made them feel seen and heard. In the third theme, referencing the impact of instability in the foster home and the conditions surrounding the treatment, the importance of having frequent (but flexible) therapy sessions was highlighted.

4.1 | Access to Treatment

Our finding that the youth's access to treatment seems to be arbitrary indicates that there is no straightforward access to mental health services for youth in foster care having internalizing problems. This arbitrariness may partly be due to the many barriers to accessing mental health services for youth in general (Gulliver, Griffiths, and Christensen 2010; Kazdin 2000), and particularly for those with anxiety (Salloum et al. 2016) and depression (Wisdom, Clarke, and Green 2006). This is concerning, as evidence suggests that mental health problems among youth in foster care may have harmful effects on the youth's development and social well-being (Asselmann et al. 2018; Layard et al. 2014).

Our findings are in line with previous research demonstrating that, among other factors, disruptions of and instability in placement of foster youth impact the youth's service utilization (Beal et al. 2022). From our findings, it seems that many youth have received mental health care after their internalizing problems have grown more severe over time or at the time when they have been moved from one home to another. Also, the treatment they receive is not necessarily adjusted to their complex history or current life situation.

Youth in foster care have had a range of adults involved throughout their childhood, including CWS caseworkers and teachers, and do not necessarily have adults in their life who know them well (e.g., their history and needs). Thus, it may be more arbitrary as to who recognizes changes in the youth or difficulties they may be experiencing and initiates further help. In addition to this, they have had changes in their primary caregivers, from biological to foster parents. The role of primary caregiver may for some vary between foster and biological parents, as foster parents do not possess full legal rights toward the youth. Foster parents' function as gatekeepers for access to treatment is crucial (Schneiderman and Villagrana 2010) but may be limited by the CWS where the caseworker may also assess the need for treatments. Consequently, youth in foster care have more complicated paths toward receiving adequate health services. This may be reflected in our finding that youth's access to mental health treatment appeared to be arbitrary. Rather than relying on the more arbitrary processes of accessing treatment, integrating screening procedures and referrals in to the CWS system could be beneficial to identify those in need of mental health care services in time (Cocker, Minnis, and Sweeting 2018; Hayek et al. 2014; Pullmann et al. 2018).

4.2 | Youth–Therapist Alliance

Alliance refers to the agreement about goals and tasks in therapy, in addition to the development of a bond between therapist and patient (Bordin 1979). It is considered a crucial aspect of therapy and plays a decisive role in overall progress (McLeod 2011). Research shows that the patient–therapist alliance is significant for predicting long-term outcomes in cognitive behavioural therapy (CBT) for anxiety disorders in youth (Fjermestad et al. 2016). A recent study of youth in foster care who attended a support programme described the quality of the relationship with the staff as impactful. The staff was experienced as not only professionals offering their services but also as carers with whom the youth developed authentic bonds (Wesley et al. 2020). Furthermore, a study among youth in foster care showed that distrust from past therapeutic relationships can affect motivation concerning future therapeutic involvement (Narendorf et al. 2021).

In the present study, the youth's relationship with the therapist seemed to be especially important. Many of the youth expressed their uncertainty toward adults, independent of role (e.g., foster parents and CWS caseworkers alike), perhaps rooted in previous relational experiences. Given the youth's history of severe family instability and/or maltreatment, it is crucial that therapists establish a safe, secure relationship with them. This foundation may be essential to allow for the utilization of more targeted treatment strategies to alleviate symptoms of anxiety and depression.

4.3 | Psychoeducation

All youth stressed their curiosity about and need to understand their own mental health problems. Receiving psychoeducation about their symptoms made them regard the therapist as competent, trustworthy and attentive. Psychoeducation thus proved important, both for building trust in the therapist and to test strategies the therapist suggested for coping with their anxiety and depression symptoms. This finding corresponds with previous research showing that even passive psychoeducational interventions, such as information leaflets or feedback from psychological screenings, may reduce symptoms of depression and psychological distress (Donker et al. 2009). Another study of youth in foster care highlighted that, among other things, psychoeducative tasks could empower the youth (Narendorf et al. 2021).

