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The health of looked after children and young people: a summary of the literature.



Dr Andrea Priestley and Dr Lisa Ann Kennedy
Centre for Excellence for Looked After Children (CELCIS)
University of Strathclyde

Making a difference to policy outcomes locally, nationally and globally

IPPI OCCASIONAL PAPER

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University of Strathclyde.

The health of looked after children and young people: a summary of the literature.

Dr Andrea Priestley and Dr Lisa Ann Kennedy,
Centre for Excellence for Looked After Children (CELCIS)

Abstract

This paper gives an overview of some of the main research findings regarding the physical health, mental health and health behaviours of looked after children. The paper begins with a child-level discussion of the health needs of looked after children, before considering some factors at the family-level, community-level and societal level which impact on the health of looked after children. The approach taken emphasises the importance of context and illustrates the need to attend to and understand the environment in which children, young people and adults are situated. The emerging implications for policy and practice have a common component in that they require an attendance to the diversity and individuality of looked after children. This is reflected in the call for more targeted data collection, robustness of research, reviews of the effectiveness of current interventions and consistent evaluation.

I Introduction

1.1 Understanding looked after children's health needs

Children who become looked after are *children* first and foremost. There is a need to acknowledge and understand their diversity and individuality. Being 'looked after' is only one dimension of their identity and account needs to be taken of their wide variety of backgrounds, experiences, abilities and needs. Reflecting this complexity, understanding the health needs of looked after children is far from straightforward. In July 2014, the total number of looked after children in Scotland was 15,580. This represented 1% of Scotland's under-22-year-old population. Of the total 'looked after' population, 91% lived in community settings [that is: with parents (4,144), friends and family (4,181), foster carers (5,533), prospective adopters (201) or other community placements (51)], with the remaining 9% (1,470) in residential settings [that is: in residential homes (697), in residential schools (393), in secure accommodation (82), in crisis care (16) or other residential placements (282)] (Scottish Government, 2015). The numbers and proportion of children looked after by friends, relatives or foster carers have been increasing since 2010, despite a levelling-off in the size of the total population over the same period.

Over the past decade, the age profile of Scotland's looked after children has changed, with the proportion of under-11 year olds increasing. In 2014, 21% of looked after children were of 'pre-school age' (0-4 years) and 37% of 'primary school age' (5-11 years) (Ibid.). This trend towards a younger 'in care' population may reflect changes in child welfare practice, with intervention (voluntary or compulsory) taking place earlier in a child's life.

Almost half of the looked after children in Scotland are located in just two health board areas: NHS Greater Glasgow and Clyde, and NHS Lothian. NHS Greater Glasgow and Clyde has responsibility for 33% of the Scottish looked after population and NHS Lothian 15% (Scottish Government, 2014.). However, while these figures are an indicator of the unequal distribution of looked after children across Health Board areas, they hide the fact that many looked after children are placed away from their home health board. Areas such as Dumfries and Galloway, with a high density of privately (independent or third sector) managed residential units and foster carers are likely to provide services to a much higher number of looked after children placed by other, more distant, local authorities than figures from the representative local authority areas suggest.¹ No official figures for children placed out of their home local authority or Health Board area are available.

The information above begins to raise awareness that the lived experiences of looked after children are likely to be diverse. Some looked after children still live at home with their birth families, whilst others might need to live outwith the family home. Some children may have begun to be looked after at birth, whereas other children may have entered the care system at 15 years old. Some children may have experienced sexual abuse, neglect, domestic violence; they may have parents who have passed away, have mental health issues, misuse drugs, and they may have experienced a number of these issues, or others, simultaneously. Some children may be looked after due to their disability. Moreover, in Scotland, there is an incomplete picture of the number of looked after disabled children, and their associated needs (For further discussion see Hill et al., 2015). Therefore, looked after children's pathways through care differ depending on their needs, age, family circumstances and so forth. Equally, whilst on that care journey, some might have really positive experiences and outcomes whilst others might experience multiple placement moves between home, foster care and residential care, and disrupted access to education and health services. The health needs of looked after children will reflect this complexity and diversity.

