

The health of looked after and accommodated children and young people in Scotland

messages from research

Jane Scott and Malcolm Hill

commissioned for the review of looked after children in Scotland



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inspection agency

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Executive summary

Introduction

- This report considers what research tells us about the health of children and young people in general living in Scotland, and the looked after and accommodated population in particular.
- Research from across the UK has been included, as many children and young people who are looked after and accommodated in Scotland share similar characteristics and experiences with their peers elsewhere in the UK. It should be borne in mind, however, that in England and Wales, the term *looked after children* for the most part corresponds with children described in Scotland as *looked after and accommodated*, but there are some differences. For example, a young person counts as looked after in England and Wales even when placed at home under a care order, while a child on home supervision in Scotland is looked after, but not looked after and accommodated.
- A drive to improve the health of the Scottish nation has been taken forward by the Scottish Executive. *For Scotland's Children* sets out a vision for all children and young people in Scotland by emphasising that all should have access from birth to the services and environments necessary to ensure they fulfil their potential. Health policy documents such as the White Paper *Towards a Healthier Scotland and Our National Health: A plan for action, a plan for change* aim to improve the health of children and young people and tackle inequalities in health provision, often through interventions early in life.
- Low income, deprivation and social exclusion are related to poorer mental, physical and emotional health and diet. Smaller rises in household income, unemployment, poorer quality of housing or homelessness and lack of access to private means of transport are all associated with poorer health outcomes.

The health needs of children and young people across Scotland

- In Scotland, many children are born into families from lower socio-economic groups with the characteristics that may impact adversely on their health. Many unhealthy lifestyles are more common in those who are economically deprived or socially excluded.

Health related behaviour and lifestyles

- Despite efforts by professionals and government, the average Scottish diet remains unhealthy, being high in fat, salt and sugar and low in fruit and vegetables. Childhood obesity is on the increase.
- Smoking is another significant component of health inequalities; it is related to deprivation and leads to poor health outcomes. Associations have been found between adolescent smoking (boys and girls) and the number of smoking parents a young person has, perceptions of parental disapproval and where the head of household is unemployed. There is a link between smoking, a poorer diet and lack of physical exercise. Research studies have found increases during the past decade in daily smoking among boys (12.4% to 19.2%) and girls (12% to 24%). This is the highest rate in Europe for smoking among 15 year olds.
- In Scotland, there has been an increase in the number of children and young people under 16 using alcohol and an increase in the frequency of use. In 2000, there were 1,428 emergency admissions of young people aged 10 to 19 with a diagnosis of acute intoxication, the majority of which (1,036) were between 15 and 19.
- Recent surveys of Scotland's young population have showed that the awareness and use of legal and illegal drugs is prevalent across the country; by their mid-teens around 40% of 15 to 16-year-olds will have tried at least one illegal drug.
- Early pregnancy brings health risks for the mothers and, on average, poor outcomes for the resulting children. The lowest proportion of contraception or condom use was found in cases where intercourse was unexpected and/or carried out for the first time with a partner of less than a month's duration. Such unprotected sex carries the greatest health risks.

Mental health and emotional wellbeing

- In Scotland, about 125,000 young people experience mental health problems that interfere with their daily lives.
- A follow-up survey of the mental health of children and adolescents in Great Britain found that almost a fifth (573) of the total sample (2,938) was identified as having a mental disorder. Three years later, 43% of the 573 children and young people were again assessed as having conduct disorders and 25% were assessed as having a clinically-rated emotional disorder.
- One key factor that emerged linked the presence of an emotional disorder in a child with the mother's poor mental health.
- Children and young people with a persistent mental disorder missed more days at school than their peers without a disorder, and young people aged 16 and over with persistent mental health problems were twice as likely to have no qualification as those with no disorder.

Suicide and deliberate self-harm

- In 2001, there were 887 suicides and indeterminate deaths – an increase of 22% since the 1980s – with boys and men aged 11 to 24 as the group at particular risk. Scotland's rate is much higher than for other areas in the UK and one of the highest in Europe.

Oral health

- In Scotland, child oral health remains poor with only 45% of Scottish five year olds free from dental decay in 2000; 15% short of the national target of 60% by 2010.

The health needs of looked after and accommodated children and young people

General health

- Despite the adverse factors in the backgrounds of children who are looked after and accommodated, and the discontinuities of placement and school, the current general

health of the majority is good. This applies largely to physical health, and is subject to two important qualifications. Firstly, many of the young people have lifestyles that present major threats to their present or future wellbeing. Secondly, there is a high incidence of mental health problems (including conduct disorders).

- The general health of looked after and accommodated children seems to improve as placements become more secure.

Health related behaviour and lifestyles

- Just under half of looked after and accommodated children in Scotland aged 11 to 17 are smokers, and over a quarter of all children who smoked reported that they had started smoking at the age of ten or under.
- From a sample of 96 looked after and accommodated young people, 50% drank alcohol once a week. Although this sample is small, high levels of alcohol use by young people in the care of local authorities has been found in other studies in Scotland and England.
- There is a significant uptake of drugs by young people with the experience of being looked after compared with other teenagers. Around a third (31%) have first tried drugs while in care, but just over two-thirds had taken drugs before coming into care.
- Looked after and accommodated children in Scotland aged 11 to 17 were twice as likely to smoke, drink or take drugs as their English counterparts.
- A survey of 96 young people in and leaving care in Glasgow found gaps in young peoples' access to information on sexual health generally and safer sex in particular.

Mental health and emotional wellbeing

- A number of studies, including several in Scotland, have identified that the mental health problems for looked after and accommodated children and young people are markedly greater than that of their peers in the community. Reasons include the child's experience in terms of poor parenting, trauma, bereavement or serious illness, including mental health difficulties in one or both parents, and the impact on the child of the environment such as poor neighbourhoods, deprivation, social exclusion and poverty.

- Similar numbers of children placed with parents experience mental health difficulties as those in foster and residential care. However much less is known about the support and services offered to these equally vulnerable children and their families.

Suicide and deliberate self-harm

- The key factors, events or triggers for suicidal thoughts and attempted suicide are often disproportionately present in the lives of children and young people looked after and accommodated. The recent Child Protection review undertaken by the Scottish Executive found that from 50 deaths of looked after children between 1997 and 2001, 11 were completed suicides.

Oral Health

- Oral health was highlighted as a neglected area by respondents to a small survey of 96 young people who were looked after and accommodated; half had not visited a dentist during the last year, 70% of that figure being male.

Factors affecting the health of looked after and accommodated children and young people

- Many looked after children have been born into families from lower socio-economic groups. So before a child is looked after and accommodated, factors within their circumstances, such as dysfunction or discord within the family, can mean that they are at risk of missing routine health surveillance checks and participating in an immunisation programme.
- The process of conducting health checks and assessments for a child in the care of the local authority, through the medical or health assessment, has not always been satisfactory.
- Looked after children experience a greater number of moves than children in the general population. Moving between different homes or units can mean that issues get overlooked. Moves may involve changing health board areas, resulting in appointments being changed, missed, delayed or cancelled. Changes in placement can also result in changes in schools and this, together with higher truancy rates, can mean looked after children miss out on routine medical checks and health promotion initiatives within school.

- The potential loss of the family health history can mean important information about a child's future health may be lost. There is also an absence of accurate up-to-date recording of children's needs in the files of many looked after children.
- The research would suggest that fewer changes in placement and more stable placements is a factor in promoting the health and wellbeing of looked after and accommodated children. More accurate recording of a child's health history and current health and wellbeing would provide a clearer picture of the child's needs and the supports required for the child to develop as well as the needs of their carers.

The health needs of young people leaving or who have recently left care

- Research in several countries has shown how poorly equipped many young people leaving care are to cope with life after care – practically, emotionally and educationally – and has made connections with their subsequent experiences of loneliness, isolation, poor mental health, unemployment, poverty, drift and homelessness.
- From research in England, it is estimated that a quarter of young women leaving care are pregnant or have a child and that the numbers of young women who give birth increases within 18-24 months of leaving care.
- Young people have criticised the timing and poor preparation for leaving care which result in high levels of depressive moods, low self esteem and deliberate self harm.

What do young people think about health issues?

- Evidence suggests that children generally view health as primarily to do with diet, exercise and dental hygiene. Many young people have a different view of the meaning of the terms 'mental health' and 'mental illness' compared to health professionals. Accessing services can be seen as stigmatising.
- A survey of looked after and accommodated young people in Glasgow showed that they identified exactly the same factors contributing to good health as the general youth population: physical fitness, healthy eating and physical attractiveness.
- Young people wished to be listened to during consultations whether for a routine health check or for more specialist intervention, often reporting that they did not feel listened to and that professionals and the organisations were difficult to approach.

Messages for policy and practice

The wider context

- While the health of children in general is often good, the incidence of some health problems, such as asthma and psychiatric difficulties, have increased considerably over the last few decades. A sizeable number of our young population struggles with mental health problems as well as dealing with the stresses related to growing up in a society where the structure of our families and communities is changing.
- Children and young people who are looked after and accommodated tend to express exactly the same concerns about their health as children and young people across Scotland. The difference, however, is the context in which these challenges are faced – discord within their own families, moves of home, changes in school or interrupted school careers, and a lack of access to the support and advice of trusted adults.

The health risks and needs of looked after and accommodated children and young people

- Looked after and accommodated children and young people share many of the health risks and problems of their peers, but often to a greater degree.
- Research on the physical and mental health of children and young people who are looked after and accommodated has shown that in most respects this group is doing less well than their peers and these children have extensive health care needs.
- The health issues or concerns for looked after and accommodated children are usually multifaceted. A concern in one area of a child's life should not be addressed in isolation from its impact on other parts of the child's development. Solutions to health concerns should be provided as a partnership across agencies and with carers.
- Much of the literature about looked after and accommodated children focuses on those in residential or foster care. Little is known about the needs of children looked after at home by their families, or about how families are supported to care for their children. A better understanding of how to meet the needs of these families is essential in order not to fail the children and young people.

Variations in health risk

- Certain groups within the looked after and accommodated population have higher health risks than others; males are reportedly more at risk than females. Recent reports have also identified the growing mental health needs of black and minority ethnic communities within Scotland.
- A particularly vulnerable group comprises those young adults preparing to leave care and move to (semi-) independent living while still in their teens. This contrasts with the majority of young people in the community who remain dependent, to varying degrees, upon their families until their mid twenties.

Access to appropriate health care

- It is important to consider how services are delivered. Much evidence exists that many children who are looked after and accommodated do not receive the health assessments and treatments they need from conventional health services.
- Even when needs are identified, it has been argued that there is a gap in the delivery of effective interventions to children and young people with mental health problems.
- Recent initiatives have begun to consider more flexible approaches to delivering health services, especially through the recent, but fast developing, use of specialist looked after children nurses in schools. Innovative approaches to mental health services have developed, such as *Open Door*, *LACES* and the *Residential Health Care Project*, which put the needs and wishes of the young person at the centre, and consider more flexible approaches to service delivery.
- Greater attention should be given to the health and mental health of children before they become looked after and accommodated through activities that support families and provide access to enhanced community-based resources.
- Many looked after and accommodated children return to the birth families once they care. Strategies to support positive change need to be considered well before the child or young person leaves the care of the local authority if change is to be maintained.

- Opportunities exist for professionals to work together with politicians, policymakers, children, young people and their families to improve the health of all children in our society and, in particular, those for whom we have legal responsibilities.

1 Introduction

In their recent report on the evidence base for promoting the health and wellbeing of looked after children and young people in England and Wales, Chambers and colleagues wrote that:

The physical and mental health of children in care is often very poor in comparison to that of their peers with higher levels of substance misuse (Department of Health 1997a), significantly higher rates of teenage pregnancy than for the non-care population (Corlyon and McGuire 1997; Brodie, Berridge and Beckett 1997; Biehal and others 1992 and 1995) and a much greater prevalence of mental health problems (Bamford and Wolkind 1988; McCann and others 1996; Buchanan 1999; Avcelus, Belerby and Vostanis 1999, Dimigen and others 1999, Richardson and Joughlin 2000).

(Chambers *et al.* 2003, p8)

This report aims to bring together the evidence from research and official statistics to test whether this statement is true for children and young people who are looked after and accommodated in Scotland. Broadly, these are children and young people living in foster care or residential units, though an increasing number are being placed with relatives or friends. They are usually placed there as a result of a voluntary agreement between the family and a local authority, by a supervision requirement from a children's hearing or following an emergency protection order. The report considers what research tells us about the health of children and young people in general in Scotland, and the looked after and accommodated population in particular.

Research from across the UK has been considered as many children and young people looked after and accommodated in Scotland share similar characteristics and experiences with their counterparts elsewhere in the UK. Distinctions have been made when discussing research from England, Wales and Scotland. It should be remembered that, in England and Wales, the term looked after children, for the most part, corresponds with children described in Scotland as looked after and accommodated. There are some differences,

however; for example, a young person counts as looked after in England and Wales even when placed at home under a Care Order, while a child on home supervision in Scotland is looked after but not looked after and accommodated. This report will also consider the messages for policy and practice and identify if there are significant gaps in our knowledge.

Goals for a Healthy Scottish Nation

Article 24 of the United Nations Convention on the Rights of the Child (1989) states that:

State parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.

(United Nations)

Much of the literature on health discusses a medical model or ‘absence of illness’, but there has been a move more recently to a more holistic definition. This is embodied in the World Health Organisation’s well-known definition of health as ‘*a state of complete, physical, social and mental wellbeing and not merely the absence of disease or infirmity*’; in other words, health is about focussing on the prevention of disease and the promotion of healthy lifestyles, as well as managing and ‘curing’ illness.

The agenda for improving the health of the nation and, in particular, of looked after and accommodated children and young people, is shared by politicians and policymakers across the UK. In 1998, the House of Commons Select Committee reported on the health of looked after children and concluded that:

... the failure of local authorities to secure good health outcomes for the children and young people they look after is a failure of corporate parenting.

(House of Commons Select Committee, para. 265)

This combined with the findings of the independent inquiry led by Sir Donald Acheson in 1998 into the inequalities in health, raised the profile of the health needs of children and young people. In England and Wales, efforts to address this were promoted through the introduction of *Quality Protects* (1999) and *Children First* (2000) respectively. These initiatives aimed to improve the life chances of children in care. In 2002, the Department of Health published *Promoting the Health Care of looked after children*, which charged chief

executives of primary care trusts with improving the health care of the most disadvantaged children. More recently, the Green Paper *Every Child Matters* (2003), identified health as a key area to which services must respond in an integrated way.

A similar drive to improve the health of the Scottish nation has been taken forward by the Scottish Executive. *For Scotland's Children* sets out a vision for all children and young people in Scotland by emphasising that all should have access, from birth, to the services and environments necessary to ensure they fulfil their potential. It is a vision that depends on an ability to take account of and respond to the whole child, including their health. Health policy documents such as the White Paper *Towards a Healthier Scotland* and *Our National Health: A plan for action, a plan for change* aimed to improve the health of children and young people and tackle inequalities in health provision, often through interventions early in life.

The government has priority objectives to reduce smoking, alcohol and drug misuse, dental decay among five-year-olds, and pregnancies among 13 to 15 year olds (Scottish Executive 1999). *Choose Life* (Scottish Executive 2002a) also set out the key targets for reducing the number of incidents of deliberate self-harm and suicides.

Health inequalities in general

Sir Donald Acheson (1999) identified trends in socio-economic determinants for health. Unemployment, poorer quality of housing or homelessness and lack of access to private means of transport were all associated with poorer health outcomes. Adults who had bought housing with the aid of a mortgage and had access to private transport tended to be more economically active, and in the socio-economic groups which enjoyed higher average disposable income, better health outcomes were found. Low income, deprivation and social exclusion are related to poorer mental, physical and emotional health and diet, as well as a low incidence of breastfeeding (Hill and Tisdall 1997; Acheson 1999; van Beinum, Martin and Bonnett in Scott and Ward (eds)).

The Acheson report also reported differences in health trends between different ethnic groups. People from black (Caribbean, African and other) and Indian communities have higher rates of limiting long standing illness than white people, but those of Pakistani or Bangladeshi origin have the highest rates. Furthermore, it reported excess mortality among men born on the Indian sub-continent and among men and women born in Africa, and both Scotland and Ireland (Acheson 1999).

2 The health needs of children and young people across Scotland

In Scotland, many children are born into families from lower socio-economic groups with characteristics that may impact adversely on their health. Many unhealthy lifestyles are more common in those who are economically deprived or socially excluded (NHS Fact File 2003).

Health related behaviour and lifestyles

Recent Scottish Executive health promotion initiatives have tended to focus on health-related behaviour. These have included television campaigns on the risks of smoking and drug misuse and the importance of healthier lifestyles and of regular exercise. Also, free fresh fruit is now provided to children in primary schools.

Diet is one important lifestyle factor where inequalities relating to deprivation are particularly evident and, despite efforts by professionals and government, the average Scottish diet remains unhealthy, being high in fat, salt and sugar and low in fruit and vegetables. However, since 1990, there has been an increase in the consumption of fruit, raw vegetables and salads on a daily basis by all age groups (NHS Fact File 2003). Even so, childhood obesity is on the increase; in 1998-99, the prevalence of obesity in Scottish children aged 3 to 4 years was almost nine per cent compared with the UK reference standard of five percent (NHS Fact File 2003).

Furthermore, three in ten boys and four in ten girls fall short of the amount of physical activity required for good health; this applies particularly to school age children between primary three and seven (NHS Fact File 2003). In the UK as a whole, accidents are the most common cause of hospital admissions for children, whereas the most frequent reason for visiting the GP, accounting for half the visits to GPs of children under five, are respiratory conditions, including asthma and bronchitis (Hill and Tisdall 1997).

Smoking is another significant component of inequalities, in the dual sense that smoking is related to deprivation and itself leads to poor health outcomes. Evidence from inside and outside Scotland has shown that rates of adolescent smoking were higher in households where the head of the house was unemployed. Associations have been found between adolescent smoking (boys and girls) and in both the number of smoking parents a young person has (Greishbach and Currie 2001; Charles, Cosgrove and Hill 2002) and the young peoples' perceptions of parental disapproval. Daily smoking by boys and girls was higher if both parents smoked (Royal College of Physicians cited in Charles, Cosgrove and Hill 2002). There is also a link between smoking and poorer diet and lack of physical exercise. Daily smokers are significantly less likely than non-smokers to eat a consistently healthy diet (Greishbach and Currie 2001).

The NHS Fact File (2003) reported that smoking rates in Scotland for boys aged 14 to 15 years have fallen from 11% to eight per cent, but the figure for girls (13%) remained unchanged. However, these figures have been challenged by other research studies which found increases during the past decade in daily smoking among boys (12.4% to 19.2%) and girls (12% to 24%) (Greishbach and Currie 2001). This is the highest rate in Europe for smoking among 15 year olds. Moreover, smoking daily is an indicator that future patterns of habitual smoking have begun to be established; smoking rates for women in Scotland are already amongst the worst in Europe, at 32% (NHS Fact File 2003).

Of concern is the growing number of young people drinking alcohol and the link between smoking, drinking and drug use. In Scotland, there has been an increase in the number of children and young people under 16 using alcohol and an increase in the frequency of use. The number of pupils aged 12 to 15 who had consumed an alcoholic drink in the previous week rose from 14% in 1990 to 20% in 2000 (NHS Fact File 2003). The likelihood of weekly drinking increases with age and more young girls are drinking at least once a week, although boys aged 12 to 15 are drinking more than girls (12.8 units compared with 9.6) (NHS Fact File 2003). In 2000, there were 1,428 emergency admissions of young people aged 10 to 19 with a diagnosis of acute intoxication, the majority of which (1,036) were aged between 15 and 19 (NHS fact file 2003).

Older young people aged between 16 to 24 years are also drinking more; the average weekly consumption has risen from 20.8 units (1995) to 23.4 (1998) for men and 8.4 to 10 units for women during the same period. Young people in this age group are the most likely to exceed weekly recommended limits

Recent surveys of Scotland's young population have showed that the awareness and use of legal and illegal drugs is prevalent across the country; by their mid-teens around 40% of 15 to 16 year olds will have tried at least one illegal drug (McKeganey and Beaton 2001). Children aged 12 to 15, who drink frequently, are more likely to report drug use. Boys were more likely than girls to have used drugs during the previous month (11% compared with 8%) and were also more likely to have been offered drugs than girls (41% compared with 36%) (NHS Fact File 2003).

Early pregnancy brings health risk for the mothers and, on average, poor outcomes for the resulting children. Some research has found that sexual intercourse before the age of 16 may be associated with factors such as deprivation and low educational levels, and is more common among young people who have poor relationships with their own parents or whose mothers also gave birth while in their teens (Corlyon and McGuire 1997; Henderson *et al.* 2002). Sweeting and West (cited in Ely *et al.* 2000) also found that less time spent at home at the age of 15 was associated with early pregnancy. However, it is important to stress that the focus of this report is not on early sexual activity *per se*, but sexual behaviour that poses a threat to the young person's health in terms of sexually transmitted diseases and unplanned pregnancies.

A study set up to examine heterosexual risk behaviour in teenagers in Scotland (Greishbach and Currie 2001) found that those most likely to use contraception were those where the sexual relationship had lasted longer than a month, and where the couple had planned to have sex and had discussed contraception prior to doing so. The lowest proportion of contraception or condom use was found in cases where intercourse was unexpected and/or was carried out for the first time with a partner of less than a month's duration. Such unprotected sex carries the greatest health risks (Hill and Tisdall 1997; Greishbach and Currie 2001).

Mental health and emotional wellbeing

In Scotland, about 125,000 young people experience mental health problems that interfere with their daily lives (Health in Scotland 2002).

In 2002, Meltzer and colleagues conducted a three-year follow up survey of the mental health of children and adolescents in Great Britain. Information was collected twice from 2,938 children and, from the first round of data collection, 573 children were identified as having a mental disorder. The researchers found that 43% of the children assessed in 1999 as having a conduct disorder were also rated as having a disorder three years later. For children assessed as having a clinically-rated emotional disorder in 1999, 25% were assessed as having an emotional disorder three years on.

The authors concluded that children were more vulnerable to the onset of a mental disorder if the mother's mental health had deteriorated; if family functioning and relationships had worsened; if the child had experienced a number of stressful events; if there were changes in the employment status of the main breadwinner; and if children lived in households with high discord (Meltzer *et al.* 2003). One key factor that emerged linked the presence of an emotional disorder in a child with the mother's poor mental health.

Meltzer and colleagues (2003) also found that 18% of those with a persistent mental disorder were permanently or temporarily excluded from school. Children with either emotional or conduct disorders had missed more days at school than their peers without a disorder. Young people aged 15 and over with a mental health problem were less likely to be in full time education (63%) compared to young people with no mental health difficulties (83%). Young people aged 16 and over with persistent mental health problems were twice as likely to have no qualification as those with no disorder. More positively, those who recovered tended to obtain higher levels of qualifications than those who did not.

According to the NHS Fact File 2003, mental health problems may also be on the increase within minority ethnic communities in Scotland. This could be due to increased tensions between values and ways of life for different cultures and different generations, conflicting perspectives on the role of women and arranged marriages, and experiences associated with being a refugee or asylum seeker. However, further research is needed on this.

Suicide and deliberate self-harm

There has been a steady rise in both the number and rate of suicide in Scotland during the last 16 years. Scotland's rate is much higher than for other areas in the UK and one of the highest in Europe (NHS Fact File 2003).

In 2001, there were 887 suicides and indeterminate deaths – an increase of 22% since the 1980s, with boys and men aged 11 to 24 as the group at particular risk (Hill and Tisdall 1997; *Choose Life* 2002a). The Scottish Executive reported in *Choose Life* (2002a) that, for the general population, key factors, events or triggers for suicidal thoughts include sexual abuse, homelessness, running away from home, experiencing violence, expulsion from school, major financial crisis, court appearance and looking for work for over one month. Those who reported three or more of these events were over three times as likely to have suicidal thoughts, while those experiencing six were nine times as more likely.

Oral health

In Scotland, child oral health remains poor with only 45% of Scottish five year olds free from dental decay in 2000, 15% short of the national target of 60% by 2010 (NHS Fact File 2003).

The 1993 national child dental survey found significant associations between dental decay and deprivation for 15-year-olds living in the UK (cited in Jones, Woods and Taylor 1997). This association is echoed in the findings from surveys of five-year-olds, 12-year-olds and 14-year olds in Scotland (Jones, Wood and Taylor 1997) and from a dental health project set up to promote dental health among under-threes in the Drumchapel area of Glasgow, a housing estate associated with poverty and deprivation (McFayden, Lamb and Harper 2000).

3 The health needs of looked after and accommodated children and young people

General health

Despite the adverse factors in the backgrounds of children who are looked after and accommodated, and those resulting from discontinuities of placement and school, the current general health of the majority is good. This applies largely to physical health, however, and is subject to two important qualifications. Firstly, many of the young people have lifestyles that present major threats to their present or future wellbeing. Secondly there is a high incidence of mental health problems (including conduct disorders).

The literature suggests that for around three quarters of young people looked after and accommodated in Scotland, their health is assessed as good or very good by both the young people themselves and those who care for them (Triseliotis *et al.* 1995; Meltzer *et al.* 2004). A survey by Meltzer and colleagues (2004) of children looked after in Scotland asked carers and parents to rate the health of the children they care for. Children living with foster carers were more likely to be rated as having very good health (70%) compared to children living in other types of placement, particularly residential care (38%).

An important point made by Meltzer and colleagues (2004) was that the general health of children seemed to improve as placements became more secure. Over two-thirds of children who had been in placement for two years or more were assessed as having very good health, but this reduced to just under half for those who had been in placement for less than two years.

Health-related behaviour and lifestyles

In a recent survey of looked after and accommodated children, information about the use of legal and illegal substances was asked for. Meltzer and colleagues (2004) found that 44% of looked after and accommodated children in Scotland aged 11 to 17 were smokers and over a quarter of all children who smoked reported that they had started smoking at the

age of ten or under. This reflects the responses from young people themselves. Scottish Health Feedback (2003) found that from 96 survey responses of looked after and accommodated young people, 75% were smokers and that more females smoked (79%) than males (73%), in line with national trends.

The same survey (Scottish Health Feedback 2003) also identified high levels of under-age and problem drinking among the sample. Fifty per cent of respondents drank alcohol once a week. Although this sample is small, high levels of alcohol use by young people in the care of local authorities has been found in other studies in Scotland and England (Triseliotis *et al.* 1995; Saunders and Broad 1997).

Griesbach and Currie (2001) found a significant uptake of drugs by young people who had experienced care, compared to other teenagers. Among the many reasons given by those in public care was that it helped them to forget 'bad things', to relax or to give them more confidence. Around a third (31%) had first tried drugs while in care, but just over two-thirds had taken drugs before coming into care.

Meltzer and colleagues (2004) found that looked after and accommodated children in Scotland aged 11 to 17 were twice as likely to smoke, drink or take drugs as their English counterparts.

A survey of 96 young people in and leaving care in Glasgow (Scottish Health Feedback 2003) found gaps in young peoples' access to information on sexual health generally and safer sex in particular. Sexual health programmes are often delivered through schools but, as mentioned above, looked after and accommodated children and young people often miss school more frequently than their peers. Forty percent did not know where the nearest sexual health or contraception service was and a significant number (26%) worried about getting pregnant or getting their girlfriend pregnant. Other studies have also shown gaps in young people's knowledge around the risks of unsafe sex in terms of sexually transmitted disease and pregnancies (Triseliotis *et al.* 1995).

Corlyon and McGuire (1997) concluded that for many teenagers there is an attitude of 'it won't happen to me'. However, looked after and accommodated children are often having to deal with feelings of loss and rejection and must prepare for independent living at an earlier age, and with fewer supports than their peers. This can contribute to a lack of confidence and self esteem. Young people in the care system aspire to the same things as

young people within the community including access to education, training and employment. However, early marriage and parenting are also considered as options to a greater extent than their peers.

Mental health and emotional wellbeing

A number of studies, including several in Scotland, have identified that the mental health problems for looked after and accommodated children and young people are markedly greater than that of their peers in the community (McCann, James, Wilson and Dunn 1996; Dimigen *et al.* 1999; Ward and Skuse 1999; Ridley and McCluskey 2003; Meltzer *et al.* 2004). Reasons include the child's experience in terms of poor parenting, trauma, bereavement or serious illness, including mental health difficulties in one or both parents, and the impact on the child of the environment such as poor neighbourhoods, deprivation, social exclusion and poverty (van Beinum, Martin and Bonnett in Scott and Ward (eds)). What is also clear is that a considerable proportion of children suffer mental health problems at the time they enter the care of the local authority (Dimigen *et al.* 1999).

In the late nineties, some publications reported that looked after children living in residential care in England experienced more difficulties than children placed in foster care (McCann *et al.* 1996; Dimigen *et al.* 1999). A more recent survey of 355 children in the looked after system in Scotland found that looked after children, including those looked after at home, experienced higher levels of mental health difficulties than that of their peers (Meltzer *et al.* 2004). Similar numbers of children living with parents experienced mental health difficulties as those in foster and residential care, at around 40%. However much less is known about the support and services offered to these equally vulnerable children and their families.

From this survey (Meltzer *et al.* 2004), 45% of those aged between 5 to 17 years of age were assessed as having a mental disorder. Those aged 5 to 10 who were looked after at home or accommodated were six times more likely to have a mental disorder than those children living with families in the community (52% compared with 8%). The rates for the different types of disorder were as follows:

- emotional disorders: 14% compared with 4%
- conduct disorders: 44% compared with 4%
- hyperkinetic disorders: 11% compared with 1%

Some children had more than one type of disorder and these were more likely to be boys.

Those aged 11 to 15 and either looked after at home or looked after and accommodated were four times more likely to have a mental disorder than those children living with families in the community (41% compared with 9%). For different types of disorder the rates were as follows:

- emotional disorders: 14% compared with 5%
- conduct disorders: 35% compared with 6%
- hyperkinetic disorders: 8% compared with 1%

Again, some young people had more than one type of disorder.

Six per cent of children surveyed were reported to be taking one of 14 types of medication commonly used in the treatment of childhood mental disorders and a fifth diagnosed as having hyperkinetic disorders were taking some form of psycho-stimulant such as Ritalin (Meltzer *et al.* 2004).

In another Scottish study, Minnis and Del Priore (2001) found that looked after and accommodated children were more likely than children not known to social work services and living with their families, to have some form of attachment disorder. In the past, attachment disorders have been less recognised by health professionals. However, if these issues are not addressed, there are increased risks of placements breaking down because of a child's failure to form secure attachments and implications for the child's future health, wellbeing and ability to form relationships in adulthood (Minnis and Del Priore 2001).

Minnis and Del Priore also commented that the children in the above study were predominantly white. Whilst this may reflect low rates of ethnic minority looked after children in Scotland, the impact of mental health difficulties on children and families from ethnic minority communities will be just as great as for other groups in society.

Impact of mental health difficulties

McCarthy and colleagues (2003) found that 40% of a sample of children looked after by one English authority were experiencing significant difficulties in three of four key areas: home life, friendships, learning and leisure activities. The authors comment that '*children and young people with multiple adjustment problems are at high risk of developing a range*

of very significant psychosocial outcomes in later adolescence and early adulthood (p17). There are also implications for those caring for these children and young people.

Studies have found that carers' perceptions of feeling burdened were related to caring for a child reported to be displaying high levels of behavioural problems, such as conduct disorder. Carers have reported that where problems had been identified the symptoms had been present for over a year (McCarthy, Janeway and Geddes 2003). Carers need to be informed of a child's emotional and behavioural problems and supported to help the child. Otherwise, they may feel the child has been misrepresented to them, which has the potential to contribute to breakdown of the placement (Richardson and Joughlin 2000; Wilson, Sinclair and Gibbs 2000).

Foster carers and residential workers require a range of support services while caring for a looked after child with mental health difficulties. They are likely to benefit from specific training and ongoing support in the management of conduct disorders in order to minimise the consequences.

Suicide and deliberate self-harm

The key factors, events or triggers for suicidal thoughts and attempted suicide mentioned previously in the report are often disproportionately present in the lives of looked after and accommodated children and young people (Wade and Smart 2002). The child protection audit undertaken by the Scottish Executive in 2002 found that from 50 deaths of looked after children between 1997 and 2001, 11 were suicides (Scottish Executive 2002b).

A survey of 96 young people in Glasgow looked after away from home reported that 45% of respondents had harmed or self harmed at some point in their lives and a third had asked for help in relation to this behaviour. Females were most likely to deliberately self-harm, especially younger females aged 14 to 15 years. For those who had deliberately self-harmed, there was a clear link between with depression and low self esteem (Scottish Health Feedback 2003).

Oral health

Oral health was highlighted as a neglected area by respondents to a small survey of young people looked after and accommodated (Scottish Health Feedback 2003), with about half of the 96 respondents not having visited a dentist during the last year, 70% of those being male.

4 Factors affecting the health of looked after and accommodated children and young people

For a significant number of looked after and accommodated children, the factors which wider research has shown to be associated with poorer health outcomes are present within the child's original family and environment. Many were born into families from lower socio-economic groups (Bebbington and Miles 1989), exposed to discord likely to heighten the child's stress (Triseliotis *et al.* 1993) and a significant proportion have become looked after as a result of physical injury, neglect or sexual abuse (Minnis and Del Priore 2001). Thus children who are looked after and accommodated tend to have backgrounds and previous experiences which heighten the risk of poorer than average current and future health and wellbeing.

The factors within a child's family circumstances may mean that they are at considerable risk of missing out on routine health surveillance such as immunisations or regular health care (Ward *et al.* 2002). Immunisation programmes can offer prevention from diseases which are likely to have long term consequences for children whose health, as Ward and colleagues (2002) point out, is already weakened by a poor diet or adverse living conditions. It is also indicative of the fact that some children entering the looked after system will require compensatory health care, but as Polnay (2000) comments '*The potential for the care service to compensate for previous deficits rather than simply to provide accommodation until children reach adulthood is not always explicitly understood*' (p661).

Once in the care of a local authority, the process of conducting health checks and assessments required through routine medical examinations has not always been satisfactory. In England, there has been no standard format for the content of medical reports, which were often poorly recorded. Furthermore, children and young people did not view the annual medical in a favourable light and refused to be taken out of school to attend their medical assessment undertaken by a practitioner barely known to them (Butler and Payne 1997). In Scotland, the approach taken was different, in light of this experience. The Arrangement to Look After Children (Scotland) Regulations 1996 did require local authorities to arrange medical

examinations and written health assessment for all children before a child is placed, or as soon as possible thereafter, but there was no expectation to arrange an annual health assessment. Although this may help avoid an experience that some young people find stigmatising or pointless, it could also mean that both routine checks and the need for compensatory health care are overlooked. A study of nine health districts across England, Scotland and Wales showed that 33% of children in public care did not receive the meningococcal C vaccine compared with 15% of children who were living at home and not known to social work services (Hill, Mather and Goddard 2003).

The number of moves experienced by children looked after away from home impacts on the continuity of their development across all areas of their lives including health (Chambers *et al.* 2003; Ward *et al.* 2002). National figures from England show that 16% of looked after children experience three or more placements in any year (Ward *et al.* 2002). Statistics published by the Scottish Executive showed that in the year ending 31 March 2004, 30% of looked after and accommodated children in Scotland had three or more placements (Scottish Executive looked after children statistics, 2004a). Moving between different homes or units can result in issues being overlooked. Moving, which involves changing health authority, can result in appointments being changed, missed or subject to delay. Not only is information about current health issues lost, but just as important is the potential loss of the family health history (Butler and Payne 1997; Hill 2001).

Hill (2001) identified a number of reasons why an accurate record of the child's family health history is important to a child:

- genetic transmission: inherited conditions may remain unnoticed or not be picked up by carers. A common example given was the sickle cell trait where failure to screen could place the child at risk under anaesthesia. Genetic conditions which do not manifest in childhood or in the carrier may not be important during the years of childhood, but knowledge of these conditions may influence important decisions in adult life
- promoting health through prevention: Hill (2001) cites the example of parental history which highlighted that the birth father suffered from coeliac disease. The carers were then advised to delay introduction of gluten to the infant's diet

- infection risk: this includes the transmission of blood-borne diseases such as HIV and hepatitis. Testing needs to be undertaken to ensure the child is not at risk
- prognosis: emotional and behavioural difficulties in children and the child's learning abilities impact on the ability of the child to maximise educational opportunities. Knowledge of the family history may shed some light on the cause of established or emerging problems

Gathering accurate family history is not necessarily an easy task. Some parents may be deceased, untraceable or refuse consent, but it is key that professionals working with children understand the importance of this information in a child's current and later life.

A number of studies have also identified the absence of accurate up-to-date recording of children's health needs (Butler and Payne 1997; Ward and Skuse 1999; Cleaver and Walker 2002). It seems that social workers do not regard this activity as part of their daily routine and, if they do, regard it as a lower priority than other pressing matters of family conflict or finding the child a home. With a less stable workforce struggling with vacancies and high turnover of staff, it is essential to have an accurate record of the child's life when all else around may be changing.

Changes in placement can also result in changes in school and this, together with higher truancy rates, can mean looked after and accommodated children miss out on routine medical checks and health promotion initiatives within the school. This can include informed discussion on healthy lifestyles, contraception, sexually transmitted diseases, sexual choices and risk-taking behaviours such as misuse of drugs, tobacco and alcohol (Ward *et al.* 2002). When children and young people entered the care system in England they were ten times more likely than their peers to become excluded from school (Polnay and Ward 2000).

The research would suggest that fewer changes in placement and more stable placements are factors in promoting the health and wellbeing of looked after and accommodated children and young people. More attention to and accurate recording of a child's health history, current health and wellbeing would provide a fuller picture of the child's needs, the strategies required to promote the child's development and the supports needed by those who care for them.

5 The health needs of young people leaving, or who have recently left, care

Stein and others in several countries have shown how poorly equipped many young people leaving care are to cope with life after care – practically, emotionally and educationally – and have made connections with their subsequent experiences of loneliness, isolation, poor mental health, unemployment, poverty, drift and homelessness (Stein and Kufeldt, in Scott and Ward (2005)). Meltzer and colleagues (2003) noted that 47% of looked after and accommodated 16-year-olds were assessed as having a mental disorder.

From research in England, it is estimated that a quarter of young women leaving care are pregnant or have a child and that the numbers of young women who give birth increases within 18 to 24 months of leaving care (Biehal *et al.* 1995). This is of particular concern because a significant number of looked after young people of this age have the added pressure of moving to independent living and many experience heightened feelings of anxiety and isolation. This echoes the feedback from young people themselves (Scottish Health Feedback 2003).

Young people have criticised the timing and poor preparation for leaving care. The transition from care to independent living has been considered to be detrimental in terms of health and wellbeing with high levels of depressive moods, low self esteem and deliberate self harm (Ridley and McCluskey 2003; Scottish Health Feedback 2003).

Many of the factors, identified by Stein and others, are associated with the areas of risk identified for those likely to self-harm or attempt suicide (Choose Life 2002). Factors such as changes in family composition; poor social cohesion or integration including neighbourhood deprivation and poverty; isolation; feelings of fear; inadequate access to services; employment status; substance misuse and alcohol problems; low self esteem; lack of confidence; and experience of abuse are present in many of the lives of young people looked after and accommodated who, from 16 onwards, are expected to move towards independent living.

6 What do young people think about health issues?

Evidence suggests that children generally view health as primarily to do with diet, exercise and dental hygiene (Hill and Tisdall 1997; Armstrong, Hill and Secker 2000; Ridley and McCluskey 2003). Judgements of whether a young person is healthy are usually based on appearance (slim or fat), eating habits and athletic ability. The relationship between health and appearance is particularly evident in adolescence and impacts on eating patterns. Adolescent females tend to perceive slimness as a 'good thing', a social asset or being fit (Brannen *et al.* cited in Hill and Tisdall 1997; Armstrong, Hill and Secker 2000).

Younger children often describe ill health in terms of behaviour such as wanting to lie down, although they often explain illness in terms of contagion. Older children have more understanding of symptoms and a greater awareness of the social context (Hill and Tisdall 1997).

Many young people have a different view of the meaning of the terms 'mental health' and 'mental illness' compared to health professionals. Accessing services can be seen as stigmatising. One study (Secker, Armstrong and Hill 1999) interviewed 120 young people from a variety of social and minority ethnic backgrounds, who attended mainstream schools in rural, suburban and inner city areas in Scotland, about their views of mental health. The focus of the study was on the young people's perceptions of mental health. They identified four key features which contributed to, or promoted good mental health: family and friends, having people to talk to, personal achievements and feeling good about yourself. These are features not always present in the lives of looked after and accommodated children and young people.

A major theme to emerge from the interviews was the need for adults to make young people feel safe and cared for both physically and emotionally in terms of promoting good mental health. Professionals did not feature significantly as a group of adults the young people would turn to or trust, but they often had access to wider family networks

(Armstrong, Hill and Secker 2000). It has been suggested that many looked after children do not have access to a number of trusted adults to whom they can turn for advice or support, in stark contrast to the majority of children in the community (Mather, Humphrey and Robson 1997), though usually, but not invariably, there is at least one person who is seen as a source of support (Hill 1999).

A survey of looked after and accommodated young people in Glasgow (Scottish Health Feedback 2003) showed that they identified exactly the same factors contributing to good health as the general youth population: physical fitness, healthy eating and physical attractiveness. Praise and encouragement were thought to promote health or make you healthy; providing a link between how you feel, your level of self esteem and how you are able to function in life. Those young people also asked for more information or advice on a range of health topics including sexual health, mental health, drug and alcohol problems as well as physical health. Young people saw living in residential care as a barrier to a healthy lifestyle, for example through not having the opportunity or enough money to meet the cost of some sports or exercise activities (Ridley and McCluskey 2003).

Young people also wished to be listened to during consultations, whether it was a routine health check or more specialist intervention. Young people often reported that they did not feel listened to (Bundle 2002; van Benium, Martin and Bonnett, in Scott and Ward (2005) and that professionals and health organisations were difficult to approach (Buston 2002).

7 Messages for policy and practice

The wider context

While the health of children in general is often good, the incidence of some health problems such as asthma and psychiatric difficulties have increased considerably over the last few decades. In today's society there are concerns about the lifestyles chosen or followed by some of our children and young people. The average Scottish diet remains unhealthy, with childhood obesity on the increase (NHS Factfile 2003). Recent surveys of Scotland's young population have showed that the awareness and use of legal and illegal drugs is prevalent across the country (McKeganey and Beaton 2001). A sizeable number of our young population struggles with mental health problems which interfere with their daily lives (SNAP 2003b) as well as dealing with the stresses related to growing up in a society where the structure of our families and communities is changing. Families are separating more, often resulting in new partnerships or remarriage, which pose challenges for the children concerned (Wade and Smart 2002; Jensen and McKee 2003).

Children and young people who are looked after and accommodated tend to express exactly the same concerns about their health as children and young people across Scotland (Scottish Health Feedback 2003). The difference, however, is the context in which these challenges are faced. Discord within their own families, moves of home, changes in school or interrupted school careers, and a lack of access to the support and advice of trusted adults can load additional pressures on young and vulnerable shoulders.

Health risks and needs

Looked after and accommodated children and young people share many of the health risks and problems of their peers, but often to a greater degree. This is because some become accommodated, in part, as a result of health issues, while in other cases reasons prompting removal from home (such as child abuse or family tensions) have health components and

consequences. The usual arrangements for health monitoring and care may not function so well, especially when there are frequent changes of home and school.

Research on the physical and mental health of children and young people who are looked after and accommodated has shown that in most respects this group is doing less well than their peers and these children have extensive health care needs. Correspondingly, children and young people with severe health problems are considerably over-represented in the looked after and accommodated population. This applies particularly to poor diet and lack of exercise, excessive drug and alcohol use, mental health problems including attempted or completed suicides, and some aspects of sexual behaviour.

The health issues or concerns for looked after and accommodated children are usually multifaceted. A concern in one area of a child's life should not be addressed in isolation from its impact on other parts of the child's development. The presence of a conduct disorder may have implications for the stability of the child's home life and participation within the school environment. Self esteem and self confidence are crucial factors in shaping how young people perceive their own health and build their confidence in order to seek out and access advice from the more sensitive or potentially stigmatising services such as sexual or mental health. It would seem logical that the solutions to health concerns should not be seen as the sole responsibility of one agency, but as a partnership across agencies and with carers.

Much of the literature about looked after and accommodated children focuses on those in residential or foster care. Little is known about the needs of children looked after at home by their families, about how families are supported to care for their child, and about the extent, nature and impact of services on families, children and young people. This is important in its own right, and also because many such children have often been accommodated previously and some are likely to be so in the future. The survey by Meltzer and colleagues (2004) identified that the prevalence of mental health concerns was similar for children and young people who were looked after at home as for those who were looked after and accommodated. A better understanding of how to meet the needs of these families is essential in order not to fail the children and young people.

Variations in health risk

Certain groups within the looked after and accommodated population may have greater health risks than others. In nearly all areas discussed in this report, males are reportedly more at risk than females; young males are particularly vulnerable with regard to attempting or completing suicides (Choose Life 2000); more have complex mental health needs (Meltzer *et al.* 2004); and levels of smoking, drinking and drug use are greater (Triseliotis *et al.* 1995; Griesbach and Currie 2001; Meltzer *et al.* 2004). Recent reports have also identified the growing mental health needs of black and minority ethnic communities within Scotland. Whilst numbers may be relatively small, the impact of mental health issues on these families will be just as great as for other communities within our society (NHS Fact File 2003).

A particularly vulnerable group comprises those young adults preparing to leave care and move to (semi-) independent living while still, for the majority, in their teens. The pressures of growing up, deciding whether to finish or continue education, and finding work are challenges in themselves without also finding a home and living independently. This contrasts with the majority of young people in the community, who stay on in education and remain dependent, to varying degrees, upon their families until their mid twenties (Joseph Rowntree Foundation 2002).

Access to appropriate health care

It is not enough to simply identify the health needs of this population. There is also a need to review how services are provided. Much evidence exists that many children who are looked after and accommodated do not receive the health assessments and treatments they need from conventional health services. The reasons include: frequent moves disrupting communication and records; professionals' low level of awareness of the particular circumstances of looked after children; stigma and fears associated with standardised examinations or visits to clinics; and the reluctance of some children and young people to engage with health professionals. Also, social workers and carers have sometimes not given sufficient priority to health matters.

A recent study undertaken by Blower and colleagues (2004) assessed the needs of looked after and accommodated children and concluded that there is also a gap in the delivery of effective interventions to children whose mental health problems are already identified (Blower *et al.* 2004).

Blower and colleagues (2004) acknowledge that it is uncertain to what extent the findings from one study can be generalised, but their conclusions partly reflect the writings of others who argue for a more flexible approach to mental health issues by health professionals themselves (Dimigen *et al.* 1999; Minnis and Del Priore 2001; Buston 2002; McCarthy, Janeway and Geddes 2003) and discuss the provision of training in mental health issues for those working directly with young people including carers (Secker, Armstrong and Hill 1999; van Beinum, Martin, Bonnett 2002).

Recent initiatives have begun to consider other approaches to delivering health services, especially through the recent but fast developing use of specialist looked after children nurses in schools. Innovative approaches to mental health services have been developed. These put the needs and wishes of the young person at the centre, consider more flexible approaches to service delivery and work in partnership with those caring for looked after children.

Initiatives such as *Open Door* (Van Beinum, Martin and Bonnett 2002), *LACES* or the *Residential Health Care Project* (Grant, Ennis and Stuart 2002) provide a more flexible service to looked after and accommodated children and young people. Although different in approach, both projects operated on an outreach basis, taking the services to the young people, who were not expected to attend clinics or surgeries they considered stigmatising or daunting (Grant, Ennis and Stuart 2002). Both approaches supported and trained those working directly with young people to help them deal with difficult behaviours with greater understanding and more confidence. Those involved also acknowledged the need for professionals to work together in a context of mutual respect.

The *Residential Health Care Project* also took an open-minded approach with the young people in terms of health promotion and various methods were explored including drama, group work, individual work and work involving specialist agencies. There was a need to tailor the work to a particular group or individuals living in the residential unit at any one time. Grant and colleagues (2002) emphasise the value of positive role modelling which can be used to develop the idea of the health promoting unit where staff and young people pull together to make their lifestyles as healthy and enjoyable as possible.

The evaluation of this project concluded that all agencies need to be proactive in nurturing inter-agency links, to encouraging reflective practice and an approach aimed at the continuous improvement of services. Health services need to provide more opportunities for more meaningful health assessments (Grant 2002). In some areas, specialist looked after nurses are increasingly working within school settings, a development which allows young people to access health care and advice in a more routine and non stigmatising way, rather than having to be taken out of class for formal medicals.

While we have seen that for some children, their health may improve once they are looked after, we also know that many looked after children enter the care system with significant health deficits. It is important then, that children's health needs, including their mental health needs, should be addressed as far as possible before this stage. Future customers can be more positive if attention is given to the health needs of a child still living with the family and if effective supports are in place early in a child's life. *Starting Well* is one of the national health demonstration projects which aims to show that child health in Glasgow can be improved by a programme of activities which both supports families in the period leading up to birth and throughout the first three years of childhood and provides them with access to enhanced community-based resources. Two key components of this project are intensive home-based support and the provision of a strengthened network of community support services for children and families. The project is being evaluated to assess its impact on health outcomes on children.

Many looked after and accommodated children return to the birth home or to live with relatives, or leave care. Often their mental health difficulties and habits, such as smoking, drinking and drug use, were present or established before entering the care system. In order to change or modify behaviours and habits successfully, these issues need to be considered before the child or young person leaves the care of the local authority to a situation where less or no support is provided.

Final comments

Politicians are increasingly aware of the dangers of ignoring the health needs of our young population and there is a policy agenda beginning to address these issues. There is also a greater understanding of the complexities of the health problems of looked after children and how this impacts on children, those who care for them and their communities. The literature recognises that service delivery, particularly in the areas of mental and sexual health, needs to be re-considered and some practice developments have begun to develop these ideas and approaches. Parallels may be drawn with the educational disadvantage of looked after children, which required concerted efforts at individual, local and national levels to instigate organisational, attitudinal and training changes required to ensure that suitable learning support has been made available (Borland *et al.* 1998; McLean and Gunion 2003). The drive and opportunities are there for professionals to work together with politicians, policymakers, children, young people and their families to improve the health of all children in our society, and, in particular, those for whom we have legal responsibilities to parent to the best of our abilities.

Appendix – Textual references

A Partnership for a Better Scotland (2003)

Acheson, D., (1998) *Independent Inquiry into the Inequalities in Health*. London, The Stationery Office

Armstrong, C., Hill, M. and Secker, J. (2000) 'Young people's perceptions of mental health'. *Children and Society*, 14(1) pp. 60-72

Bebbington, A. and Miles, J (1989) 'The background of children who enter local authority care.' *British Journal of Social Work*, 19 pp. 349-368

Benium van. M., Martin, A. and Bonnett, C. (2002) 'Catching children as they fall: mental health promotion in residential child care in East Dunbartonshire'. *Scottish Journal of Residential Child Care*, pp. 14-22

Benium van. M., Martin, A. and Bonnett, C. (forthcoming) 'Catching children as they fall: the East Dunbartonshire looked after children mental health project'. In J. Scott and H. Ward (eds) *Promoting the Well Being of Children, Families and Communities*. London: Jessica Kingsley

Biehal, N., Clayden, J., Stein, M. and Wade, J. (1995) 'Leaving Care in England: A research perspective' *Children and Youth Services Review*, 16(3/4) pp. 231-254

Blower, A., Addo, A., Hodgson, J., Lamington, L. and Towison, K. (2004) 'Mental Health Needs of Looked After Children. A Needs Assessment. *Clinical Child Psychology and Psychiatry*, 9(1) pp. 117-129

Borland, M., Pearson, C., Hill, M., Tisdall, K and Bloomfield, I. (1998) *Education and Care Away from Home: A review of research, policy and practice*. Edinburgh: SCORE.

- Boys, A., Farrell, M., Taylor, C., Marsden, J., Goodman, R., Brugha, T., Bebbington, P., Jenkins, R. and Meltzer, H. (2003) 'Psychiatric morbidity and substance use in young people aged 13-15 years: results from the Child and Adolescent Survey of Mental Health'. *British Journal of Psychiatry*, 182 pp. 509-517
- Bundle, A. (2002) 'Health information and teenagers in residential care: a qualitative study to identify young people's views'. *Adoption and Fostering*, 26(4) pp. 19-25
- Buston, K (2002) 'Adolescents with mental health problems: what do they say about health services?' *Journal of Adolescence*, 25(2) pp. 231-242
- Butler, I. and Payne, H. (1997) 'The health of children looked after by the local authority'. *Adoption and Fostering*, 21(2) pp. 28-35
- Callaghan, J., Vostanisis, P. and Young, B. (2003) 'Developing new mental health services for looked after children: a focus group study'. *Adoption and Fostering*, 27(4) pp. 51-63
- Chambers, H. with Howell, S., Madge, N. and Olle, H. (2002) *Healthy care: building an evidence base for promoting the health and well being of looked after children and young people*. London: National Children's Bureau
- Charles, T., Cosgrove, C. and Hill, C. (2003) Tobacco smoke – the impact on looked after children. *Adoption and Fostering*, 26(2) pp. 78-80
- Children (Scotland) Act 1995*, London: HMSO
- Cleaver, H. and Walker, S. with Meadows P. (2004) *Assessing Children's Needs and Circumstances*. London: Jessica Kingsley.
- Corlyon, J. and McGuire, C. (1997) *Pregnancy & Parenthood: the views and experiences of young people in care*. London: National Children's Bureau
- Dimigen, C., Del Priore, C., Butler, S., Evans, S., Ferguson, L. and Swan, M. (1999) 'Psychiatric disorder among children at time of entering local authority care: questionnaire survey'. *British Medical Journal*, 319(7211) p. 675

Dunnett, K. (2002) 'Looked after children: school nurses lead the way'. *Community Practitioner*, 75(4) p. 118

Dunnett, K. and Payne, H. (2000) 'How can we make health assessments more acceptable to looked after young people of secondary school age?' *Adoption and Fostering*, 24(3) pp. 83-84

Ely, M., West, P., Sweeting, H. & Richards, M. (2000) 'Teenage family life, life chances, lifestyles and health: a comparison to two contemporary cohorts'. *International Journal of Law, Policy and the Family*, 14(1) pp. 1-30

Ford, T., Goodman, R. and Meltzer, H (2003) 'Service use over 18 months among a nationally representative sample of British children with psychiatric disorder'. *Clinical Child Psychology and Psychiatry*, 8(1) pp. 37-51

Government response to the Second Report of the Health Select Committee on children Looked After by Local Authorities: Session 1997-98 (1998) London: The Stationery Office

Grant, A., Ennis, J. and Stuart, F. (2002) 'Looking after health: a joint working approach to improving the health outcomes of looked after and accommodated children and young people'. *Scottish Journal of Residential Child Care*, 1 pp. 23-30

Greishbach, D. and Currie, C. (2001) *Health Behaviours of Scottish Schoolchildren. Report 7: Control of Adolescent Smoking in Scotland*. Edinburgh: University of Edinburgh

Hall, D. and Elliman, D. (2003) *Health for all Children (Fourth edition)*. Oxford: Oxford University Press

Henderson, M., Wight, DD., Raab, G., Abraham, C., Buston, K., Hart, G. & Scott, S. (2002) 'Heterosexual Risk Behaviour among Young Teenagers in Scotland'. *Journal of Adolescence*, 25(5) pp. 483-494

Hill, C. (2001) 'Health inheritance: the importance of family history for children in public care'. *Adoption and Fostering*, 25(1) pp. 75-77

Hill, C., Wright, V., Sampeys, C., Dunnett, K., Daniel, S., O'Dell, L. & Watkins, J. (2002) 'The emerging role of the specialist nurse: promoting the health of looked after children'. *Adoption and Fostering*, 26(4) pp. 35-43

- Hill, C. & Mather, M. (2003) 'Achieving health for children in public care'. *British Medical Journal*, 326(7389) pp. 560-561
- Hill, C., Mather, M. & Goddard, J. (2003) 'Cross sectional survey of meningococcal C immunisation in children looked after by local authorities and those living at home'. *British Medical Journal*, 326(7385) pp. 364-365
- Hill, M. and Tisdall, K. (1997) *Children and Society*. Harlow: Longman
- Jensen, A-M. & McKee, L. (2003) *Children and the Changing Family*. London: Routledge-Falmer
- Jones, C., Woods, K. & Taylor, G. (1997) 'Short communications: social deprivation and tooth decay in Scottish schoolchildren'. *Health Bulletin*, 55(1) pp. 11-15
- Kelly, C., Allan, S., Roscoe, P. and Herrick, E. (2003) 'The mental health needs of looked after children: an integrated multi-agency model of care'. *Clinical Child Psychology and Psychiatry*. 8(3) pp. 323-335
- Kershaw, A., Singleton, N. and Meltzer, H. (2000) *Survey of the health and well being of homeless population in Glasgow*. London: The Stationery Office
- Martin, C., de Caestecker, L., Hunter, R., Gilloran, A., Allsobrook, D. & Jones, L. (1999) 'Developing Community Mental Health Services: An Evaluation of Glasgow's Mental Health Resource Centres'. *Health & Social Care in the Community*, 7(1) pp. 51-60
- Mather, M., Humphrey, J. and Robson, J. (1997) 'The statutory medical and health needs of looked after children, time for a radical review?' *Adoption and Fostering* 21(2) pp. 36-40
- Mayall, B., Storey, P. & Polnay, L. (1998) 'A school health service for children?' *Children and Society*, 12(2) pp. 86-100
- McCann, J., James, A., Wilson, S. and Dunn, G. (1996) 'Prevalence of psychiatric disorders in young people in the care system'. *British Medical Journal*, 313 pp. 1529-30

McCarthy, G., Janeway, J. and Geddes, A. (2003) 'The impact of emotional and behavioural problems on the lives of children growing up in the care system'. *Adoption and Fostering*, 27(3) pp. 14-18

McFadyen, J., Lamb, L. & Harper, C. (2000) 'Promoting dental health among Glasgow estate's under-threes'. *Community Practitioner*, 73(3) pp. 522-524

McKeganey, N. and Beaton, K. (2001) *Drug and Alcohol Use Amongst a Sample of Looked After Children in Scotland*. Unpublished paper, University of Glasgow

McLean, K. & Gunion, M. (2003) 'Learning with Care: The education of children looked after away from home by local authorities in Scotland'. *Adoption and Fostering* 27 pp. 20-31

McVea, J., Ross, M., de Caestecker, L., Milne, D., McEwen, A., Rees, N., Wilkie, L. & Morton, C. (2001) 'The national health demonstration projects'. *Health Bulletin*, 59(4) pp. 268-275

Meltzer, H., Gatward, R., Corbin, T., Goodman, R. and Ford, T. (2003) *Persistent, Onset, Risk Factors and Outcomes of Childhood Mental Disorders*. Edinburgh: The Stationery Office

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

Meltzer, H., Lader, D., Corbin, T., Singleton, N., Jenkins, R. and Brugha, T. (2002) *Non-fatal Suicide Behaviour among Adults aged 16-74 in Great Britain*. London: The Stationery Office

Minnis, H. & Del Priore, C. (2001) 'Mental health services for looked after children: implications from two studies'. *Adoption and Fostering*, 25(4) pp. 27-38

NHS Fact File (2003)

NHS Scotland (2003) *Needs Assessment report on child and adolescent mental health public health in Scotland*

Polnay, L. and Ward, H. (2000) 'Promoting the health of looked after children'. *British Medical Journal*, 320(7236) pp. 661-662

- Ridley, J. and McCluskey, S. (2003) 'Exploring the perceptions of young people in care and care leavers of their health needs'. *Scottish Journal of Residential Child Care* 2(1) pp. 55-65
- Richardson, J. and Joughin, C. (2000) *The mental health needs of looked after children*. London: Gaskill
- Saunders, L. & Broad, B. (1997) *The health needs of young people leaving care*. Leicester: De Montfort University
- Scott, J. and Ward, H. (2005) *Safeguarding and promoting the well being of children, families and their communities*. London: Jessica Kingsley Publishers
- Scottish Office (1998) *Working Together for a Healthier Scotland*. Edinburgh: Scottish Office
- Scottish Executive (2001) *Social Justice ... a Scotland where everyone matters*. Edinburgh: Scottish Executive
- Scottish Executive (2001) *For Scotland's Children*. Edinburgh: Scottish Executive
- Scottish Executive (2002a) *Choose life: a national strategy and action plan to prevent suicide in Scotland*. Edinburgh: Scottish Executive
- Scottish Executive (2002b) *It's everyone's job to make sure I'm alright"*. Report of the Child Protection Audit and Review. Edinburgh: Scottish Executive
- Scottish Executive (2003a) *Making it work for Scotland's Children: Child Health Support Group Overview Report*. Edinburgh: Scottish Executive
- Scottish Executive (2003b) *Scottish Needs Assessment Programme (SNAP). Review of Child and Adolescent Mental Health*. Edinburgh: Scottish Executive
- Scottish Executive, *The Residential Health Care Project 2000-2003 (2004), Forgotten Children Executive Summary*, Edinburgh: Scottish Executive
- Stein, M. and Kufeldt, K (forthcoming) *The Voice of Young People: Reflections on the in care experience and process of leaving care*. In J. Scott and H. Ward (eds) *Promoting the Well Being of Children, Families and Communities*. London: Jessica Kingsley

The Big Step (2001) The health of young people in care and leaving care in Glasgow. Glasgow: The Big Step: Social Inclusion Project

Triseliotis, J., Borland, M., Hill, M. and Lambert, L. (1995) Teenagers and the Social Work Services. London: The Stationery Office

United Nations Convention on the Rights of the Child (1989). Geneva: United Nations

Wade, A. and Smart, C. (2002) Facing Family Change: Children's circumstances, strategies and resources. York: York Publishing Services

Ward, H., Jones, H., Lynch, M. and Skuse, T. (2002) 'Issues concerning the Health of Looked After Children'. *Adoption & Fostering*, 26(4) pp. 8-18

Ward H., Macdonald I. and Skuse, T. (forthcoming) Looking After Children: Longitudinal cohort study – Final report to the Department of Health. Loughborough: University of Loughborough

Ward H. and Skuse, T. (1999) Looking After Children: Transforming data into management information: report on the first year of data collection. Totnes: Dartington Social Research Unit

Wilson, K., Sinclair, I. & Gibbs, I. (2000) "The trouble with foster care: the impact of stressful 'events' on foster carers". *British Journal of Social Work*, 30(2) pp.193-210

The health of looked after and accommodated children and young people in Scotland

This report, commissioned by the Social Work Services Inspectorate, now the Social Work Inspection Agency, provides a review of literature relating to the health of children and young people looked after by local authorities in Scotland. It is published as one of several supporting documents for a wider review of services and outcomes for looked after children, the main report of which is entitled *Extraordinary Lives*. The content of this report does not necessarily reflect the views of the Social Work Inspection Agency or the Scottish Executive.

The review team chose health as an area for detailed study because we consider it a fundamental aspect of children's well-being.

The key messages of this report are that children and young people who are looked after by local authorities have the same health needs as other young people but their backgrounds and past experiences, and sometimes their experiences while they are looked after, make them especially vulnerable. In particular, many looked after young people have to cope with sadness, distress and trauma which affects their mental health and causes them to behave in ways that put their health and safety at risk. Our aim is for looked after children to be physically and emotionally healthy as young people, and to grow into healthy and confident adults. To achieve this, young people need appropriate responses from the adults around them, stable and consistent care which meets their needs, and help to recover from past trauma.

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