4.4 | Strategies to Cope With Anxiety and Depression

Many of the youth found the CBT techniques they learned in treatment to be helpful, which aligns with the robust evidence supporting the efficacy of CBT in treating anxiety and depression among youth (Higa-McMillan et al. 2016; Weersing et al. 2017; Wergeland, Riise, and Öst 2021). CBT commonly includes various interventions such as psychoeducation, cognitive restructuring, problem solving, exposure training, behavioural activation, social skills training and relaxation techniques (Gosch et al. 2006; Weersing and Brent 2006). However, the existing evidence supporting the effectiveness of CBT for internalizing disorders primarily focuses on youth who are not in foster care. Therefore, further studies investigating CBT in this population are needed.

Moreover, the youth expressed the usefulness of physically activating tasks, such as jogging or handball, as well as creative tasks (e.g., drawing/painting or music), tension-reducing techniques and breathing exercises (e.g., mindfulness). They also described it as useful to focus on activities they had previously been interested in or mastered. The youth described distressing thoughts

and emotions related to stressors in their past and present lives. Concrete strategies that enabled them to refocus and experience mastery were helpful. This is supported by a previous study of youth in foster care, in which arts-based methods in mindfulness therapy were applied (Lougheed and Coholic 2018). The youth in this study reported increased optimism, better emotion regulation and improved sleep and found art to be an effective learning strategy.

4.5 | Introspection

Youth in the present study seemed to need attention inward to comprehend their thoughts and feelings. While established treatments for internalizing problems, such as CBT, to a large degree focus on concrete strategies to master anxiety or depressive symptoms, the youth in this study tried to understand their symptoms in the context of their life experiences. This might be because youth in foster care have a more fragmented life story and need to be more independent at an earlier developmental stage. A previous study reports that leaving foster care in late adolescence influenced youth's identity development, stimulating their maturation process, sense of self and their need for introspection (Mulkerns and Owen 2008). Thus, including introspection and understanding the relationship between past experiences and present symptoms might help youth come to terms with a fragmented life history, to explore their feelings and identity and to mentally prepare them for a life independent of the foster family.

4.6 | Advocacy

The youth in the present study described problems that are unique to youth in foster care, such as being taken seriously by the CWS regarding their foster care situation, not being allowed to contact their biological family without permission or being present in court when custody decisions are made. Therapists or caseworkers who supported the youth in these situations, acting on their behalf and being their advocate, were highly valued. This is in line with other research highlighting the importance of social workers' commitment, accessibility and recognition when interacting with youth in foster care (Križ and Roundtree-Swain 2017). Although CWS caseworkers or others may have intervened to improve the youth's life situation, the youth expressed that few adults had engaged them in a way that made them feel like what mattered to them was prioritized. These findings are supported by other studies finding that the youth reported not feeling seen or heard by CWS workers (Toros 2021).

4.7 | The Role of Foster Care

Our finding that factors in the youth's foster care (e.g., unstable or high-conflict foster homes) might hinder their access to or ability to benefit from treatment is critical. The youth's relationship to the foster parents is important, as previous research finds that youth placed in foster care who report positive relationships with their foster family also have higher life satisfaction (Mabille et al. 2021). The CWS has a crucial role in providing follow up for youth in foster care and to ensure a good life situation in their foster family. In that way, CWS caseworkers may contribute to enabling the youth to benefit from treatment.

4.8 | Flexibility

The youth in this study conveyed the importance of having flexibility in treatment. While flexibility in treatment is generally practiced in the health and child welfare services today, there may be a need for even greater flexibility when engaging with these youth in various clinical settings. More specifically, this flexibility is desirable, especially when establishing the initial relationship in therapy, with more time and effort to establish a secure relationship. It may also be crucial to go beyond traditional therapy structures: For example, the therapy session could take place outside of the office or the therapist could initiate an activity during the session.

5 | Strengths and Limitations

Given the challenges of recruiting youth in child welfare, including the experiences of nine participants is considered sufficient to fulfil this study's objective. Nevertheless, the study has some limitations. The plan was to conduct individual interviews. However, three youth preferred to conduct the interviews together. Although this was based on their preference and may have helped to spark insights and/or make the interview setting feel safe, it may also have impacted the findings. The youth might have withheld information and been influenced by each other's presence. Also, one youth was interviewed although the interviewer specified the participant's ineligibility. Together, this may reflect the need for even more strict screening. Furthermore, the youth in this study were included only if they were not seriously physically or mentally ill at the time of the interview or had not been so during the past year. The main reason was due to the endorsement of the Regional Committee for Medical and Health Research Ethics, Western Norway. Their position was that these youth may be considered even more vulnerable if recently hospitalized and should be protected from potential harm or increased risk of suicidality following the interview, potentially triggering strong emotions. This biased the sample toward youth with mild to moderate symptoms of anxiety and depression.

The participants represent a selected sample of youth in foster care. It is likely that there are youth in foster care with internalizing problems but who do not identify with our findings. Most of the participants expressed negative experiences from being in foster care, but more positive experiences from being in therapy. Other youth in foster care may have negative experiences in both foster care and with therapists, or on the contrary positive experiences both with foster care and therapy. The present study does not reflect all these differences. In hindsight, the interview guide should have included questions concerning aspects of foster care that may have influenced the youth's access to treatment and/or the youth's perceptions of treatment. These topics could have added another layer to the discussion of this study. Moreover, as the data in this

study were based on self-reports and no health or foster care records could verify the youth's information, we have no way of validating the information gathered (e.g., at what time the treatment was conducted or reasons for referral to treatment). Despite these limitations, the results contribute valuable insights, given the lack of studies focusing on treatment experiences among youth in foster care.

6 | Conclusions

The finding of the current study emphasizes the importance of using routine assessments to evaluate internalizing symptoms among youth in foster care. Priority admissions' guidelines for children and youth in the protection of CWS to mental health treatment may be worth considering. Together, this could ensure more reliable and less arbitrary referral procedures for those requiring treatment. The results also point to the importance of adapting interventions for this group, as they have diverse, multifaceted needs that must be met when they are being treated for internalizing problems. Therapists should focus on maintaining relational stability toward youth in foster care and ensuring flexibility in treatment. These youth also seem to appreciate flexibility in treatment, for example, the frequency and duration of meetings and the therapy setting, as well as having adults who advocate for them. Further research on the treatment experiences of youth in foster care is warranted. The youth's context with the instability of adults and placements (CWS workers, foster parent) seems to affect access to treatment and have a negative impact on the youth's experiences with mental health services and benefits of treatment. Thus, these areas are important to consider when ensuring stability in the treatment.

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Ethics Statement

This study was approved by the Regional Committee for Medical and Health Research Ethics, Region West, Norway (REK Vest ID no: 7225).

Consent

Informed consent was obtained from all individual participants included in the study. Participants have consented to the submission of results obtained from their reports.

Conflicts of Interest

The authors declare no conflicts of interest.

References

Aguirre, V. A., I. S. S. Cruz, J. Billings, M. Jimenez, and S. Rowe. 2020. "What Are the Barriers, Facilitators and Interventions Targeting Help-Seeking Behaviours for Common Mental Health Problems in Adolescents? A Systematic Review." *BMC Psychiatry* 20, no. 1: 293. https://doi.org/10.1186/s12888-020-02659-0.

Anhang, P. R., M. N. Elliott, A. M. Zaslavsky, et al. 2014. "Examining the Role of Patient Experience Surveys in Measuring Health Care Quality." *Medical Care Research and Review: MCRR* 71, no. 5: 522–554. https://doi.org/10.1177/1077558714541480.

Asselmann, E., H. U. Wittchen, R. Lieb, and K. Beesdo-Baum. 2018. "Sociodemographic, Clinical, and Functional Long-Term Outcomes in Adolescents and Young Adults With Mental Disorders." *Acta Psychiatrica Scandinavica* 137, no. 1: 6–17. https://doi.org/10.1111/acps.12792.

Backe-Hansen, E., I. Kjelsaas, A. Bruvoll, D. Ellingsen, N. B. Westberg, and M. K. G. Guldvik. 2019. "Oppfølging av fosterhjem og fosterbarn [Follow-Up of Foster Care and Foster Children]." (112/2019).

Barne- ungdoms- og familiedirektoratet [Norwegian Directorate for Children, Youth and Family Affairs]. 2017. "Oppsummering og anbefalinger fra arbeidet med helsehjelp til barn i barnevernet [Summary and Recommendations From the Work With Health Care for Children in Child Welfare]." Accessed 19 November 2021, https://bibliotek.bufdir.no/BUF/101/Oppsummering-og-anbefalinger-fra-arbeidet-med-helsehjelp-til-barn-i-barnevernet.pdf.

Barne-, ungdoms- og familiedirektoratet [Norwegian Directorate for Children, Youth and Family Affairs]. 2022. "Tverrfagleg helsekartlegging av barn i barnevernet [Interdisciplinary Health Assessment of Children in Contact With Child Welfare Services]." Accessed 29 May 2023, https://www.bufdir.no/prosjekter/tverrfaglig-helsekartlegging/.

Beal, S. J., R. T. Ammerman, C. A. Mara, K. Nause, and M. V. Greiner. 2022. "Patterns of Healthcare Utilization With Placement Changes for Youth in Foster Care." *Child Abuse & Neglect* 128: 105592. https://doi.org/10.1016/j.chiabu.2022.105592.

Bergström, M., M. Cederblad, K. Håkansson, et al. 2020. "Interventions in Foster Family Care: A Systematic Review." *Research on Social Work Practice* 30, no. 1: 3–18. https://doi.org/10.1177/1049731519832101.

Bordin, E. S. 1979. "The Generalizability of the Psychoanalytic Concept of the Working Alliance." *Psychotherapy (Chicago, Ill.)* 16, no. 3: 252–260. https://doi.org/10.1037/h0085885.

Bronfenbrenner, U. 1986. "Ecology of the Family as a Context for Human Development: Research Perspectives." *Developmental Psychology* 22, no. 6: 723–742. https://doi.org/10.1037/0012-1649.22.6.723.

Bronsard, G., M. Alessandrini, G. Fond, et al. 2016. "The Prevalence of Mental Disorders Among Children and Adolescents in the Child Welfare System: A Systematic Review and Meta-Analysis." *Medicine* 95, no. 7: e2622. https://doi.org/10.1097/MD.0000000000002622.

Chamberlain, P. 2003. "The Oregon Multidimensional Treatment Foster Care Model: Features, Outcomes, and Progress in Dissemination." *Cognitive and Behavioral Practice* 10, no. 4: 303–312. https://doi.org/10.1016/S1077-7229(03)80048-2.

Cocker, C., H. Minnis, and H. Sweeting. 2018. "Potential Value of the Current Mental Health Monitoring of Children in State Care in England." *The British Journal of Psychiatry* 4, no. 6: 486–491. https://doi.org/10.1192/bjo.2018.70.

DeLuca, J. S. 2020. "Conceptualizing Adolescent Mental Illness Stigma: Youth Stigma Development and Stigma Reduction Programs." *Adolescent Research Review* 5, no. 2: 153–171. https://doi.org/10.1007/s40894-018-0106-3.

Donker, T., K. M. Griffiths, P. Cuijpers, and H. Christensen. 2009. "Psychoeducation for Depression, Anxiety and Psychological Distress: A Meta-Analysis." *BMC Medicine* 7, no. 1: 79. https://doi.org/10.1186/1741-7015-7-79.

Dubois-Comtois, K., E.-L. Bussières, C. Cyr, et al. 2021. "Are Children and Adolescents in Foster Care at Greater Risk of Mental Health Problems Than Their Counterparts? A Meta-Analysis." *Children and Youth Services Review* 127: 106100. https://doi.org/10.1016/j.childyouth.2021.106100.

Fjermestad, K. W., M. D. Lerner, B. D. McLeod, et al. 2016. "Therapist-Youth Agreement on Alliance Change Predicts Long-Term Outcome in CBT for Anxiety Disorders." *Journal of Child Psychology and Psychiatry* 57, no. 5: 625–632. https://doi.org/10.1111/jcpp.12485.

Ford, T., P. Vostanis, H. Meltzer, and R. Goodman. 2007. "Psychiatric Disorder Among British Children Looked After by Local Authorities: Comparison With Children Living in Private Households." *British Journal of Psychiatry* 190, no. 4: 319–325. https://doi.org/10.1192/bjp.bp.106.025023.

Gilbert, N., N. Parton, and M. Skivenes, eds. 2011. *Child Protection Systems: International Trends and Orientations*. New York, NY: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199793358.001.0001.

Gosch, E. A., E. Flannery-Schroeder, C. F. Mauro, and S. N. Compton. 2006. "Principles of Cognitive-Behavioral Therapy for Anxiety Disorders in Children." *Journal of Cognitive Psychotherapy* 3: 247–262. https://doi.org/10.1891/jcop.20.3.247.

Gulliver, A., K. M. Griffiths, and H. Christensen. 2010. "Perceived Barriers and Facilitators to Mental Health Help-Seeking in Young People: A Systematic Review." *BMC Psychiatry* 10: 113. https://doi.org/10.1186/1471-244X-10-113.

Hambrick, E. P., S. Oppenheim-Weller, A. M. N'zi, and H. N. Taussig. 2016. "Mental Health Interventions for Children in Foster Care: A Systematic Review." *Children and Youth Services Review* 70: 65–77. https://doi.org/10.1016/j.childyouth.2016.09.002.

Havlicek, J. R., A. R. Garcia, and D. C. Smith. 2013. "Mental Health and Substance Use Disorders Among Foster Youth Transitioning to Adulthood: Past Research and Future Directions." *Children and Youth Services Review* 35, no. 1: 194–203. https://doi.org/10.1016/j.childyouth.2012.10.003.

Hayek, M., T. I. Mackie, C. M. Mulé, et al. 2014. "A Multi-State Study on Mental Health Evaluation for Children Entering Foster Care." *Administration and Policy in Mental Health and Mental Health Services Research* 41: 552–567.

Henggeler, S. W., S. K. Schoenwald, C. M. Borduin, M. D. Rowland, and P. B. Cunningham. 2009. *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents*. New York, NY: Guilford Press.

Higa-McMillan, C. K., S. E. Francis, L. Rith-Najarian, and B. F. Chorpita. 2016. "Evidence Base Update: 50 Years of Research on Treatment for Child and Adolescent Anxiety." *Journal of Clinical Child and Adolescent Psychology* 45, no. 2: 91–113. https://doi.org/10.1080/15374416.2015.1046177.

Kazdin, A. E. 2000. "Perceived Barriers to Treatment Participation and Treatment Acceptability Among Antisocial Children and Their Families." *Journal of Child and Family Studies* 9, no. 2: 157–174. https://doi.org/10.1023/A:1009414904228.

Kjelsaas, I., E. Backe-Hansen, D. Ellingsen, M. K. Guldvik, Ø. Vennerød, and S. Pedersen. 2020. "Best egnede tiltak når barn og unge skal bo utenfor hjemmet (Nr. 134/2020)." https://www.menon.no/wp-content/uploads/2020-134-Barn-og-unge.pdf.

Kranke, D. A., J. Floersch, B. O. Kranke, and M. R. Munson. 2011. "A Qualitative Investigation of Self-Stigma Among Adolescents Taking Psychiatric Medication." *Psychiatric Services* 62, no. 8: 893–899. https://doi.org/10.1176/ps.62.8.pss6208_0893.

Križ, K., and D. Roundtree-Swain. 2017. ""We Are Merchandise on a Conveyer Belt": How Young Adults in the Public Child Protection System Perceive Their Participation in Decisions About Their Care." *Children and Youth Services Review* 78: 32–40. https://doi.org/10.1016/j.childyouth.2017.05.001.

Larsen, M., V. Baste, R. Bjørknes, T. Myrvold, and S. Lehmann. 2018. "Services According to Mental Health Needs for Youth in Foster Care?—A Multi-Informant Study." *BMC Health Services Research* 18, no. 1: 634. https://doi.org/10.1186/s12913-018-3365-6.

Layard, R., A. E. Clark, F. Cornaglia, N. Powdthavee, and J. Vernoit. 2014. "What Predicts a Successful Life? A Life-Course Model of Well-Being." *Economic Journal (London, England)* 124, no. 580: F720–F738. https://doi.org/10.1111/ecoj.12170.

Lehmann, S., O. E. Havik, T. Havik, and E. Heiervang. 2013. "Mental Disorders in Foster Children: A Study of Prevalence, Comorbidity and Risk Factors." *Child and Adolescent Psychiatry and Mental Health* 7: 39. https://doi.org/10.1186/1753-2000-7-39.

Leve, L. D., G. T. Harold, P. Chamberlain, J. A. Landsverk, P. A. Fisher, and P. Vostanis. 2012. "Practitioner Review: Children in Foster Care-Vulnerabilities and Evidence-Based Interventions That Promote Resilience Processes." *Journal of Child Psychology and Psychiatry* 53, no. 12: 1197–1211. https://doi.org/10.1111/j.1469-7610.2012.02594.x.

Lougheed, S. C., and D. A. Coholic. 2018. "Arts-Based Mindfulness Group Work With Youth Aging Out of Foster Care." *Social Work with Groups* 41, no. 1–2: 165–178. https://doi.org/10.1080/01609513.2016.1258626.

Lov om barnevern [Child Welfare Act]. 2023. https://lovdata.no/lov/2021-06-18-97/.

Lov om pasient- og brukerrettigheter [Patient- and User Rights Act]. 2001. Accessed 8 November 2021, https://lovdata.no/dokument/NL/lov/1999-07-02-63.

Luke, N., I. Sinclair, M. Woolgar, and J. Sebba. 2014. "What Works in Preventing and Treating Poor Mental Health in Looked After Children?" Accessed 10 November 2021, https://www.mhinnovation.net/sites/default/files/downloads/resource/What%20works%20in%20preventing%20treating%20mental%20health%20looked%20after%20children%20report.pdf.

Mabille, G., J. Skoglund, R. Thørnblad, and A. Holtan. 2021. "Placement Stability and Satisfaction With Foster Home as Predictors of Life Satisfaction for Young Adults Raised in Foster Care." *Child & Family Social Work* 27: 267–277. https://doi.org/10.1111/cfs.12880.

Malterud, K. 2012. "Systematic Text Condensation: A Strategy for Qualitative Analysis." *Scandinavian Journal of Public Health* 40, no. 8: 795–805.

Malterud, K. 2017. "Kvalitative forskningsmetoder for medisin og helsefag: en innføring". Oslo.

Malterud, K., V. D. Siersma, and A. D. Guassora. 2016. "Sample Size in Qualitative Interview Studies: Guided by Information Power." *Qualitative Health Research* 26, no. 13: 1753–1760. https://doi.org/10.1177/1049732315617444.

McLeod, B. D. 2011. "Relation of the Alliance With Outcomes in Youth Psychotherapy: A Meta-Analysis." *Clinical Psychology Review* 31, no. 4: 603–616. https://doi.org/10.1016/j.cpr.2011.02.001.

McMillen, J. C., B. T. Zima, L. D. Scott, et al. 2005. "Prevalence of Psychiatric Disorders Among Older Youths in the Foster Care System." *Journal of the American Academy of Child and Adolescent Psychiatry* 44, no. 1: 88–95. https://doi.org/10.1097/01.chi.0000145806.24274.d2.

Moussavi, Y., K. Breivik, G. J. Wergeland, B. S. M. Haugland, M. Larsen, and S. Lehmann. 2021. "Internalizing Symptom Profiles Among Youth in Foster Care: A Comparison Study." *Frontiers in Psychiatry* 12: 711626. https://doi.org/10.3389/fpsyt.2021.711626.

Moussavi, Y., G. J. Wergeland, T. Boe, B. S. M. Haugland, M. Larsen, and S. Lehmann. 2021. "Internalizing Symptoms Among Youth in Foster Care: Prevalence and Associations With Exposure to Maltreatment." *Child Psychiatry and Human Development* 53: 375–388. https://doi.org/10.1007/s10578-020-01118-x.

Mulkerns, H., and C. Owen. 2008. "Identity Development in Emancipated Young Adults Following Foster Care." *Smith College*

Studies in Social Work 78, no. 4: 427–449. https://doi.org/10.1080/00377310802378594.

Munson, M. R., and J. A. Lox. 2012. "Clinical Social Work Practice With Former System Youth With Mental Health Needs: Perspective of Those in Need." *Clinical Social Work Journal* 40, no. 2: 255–260. https://doi.org/10.1007/s10615-012-0381-6.

Munson, M. R., L. D. Scott Jr., S. E. Smalling, H. Kim, and J. E. Floersch. 2011. "Former System Youth With Mental Health Needs: Routes to Adult Mental Health Care, Insight, Emotions, and Mistrust." *Children and Youth Services Review* 33, no. 11: 2261–2266. https://doi.org/10.1016/j.childyouth.2011.07.015.

Narendorf, S. C., M. Glaude, M. R. Munson, K. Minott, and B. Young. 2021. "Adaptation of a Mental Health Treatment Engagement Intervention for Older Foster Youth." *Child and Adolescent Social Work Journal* 38, no. 1: 27–41.

Polanczyk, G. V., G. A. Salum, L. S. Sugaya, A. Caye, and L. A. Rohde. 2015. "Annual Research Review: A Meta-Analysis of the Worldwide Prevalence of Mental Disorders in Children and Adolescents." *Journal of Child Psychology and Psychiatry* 56, no. 3: 345–365. https://doi.org/10.1111/jcpp.12381.

Pullmann, M. D., J. Jacobson, E. Parker, et al. 2018. "Tracing the Pathway From Mental Health Screening to Services for Children and Youth in Foster Care." *Children and Youth Services Review* 89: 340–354. https://doi.org/10.1016/j.childyouth.2018.04.038.

QSR International. NVivo. 2020. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home/.

Raghavan, R., D. S. Brown, and B. T. Allaire. 2017. "Can Medicaid Claims Validly Ascertain Foster Care Status?" *Child Maltreatment* 22, no. 3: 227–235.

Reardon, T., K. Harvey, M. Baranowska, D. O'Brien, L. Smith, and C. Creswell. 2017. "What Do Parents Perceive Are the Barriers and Facilitators to Accessing Psychological Treatment for Mental Health Problems in Children and Adolescents? A Systematic Review of Qualitative and Quantitative Studies." *European Child & Adolescent Psychiatry* 26, no. 6: 623–647. https://doi.org/10.1007/s00787-016-0930-6.

Salloum, A., C. Johnco, A. B. Lewin, N. M. McBride, and E. A. Storch. 2016. "Barriers to Access and Participation in Community Mental Health Treatment for Anxious Children." *Journal of Affective Disorders* 196: 54–61. https://doi.org/10.1016/j.jad.2016.02.026.

Sawyer, M. G., N. Borojevic, K. A. Ettridge, S. H. Spence, J. Sheffield, and J. Lynch. 2012. "Do Help-Seeking Intentions During Early Adolescence Vary for Adolescents Experiencing Different Levels of Depressive Symptoms?" *Journal of Adolescent Health* 50, no. 3: 236–242. https://doi.org/10.1016/j.jadohealth.2011.06.009.

Schneiderman, J. U., and M. Villagrana. 2010. "Meeting Children's Mental and Physical Health Needs in Child Welfare: The Importance of Caregivers." *Social Work in Health Care* 49, no. 2: 91–108. https://doi.org/10.1080/00981380903158037.

Schweer-Collins, M., and P. Lanier. 2021. "Health Care Access and Quality Among Children Exposed to Adversity: Implications for Universal Screening of Adverse Childhood Experiences." *Maternal and Child Health Journal* 25: 1903–1912. https://doi.org/10.1007/s10995-021-03270-9.

Stiffman, A. R., B. Pescosolido, and L. J. Cabassa. 2004. "Building a Model to Understand Youth Service Access: The Gateway Provider Model." *Mental Health Services Research* 6, no. 4: 189–198. https://doi.org/10.1023/b:mhsr.0000044745.09952.33.

Tarren-Sweeney, M. 2021. "A Narrative Review of Mental and Relational Health Interventions for Children in Family-Based Out-of-Home Care." *Journal of Family Therapy* 43, no. 3: 376–391. https://doi.org/10.1111/1467-6427.12341.

The Organisation for Economic Co-operation and Development [OECD] Health Ministers. 2017. "The Next Generation of Health Reforms: Ministerial Statement." https://www.oecd.org/health/ministerial/ministerial-statement-2017.pdf.

Toros, K. 2021. "A Systematic Review of Children's Participation in Child Protection Decision-Making: Tokenistic Presence or Not?" *Children & Society* 35, no. 3: 395–411. https://doi.org/10.1111/chso.12418.

Turney, K., and C. Wildeman. 2016. "Mental and Physical Health of Children in Foster Care." *Pediatrics* 138, no. 5: e20161118. https://doi.org/10.1542/peds.2016-1118.

United Nations General Assembly. 1989. "The UN Convention on the Rights of the Child." https://downloads.unicef.org.uk/wpcontent/uploads/2010/05/UNCRC_PRESS200910web.pdf?_ga=2.78590034.7=95419542.1582474737-1972578648.1582474737.

Weersing, V. R., and D. A. Brent. 2006. "Cognitive Behavioral Therapy for Depression in Youth." *Child and Adolescent Psychiatric Clinics* 15, no. 4: 939–957. https://doi.org/10.1016/j.chc.2006.05.008.

Weersing, V. R., M. Jeffreys, M. T. Do, K. T. Schwartz, and C. Bolano. 2017. "Evidence Base Update of Psychosocial Treatments for Child and Adolescent Depression." *Journal of Clinical Child & Adolescent Psychology* 46, no. 1: 11–43. https://doi.org/10.1080/15374416.2016.1220310.

Wergeland, G. J. H., E. N. Riise, and L.-G. Öst. 2021. "Cognitive Behavior Therapy for Internalizing Disorders in Children and Adolescents in Routine Clinical Care: A Systematic Review and Meta-Analysis." *Clinical Psychology Review* 83: 101918. https://doi.org/10.1016/j.cpr.2020.101918.

Wesley, B. C., J. Pryce, J. Barry, and P. Y. P. Hong. 2020. "Steadfast Benevolence: A New Framework for Understanding Important Adult-Youth Relationships for Adolescents in Care." *Children and Youth Services Review* 118: 105465. https://doi.org/10.1016/j.childyouth.2020.105465.

Wisdom, J. P., G. N. Clarke, and C. A. Green. 2006. "What Teens Want: Barriers to Seeking Care for Depression." *Administration and Policy in Mental Health* 33, no. 2: 133–145. https://doi.org/10.1007/s10488-006-0036-4.