The diagram below illustrates how the health of an individual child both influences and is influenced by the contexts a child inhabits, from the immediate context of the family to the wider contexts of the community and society in which they develop. It is important to understand the

¹ See the Scottish Government Health Directorate (2013) *Establishing the Responsible Commissioner: Guidance and Directions for Health Boards* for a detailed discussion regarding the responsible Health Board.

interconnectedness of a child and their environment, alongside the temporal aspect – that is the timing of particular events and key transition points in a child's life. This also alerts us to the issue that health services are part of a much broader picture.

We need to recognise the importance of all aspects of the environment, for example, poverty, housing, education and so forth, which influence health in children, young people and adults alike. Health services are an important part of this picture, but for health interventions and services to be effective we must take into account all of these influences. In exploring the health needs of looked after children, this paper draws attention to the importance of the context in which children and young people are situated, and by means of which they act.

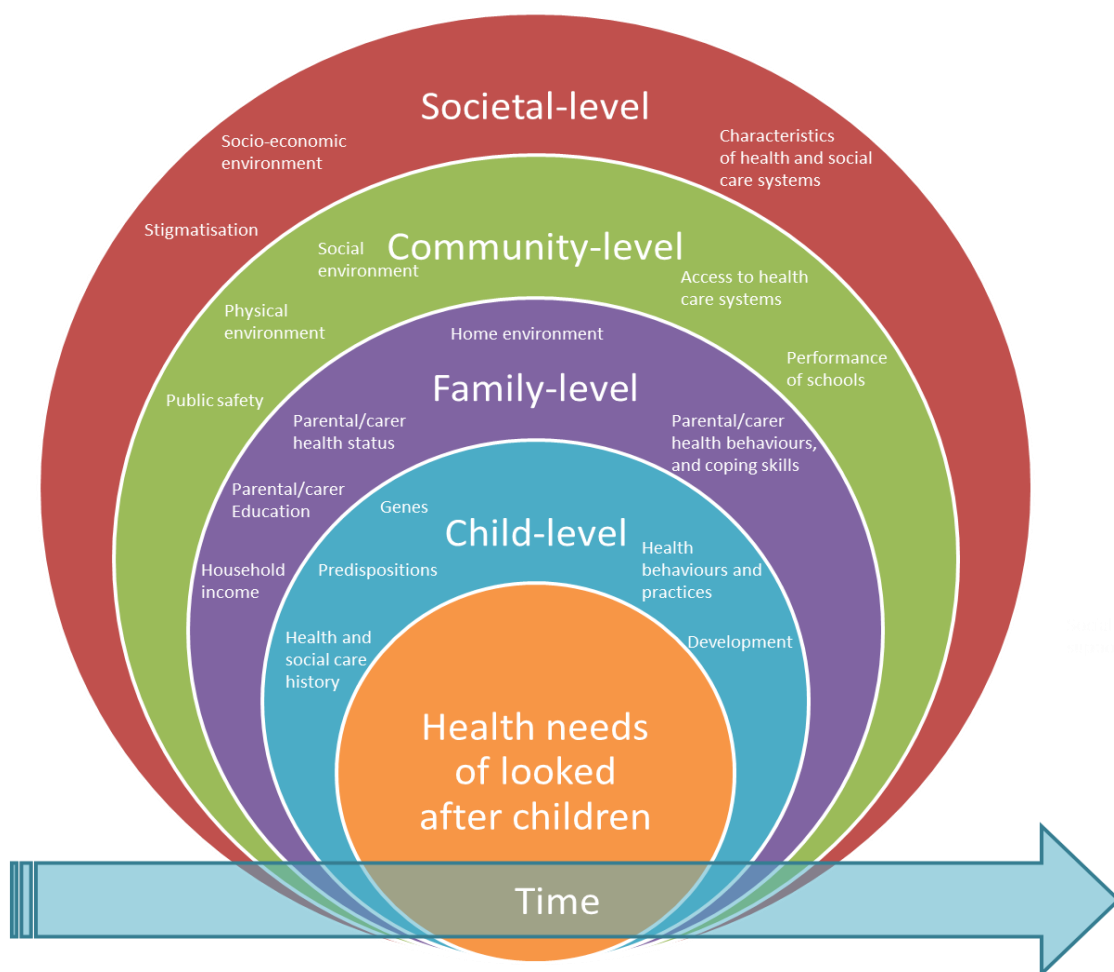


Figure 1. Adapted from Newacheck *et al.* (2006)

1.2 The legislative context

Arguably, all legislation regarding children and young people who are looked after is, in some way, concerned with their wellbeing. Health is an important part of wellbeing and so we might expect to find in the legislation the provision of extensive services with the specific intention of ensuring that their health needs are comprehensively addressed. However, in terms of the statutory (legislative) framework, the provision of health services available to looked after children and young people in Scotland is quite limited.

The relevant law relating specifically to 'health' and 'looked after children' consists of provisions contained in the *Children (Scotland) Act 1995*² (for example, the young person must be examined by a registered medical practitioner before being placed), The *Looked After Children (Scotland) Regulations 2009*³ (for example, local authorities must obtain a written assessment of the health and needs for health care), *The Leaving Care (Scotland) Regulations 2003*⁴ (for example, this stipulates that health matters must be included in the young person's pathway views) and the *Children and Young People (Scotland) Act 2014*⁵ (for example, the Corporate Parenting responsibilities require that corporate parents take a number of actions in relation to the wellbeing of looked after children and care leavers).

In addition to these statutory requirements, the Scottish Government's Chief Executive Letter (CEL) 16 (2009) sets out a number of expectations for Scotland's territorial Health Boards. These include, among others, that every Board should: (a) nominate a director to take corporate responsibility for looked after children in their area; (b) ensure that every looked after child in their area has had a health assessment; and (c) ensure every looked after child in their area is offered a mental health assessment (by 2015). In 2014 the Scottish Government published *Guidance on Health Assessments for Looked After Children and Young People in Scotland*, to assist Health Boards in fulfilling their obligation under CEL16 (2009).

The absence of any coherent requirements for data collection by NHS Boards prior to 2014-15 makes it difficult to summarise the types of health services provided for looked after children across Scotland. Scotland-focused research (see Scott *et al.*, 2013 for more discussion) has identified the following types of services: specialist nurses for accommodated looked after children ('LAAC nurses'); community nursing teams (including school nurses); multidisciplinary 'looked after children' teams; and dedicated mental health teams for looked after children.

Given this context, this paper now discusses some of the main research findings regarding looked after children's physical health, mental health and health behaviours. The discussion of the health needs of looked after children at the child-level is followed by a brief consideration of

² Children (Scotland Act) 1995: Regulation 5(2)(b)

³ Looked After Children (Scotland) Regulations 2009: Regulation 40

⁴ Leaving Care (Scotland) Regulations 2003: Regulation 3(2)

⁵ Children and Young People (Scotland) Act 2014; Part 9

examples of factors at the family-level, community-level and societal-level. This approach emphasises the importance of context and illustrates that we need to attend to, and understand, the environment in which children, young people and adults alike are situated in order to improve health outcomes.

II The Health of Looked After Children

2.1 Physical health

Key messages from literature:

- ***Looked after children appear to have higher rates of particular physical health conditions for example, dental caries, vision problems and obesity.***
- ***Some looked after children have incomplete health screenings and incomplete immunisation records.***
- ***More data is needed on the prevalence of physical health concerns among looked after children.***

Scott & Hill (2006) conducted a review that distilled research from across the UK to give some general indications about the health of looked after children in Scotland. This report suggests that the physical health of looked after and accommodated children is generally good in spite of the adverse factors in their backgrounds (some of which were discussed above). However, they offer two important caveats to this. Firstly, many of the young people have lifestyles which present major threats to their present or future wellbeing, and secondly, there is a high incidence of mental health problems (including conduct disorders). Moreover, some health problems and disabilities may only be identified later in life, including physical health issues such as foetal alcohol syndrome (FAS). This may be particularly prevalent in children who become looked after because of parental substance use.

Meltzer *et al.*, (2004), reported on a Scottish survey (407 participants) carried out in 2002/2003 by the Office for National Statistics, that asked carers and parents to rate the general health of the children they cared for. Children who were living with foster carers were more likely to have very good health (70%) than those living with birth parents (48%) or in residential care (38%). This study also found that as the placement for the child became more secure, defined here as lasting two years or more, so the general health was more likely to be rated as very good.

Other research, for example the Office for National Statistics' survey in England (Meltzer *et al.* 2003), found that two-thirds of looked after children had at least one physical complaint, such as speech and language problems, enuresis (bedwetting), co-ordination difficulties or eye or sight problems. Enuresis has been identified in a number of studies (for example, Meltzer *et al.*, 2004; Stanley *et al.*, 2004; Sempik *et al.*, 2008) as stressful for young people and their carers, especially in residential settings, where it is particularly difficult to hide (Sempik *et al.*,

2008). Scott *et al.* (2013: 44) suggest that consistently observed issues for looked after children include '[o]besity, dental caries and vision problems' and that 'rates of dental, visual and hearing problems may be higher than those of the general population'. A separate 'needs assessment' conducted by the Residential Care Health Project in 2004 (Scottish Executive) indicated that 86% of these children had incomplete childhood health screenings, while 71% had not achieved their full immunisation status.

Some caution should be exercised when interpreting the findings of the extant research on the health needs of looked after children. Scott *et al.* (2013)⁶ suggest that drawing conclusions based on prevalence rates of particular issues among looked after children and young people is problematic due to the heterogeneity of the population. They found that studies tended to lack specificity regarding the care histories of the children involved in research, including their reasons for entry into care, length of placement, placement moves and so forth. These variables should also be factored in when interpreting the findings to create a comprehensive and accurate description of children and young people's health needs. Alongside this, Scott *et al.* (2013: 48) suggest that, whilst understanding the 'absolute prevalence rates of health problems' is 'useful for corporate parents with responsibility to meet health needs', what is really required in terms of prevention, and to a certain extent the type of service required, is an understanding of 'relative rates [that is are the health problems related to the causes or consequences of care]'.

Scott *et al.*'s (2013) review found no literature regarding interventions to improve the physical health outcomes of looked after children; instead, the literature focused more on improving the mental health outcomes. The evidence on the mental health of looked after children indicates that there is much cause for concern.

⁶ Scott *et al.* (2013), after reviewing much of the research literature regarding the physical health needs of looked after children, suggest that there are concerns with the data. They considered six studies which reported on physical health concerns.

2.2 Mental health

Key messages from literature:

- ***Even when taking into account poverty and disadvantage, looked after children appear to have poorer mental health than their non-looked after peers.***
- ***Both pre-care and in-care experiences may contribute to poor mental health among looked after children.***
- ***Looked after children can face multiple barriers when it comes to addressing mental health issues, including complexity of problems, late identification, long waiting times for appointments, service inflexibility in mode of delivery and problems addressed, and stigma surrounding mental health issues.***

Mental health problems appear to be substantially higher among looked after children than among their non-looked after peers. Meltzer *et al.*'s (2004) study concluded that, in Scotland, 45% of looked after children (aged 5-17) had a least one mental health problem. This compares to an incidence of approximately 10% in the general population. Scott and Hill (2006), as mentioned above, have also suggested that looked after young people have higher rates of mental health concerns (including conduct disorder). Research by Ford *et al.* (2007) compared psychiatric morbidity rates in looked after children to children in both the general population and in the most deprived sub-group. In the diagnostic tool they used to assess psychiatric morbidity, looked after children were more likely to have at least one psychiatric diagnosis (46%) compared with the rates of children in the most deprived sub-group (15%) and in the general population (8%). Conduct disorder rates showed the highest differential in terms of type of disorder (27% in looked after children, 5% in children in the most deprived area, and 1% in the general population). This study concludes that looked after children 'had significantly poorer mental health than the most disadvantaged children outside the care system' (Ibid.: 323).

Scott *et al.*'s (2013) review of the research suggested that a high number of looked after children may have a range of diagnosed (and arguably undiagnosed) mental health problems. This additional complexity means that the child should have access to services which are able to treat these different conditions as a collective rather than considering only one condition. