HEALTH & WELLBEING OF LOOKED AFTER CHILDREN

Evidence from research and practice shows that looked after children and care leavers in the UK are much more likely to experience health problems than young people in the general population. At least 11% of looked after children have a specified disability; although due to the quality of reporting, this figure is due to be a significant underestimation.[1] Levels of mental health need are high, with over 45% of looked after children (aged 5-17) found to have at least one mental health issue (compared to approximately 10% of all children in that range).[2] The prevalence of speech and language problems is above average, as are issues with co-ordination eyes and sight. Oral and foot health can be poor, and across all age groups the number of looked after children identifying themselves as regular smokers and consumers of alcohol is significantly higher than the average.[3] Care leavers frequently report serious problems with drugs and alcohol, and issues with both their physical and mental health.[4]

This situation can be explained, in part, by the backgrounds of many looked after children. The factors leading to social work's involvement with a child or young person are often coterminous with those associated with poor health: poverty, chaotic lifestyles, poor diet, parental substance misuse (both in utero and during early years), neglect and/or abuse.[5] But it should be noted that for those children 'looked after at home', these issues may still be a feature of their lives. And while early life experiences lay a foundation for poor health outcomes, the continued disruption, lack of stability and emotional trauma (i.e. loss, separation) – so often experienced by looked after children – can compound or exacerbate existing health problems. Frequent placement changes can cause practical problems too, disrupting treatment plans and inhibiting proper information sharing (both between medical professionals, education staff and carers). Similarly, the young age at which many children 'leave care' (at 15 or 16) often coincides with a move into adult health services, and the pressures of independent living, further education or employment. For young disabled people leaving care, there are also significant concerns about appropriate transitional planning and access to information in understandable formats.[6]

[1] Scottish Government (2012) *Children Social Work Statistics 2011*, Edinburgh
[2] Meltzer, H., Lader, D., Corbin, T., Goodman, R. and Ford, T. (2004*) The mental health of young people looked after by local authorities in Scotland*. Edinburgh: The Stationery Office
[3] Ibid
[4] Dixon, J. (2008) 'Young people leaving care: health, well-being and outcomes', *Child and Family Social Work* 13, 207-217
[5] DoH & DCSF (2009) *Promoting the Health and Wellbeing of Looked After Children: Statutory Guidance*
[6] Rabiee, P, Priestley, M and Knowles, J (2001) Whatever next? Young disabled people leaving care. York: First Key.

This document includes:

- Summary of research
    - Physical Health
    - Sexual Health
    - Substance Misuse
    - Mental Health
    - Care Leavers
- Factors influencing looked after children's health
- Policy context

SUMMARY OF RESEARCH

Physical Health

A 2004 survey of Scottish looked after children found that two thirds had at least one physical health complaint, such as speech and language problems (12%), bedwetting (14%), co-ordination difficulties (10%) and eye or sight problems (19%).[7] Many reported a combination of these. The report gave a general health rating of 'very good' to just 52% of Scottish survey respondents, in comparison to 61% and 65% respectively for looked after children in England and Wales.[8]

Other studies have found a high incidence of unrecognised or undiagnosed problems among looked after children. A longitudinal study completed in 2001 showed 52% of looked after children had a physical or health condition that required outpatient treatment.[9] A 'needs assessment' conducted by the Residential Care Health Project in 2003-4 indicated that 86% of accommodated children had incomplete childhood health screenings, and 71% had not achieved their full immunisation status. 41% were found to have growth or developmental problems, 27% some form of developmental coordination disorder, 4% speech and language difficulties and 17% a specific learning difficulty. 31% of the children sampled had allergies, but only 9% had allergies recorded. Of the 82% that had a physical health issue, 74% had not been diagnosed prior to the health assessment carried out on their becoming accommodated.[10] These unrecognised complaints ranged from relatively minor but distressing conditions such as acne, to significant health problems that required careful management, including epilepsy, kidney problems and minor visual and hearing impairments.[11]

A summary of the available evidence, carried in 2006, concluded that while Scottish young people as a whole tended to have poorer physical health outcomes than young people elsewhere in the UK, the situation was particularly bad for looked after children.[12] However, there are signs things are improving. A review of residential services carried out by the Care Commission in 2010 concluded that 96% of services provided good access to healthcare and supported young people to make health lifestyle choices.[13] The Care Commission drew particular attention to the introduction of dedicated 'Looked After' nurses for children in

[7] Meltzer H. et al (2004) *The mental health of young people looked after by local authorities in Scotland*. Office for National Statistics, London: The Stationery Office, p.36
[8] Ibid. p.39
[9] Skuse, T & Ward, H (1999) Current Research Findings About the Health of Looked After Children - Paper for Quality Protects seminar 'Improving health outcomes for looked after children', Dartington Social Research Unit and Loughborough University
[10] NHS Lothian (2004) *Residential Care Health Project: Forgotten Children*
[11] Ibid
[12] Hill M & Scott J (2006) The health of looked after and accommodated children and young people in Scotland, Social Work Inspection Agency, Edinburgh
[13] Care Commission (2010) *The physical health of children and young people in residential care*, Bulletin (July)

residential and foster care by some NHS Boards.[14] This service does not extend to children looked after at home or in 'kinship care', however, and due to a paucity of research our knowledge about the health outcomes of these children looked after such 'community' placements is limited.

Substance misuse

The 2004 ONS survey found that accommodated looked after young people in Scotland were twice as likely to smoke, drink or take drugs as their English counterparts. Just under half of those aged 11-17 were smokers, and more than half reported drinking alcohol at least once a week.[15] Reported reasons for substance misuse included boredom, stress release, peer pressure and enjoyment.

- **Smoking**: A number of studies have found very high rates of smoking among looked after children. Rates varied from 45% to 100% of those questioned.[16] Many children begun smoking at a very young age, with over half the children interviewed for one study starting under the age of 12.[17] Staff interviewed for the Residential Health Care Project reported that of those young people that did smoke, just under half smoked at least 10 cigarettes a day.[18]

- **Alcohol**: Looked after children have also been found to have high levels of alcohol consumption, with over 50% reportedly drinking at least once a week.[19] Another study found that 87% of children admitted frequent alcohol use, with 13% admitting to consuming over 14 units a week. 3% were reported to consume over 28 units a week (approximately 12 pints of lager).[20] Despite high levels of alcohol consumption in the general adolescent population of Scotland,[21] such figures suggest that the consumption of alcohol by looked after children is considerably higher than the average young person.

- **Drugs**: A 2001 study found that young people who were looked after away from home were more likely to have been involved with drugs than their peers.[22] About a

[14] Care Commission (2010) *The physical health of children and young people in residential care*, p.4
[15] Meltzer, H., Lader, D., Corbin, T., Goodman, R. and Ford, T. (2004) The mental health of young people looked after by local authorities in Scotland. Edinburgh: The Stationery Office, pp. 87-116
[16] Scottish Health Feedback (2003) *The health needs and issues of young people from Glasgow living in foster care settings*, Glasgow; Rintoul, K (2005) 'They Shouldn't Judge Us Right Away', Who Cares? Scotland, Glasgow; Meltzer et al (2004)
[17] Rintoul, K (2005) 'They Shouldn't Judge Us Right Away', Who Cares? Scotland, Glasgow
[18] NHS Lothian (2004) *Residential Care Health Project: Forgotten Children*
[19] Scottish Health Feedback (2003) *The health needs and issues of young people from Glasgow living in foster care settings*, Glasgow
[20] NHS Lothian (2004) *Residential Care Health Project: Forgotten Children*
[21] NHS Scotland (2010) *Scottish Schools Adolescent Lifestyle and Substance Use Survey 2010*, Edinburgh
[22] Geishbach, D. & Currie, C. (2001) Health Behaviours of Scottish Schoolchildren: Control of Adolescent Smoking in Scotland (Report 7), University of Edinburgh

third of these had tried drugs subsequent to their admission to care, but the majority had tried drugs first before they became looked after. In one small Scottish study on looked after children, almost half the young people reported taking drugs on a regular basis.[23] Of those who reported regular drug use, half were smoking cannabis on a daily basis. There was also regular use of ecstasy, but this was confined to weekends. Half of the young people in this study began experimenting with drugs between the ages of 12 – 13 years and one third of the young people had been under 12 years when they first used drugs. In addition to cannabis and ecstasy a wide range of drugs had been used by some, including heroin, cocaine, LSD, amphetamines and valium.[24]

Sexual Health

Research into the sexual health of looked after children is limited. A 1995 English study found that a quarter of young women leaving care are pregnant or already have a child. Within 18-24 months of leaving care, over half of young women had become mothers.[25] There is also some evidence that young men who have been in the care system are likely to become fathers at a younger age than their peers.[26] The high rate of teenage parenthood in this group suggests that many looked after young people engage in unprotected sex and this increases their exposure to sexually transmitted diseases. Of those young people who admitted sexual activity to staff in the residential health care project, none claimed to use protection on all occasions of having sex. Almost half admitted they had unsafe sex sometimes, a quarter said they never used protection and the remainder refused to answer the question.[27]

Mental Health

It is now widely recognised that looked after children have a significantly increased risk of developing mental health problems. Not only are their backgrounds often characterised by chaos, trauma and neglect, but many grow up with parents who have undiagnosed or inadequately treated psychiatric issues of their own. The results of a longitudinal study published in 2008, looking at children and young people who remained in care for at least a year, found that 72% of those aged 5-15 had an emotional or behavioural problem at the point of becoming looked after.[28] A multidimensional study completed in 2012 concluded

[23] Rintoul, K (2005) *They Shouldn't Judge Us Right Away*, Who Cares? Scotland, Glasgow
[24] Ibid. pp. 47-61
[25] Biehal, N et al, (1995) *Moving On: Young people and leaving care schemes*, Barnardo's
[26] Gelder, U (2002) *Boys and Young Men: 'Half the solution' to the issue of teenage pregnancy*, Department of Health and University of Newcastle
[27] NHS Lothian (2004) *Residential Care Health Project: Forgotten Children*
[28] Sempik J., Ward H. and Darker I. (2008) 'Emotional and behavioural difficulties of children and young people at entry to care', *Clinical Child Psychology and Psychiatry*, 13, 2, 221-233

that between 33% and 47% of looked after children had mental health difficulties,[29] which echoed the findings from the 2004 ONS survey of Scottish looked after children, which concluded that 45% of those aged 5-17 had a mental health disorder. Indeed those aged 5-10 were six times more likely to have a mental disorder than those children living in families in the community (52% compared with 8%), and while this ratio fell slightly for those aged 11-15 (41% compared to 9%) the difference remained significant.[30]

Looked after children are more likely to self-harm, and a disproportionate number of commit suicide. A study carried out in Glasgow found that 45% of the looked after young people involved in the survey had harmed themselves deliberately. This was linked to depression and low self-esteem.[31]

Care Leavers

Young people leaving care represent a particularly vulnerable group, their health and wellbeing significantly poorer than that of young people who have never been in care.[32] They are much more likely than their peers to be younger parents, with one – albeit rather dated - study finding that almost half of young women leaving care become pregnant within 18-24 months, and another reporting that a quarter were pregnant or young parents within a year of leaving care.[33] Compared with responses given within three months of leaving care, those interviewed a year later were twice as likely to have problems with drugs and alcohol (increased from 18% to 32%) and to report problems with their mental health (12% to 24%). There was also increased reporting of 'other health problems' (28% to 44%) including weight loss, flu and illness related to drug or alcohol misuse.[34]

Factors influencing looked after children's health

Adverse childhood experiences: The extensive work of the US 'Adverse Childhood Experiences' programme has confirmed that trauma – such as abuse or neglect - experienced in early childhood has a direct link to health problems. Indeed the greater the trauma experienced, the higher the chances of physical and mental morbidity in later life; everything from depression to heart disease.[35] Moreover, children with disadvantaged

[29] Rees, P (2012) 'The mental health, emotional literacy cognitive ability, literacy attainment and 'resilience' of looked after children', *British Journal of Clinical Psychology*
[30] Meltzer, H., Lader, D., Corbin, T., Goodman, R. and Ford, T. (2004) *The mental health of young people looked after by local authorities in Scotland*, Edinburgh, pp. 87-116
[31] Scottish Health Feedback (2003) *The health needs and issues of young people from Glasgow living in foster care settings*, Glasgow
[32] National Children's Bureau (2008) *Promoting the health of young people leaving care*, Healthy Care Briefing
[33] Biehal, N et al, (1995) *Moving On: Young people and leaving care schemes*, Barnardo's
[34] Dixon, J. (2008) 'Young people leaving care: health, well-being and outcomes', *Child and Family Social Work* 13, 207-217
[35] Felitti, V & Anda, R (2009) 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders, and Sexual Behavior: Implications for Healthcare, in Lanius, R & Vermetten, E (editors) *The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease*, Cambridge University Press

backgrounds have a higher risk of being exposed to neonatal smoking and drinking, poor maternal health, lower post-birth physical activity levels, poor diet and other factors that relate directly to poor health outcomes.[36]

Limited health histories: Looked after children often have chaotic backgrounds, where information from their past (particularly their earliest years) is limited or unavailable. For children who are estranged from or abandoned by their families, it can be very difficult to obtain information about their birth parents' health history.

Placement disruption: The lives of many looked after children are characterised by instability and change. For those accommodated away from their family, this can include changes in school, area, even region. Often it involves the need to register with a new GP and the transfer of records and treatment plans. In this context, accurate and complete recording of health needs can be difficult, and treatment plans can be disrupted.

Attendance and exclusions from school: The problems associated with instability of school placements can be compounded by the high truancy and exclusion rates among looked after children. Children absent from school may miss out on the routine surveillance, health promotion and education provided. Moreover, some of the usual approaches for delivering health or sex education may not necessarily suit the needs of some vulnerable children, who may, for instance, have experienced sexual abuse or borne witness to domestic abuse. Similarly, addressing alcohol and drug issues may need a different approach for children whose lives have been constructed around their parents' chaotic and chronic use of drugs or alcohol.

Age at which children leave care: Looked after children (particularly those accommodated away from their families) often leave home much earlier than young people in the general population. Many will move onto independent living (tenancies, employment, etc.) at just 16.[37] Not only does this impose a significant pressure on young people in and of itself, it also coincides with the transition from child to adult health services. For young people with significant health needs this constitutes a double vulnerability, the stress of major change leading to an enhanced level of need, at the same time as they become ineligible for some services.

Access and engagement with health services: While young people themselves do not report 'access to health services' as a major concern, from a corporate parenting perspective there may be issues about securing necessary health services.[38] For school aged children who are 'looked after at home' there may be an absence of regular health monitoring. Children accommodated away from their birth families have access to a LAAC nurse, who can

[36] Scottish Government (2010) *Growing Up in Scotland: Health Inequalities in the early years*, Edinburgh
[37] SCCYP (2008) Sweet Sixteen: The Age of Leaving Care in Scotland, Edinburgh
[38] National Children's Bureau (2010) *Corporate Parenting can promote health and wellbeing*, Healthy Care Briefing

monitor general health and organise appointments with specialist health services. But these services (such as Child and Adolescent Mental Health) are often heavily over-subscribed, with restricted availability.

POLICY CONTEXT

In 2006 Scottish Ministers set out their expectations for Scotland's children and young people in *Getting Right for Every Child*. This stated that they should all feel safe, nurtured, healthy, achieving, active, respected, responsible and included (the GIRFEC principles). In a report published in the same year - *The Health of Looked After and Accommodated Children and Young People in Scotland* - the Social Work Inspection Agency (SWIA) stressed that the health needs of looked after children demanded particular attention if such ambitions were to be met. It highlighted evidence of looked after children not receiving statutory health assessments, or the treatments they needed.

In *We Can and Must Do Better* (2007) the Scottish Government recognised that educational attainment cannot be seen in isolation, but is dependent on other life circumstances, including health and wellbeing. It set out its vision as:

Scotland's looked after children and young people will benefit from access to a range of appropriate services designed to meet their emotional, mental and physical needs. Professionals, foster carers, residential workers, teaching staff and parents will be trained to understand the importance and value of meeting these needs. All of our looked after children and young people should grow to be emotionally, mentally and physically healthy.

To achieve this, the WCMDB strategy identified two actions:

- Action 15: Each NHS Board assesses the physical, mental and emotional needs of all looked after children and young people they have responsibility for and puts in place appropriate measures which take account of these assessments. They will ensure that all health service providers will work to make their services more accessible to looked after and accommodated children and young people, and to those in the transition from care to independence.

- Action 16: The Care Commission will review the health of children and young people.

Within the detail of these they committed NHS Education for Scotland to develop a competency framework to support the training and development of specialist nurses for looked after and accommodated children(published in 2008)[39], encouraged relevant organisations to undertake more joint assessment and planning and instructed NHS Health Scotland / Learning & Teaching Scotland to develop high quality sex and drugs education.

The 2008 publication *These Are Our Bairns* called on local authorities, health services and other agencies to focus on their corporate parenting duty "to promote health, to protect health, to assess and identify health-related risks and to treat health problems". It restated

[39] NHS Education Scotland (2008) *Capability Framework for LAAC Nurses*, Edinburgh

the requirements of the Children (Scotland) Act 1995, that a child is examined by a registered medical practitioner before being placed (where the placement is likely to last a year or more) and that a written assessment of healthcare needs is provided to carers. It also noted that looked after children and young people **must** be registered with their local primary health services, including GP services, dentists and opticians.

Following publication WCMDB, the 'Being Emotionally, Mentally and Physically Healthy Working Group' was established (chaired by Caroline Selkirk, the Tayside Child Health Commissioner) to consider how to specifically address Action 15 (access to appropriate services, etc.). Its 'implementation' recommendations were endorsed by Ministers and sent out to all NHS Health Boards by means of Chief Executive Letter (CEL).

The recommendations of the CEL (2009) 16 were:

- Each Territorial Health Board should nominate a Board Director who will take a corporate responsibility for Looked After children and young people and care leavers by 30 June 2009. Health Boards should let Child and Maternal Health Division know the name of the Director as soon as possible after that date;

- The Director will be responsible for ensuring that Health Boards fulfil their statutory duties under the Looked After Children Regulations 1996*. This will enable the Board, on the basis of information from local authority partners, to identify all Looked After children and young people and care leavers in their areas by 31 July 2009, including those who are Looked After at home and those placed from out with their Health Board areas.

- The Director will also be responsible for the implementation of Next Step (a) under Action 15 of *We Can and Must Do Better*.

- The Director will ensure that the Board offers every currently Looked After child and young person in their area a health assessment by April 2010. Any new child or young person coming into the system from March 2010 should have a health assessment within 4 weeks of notification to the Health Board.

- The Director will ensure that the Board offers a mental health assessment to every Looked After child or young person. This recommendation should be phased in line with the implementation of *"Mental Health of Children and Young People Framework for Promotion Prevention and Care*" by 2015.

- The Director will ensure that for every Looked After child or young person who has general and mental health needs identified as part of their health assessment, the

person undertaking that health assessment takes responsibility for ensuring their care plan is delivered / coordinated as appropriate.

- The Director will ensure, using existing systems, that the performance of the Board in carrying out general and mental health assessments for Looked After children and young people, and the health outcomes of those assessments, is reported annually to the Scottish Government.

Also published in 2009, the findings of the *National Residential Child Care Initiative* stressed the need for urgent implementation of WCMDB's Action 15. To address the significant emotional, mental and physical health needs of those in residential care, the report recommended that:

> *7.1 There should be a national policy and practice initiative, which addresses the health needs of looked after children and young people, similar to that which has focused on the educational needs of looked after children. A key role for each health board director with responsibility for looked after children and young people and care leavers must be to drive continuous improvement in the health assessment and care of these children.*
>
> *7.2 Each establishment should have a health improvement plan, detailing goals and actions to promote healthy diets, life-styles and oral care in accordance with key national health improvement messages, and support attendance at health appointments.*
>
> *7.3 Building on best practice, it is important that multi-agency services are provided to support the mental health and well-being of children and young people in residential child care. CAMHS teams have a crucial role in offering direct help. All residential services should have access to specialist consultancy to find the best approaches to help individual young people. Residential staff should be equipped and supported to identify and assist with common, non-psychotic mental health problems such as depression and anxiety, as well as addictions.*

In its response, the Scottish Government emphasised that: "improving the health outcomes of Scotland's looked after children is a priority area for the Scottish Government." It drew attention to the CEL (2009) 16, and the recently appointed nominated 'LAC directors' within NHS Health Boards, whose responsibilities would include ensuring that health boards have systems in place to identify all the looked after children and young people (and care leavers) in their areas, including those who are looked after at home and those placed from out with their health board areas. It reiterated that Health boards are required to offer every looked after child and young person in their area a health assessment by April 2010, and that any new child or young person coming into the system from March 2010 should have a health assessment within four weeks of notification to the health board. The nominated LAC

Director will ensure that every looked after child or young person who has general and mental health needs identified as part of their health assessment, the person undertaking that health assessment takes responsibility for ensuring their care plan is delivered/coordinated as appropriate.

The Scottish Government response also stated that the performance of health boards in carrying out general and mental health assessments for looked after children and young people, and the health outcomes of those assessments, will be monitored through an annual report to the Scottish Government.

In its general response to the NRCCI, the Scottish Government and COSLA committed themselves to taking forward work on five 'priority' themes, of which one was 'improving health outcomes'. These priority themes formed the basis of the Looked After Children Strategic Implementation Group's (LACSIG) Activity Hubs. The 'Health Hub' was in operation between November 2010 and April 2012, providing the Scottish Government with support on:

- Developing a tool to ensure initial and repeat health assessments of looked after children are comprehensive, identifying the broad range of potential health needs;
- Engaging with LAC Directors and other key health stakeholders in relation to their corporate parenting responsibilities;
- Produce guidance on reporting processes for looked after children, especially in relation to out of authority placements;
- Identify 'health outcome indicators' for national reporting;
- Establish the training and CPD requirements of health visitors, LAC nurses, school nurses and other health professionals;
- Overseeing research into the health needs of looked after children.

To accompany the Hub's work, NHS Scotland produced a number of publications on the Health Needs of Looked After Children.[40] The Hub itself came to close in April 2012, but LACSIG continues to progress activities designed to improve the health outcomes of looked after children.

In 2011 the Scottish Government established the Centre for excellence for looked after children in Scotland (CELCIS), which is tasked with supporting all professional groups to improve outcomes for looked after children, including health.

[40] NHS Health Scotland (2009) *Caring about Health: Improving the Health of Looked After And Accommodated Children and Young People in Scotland*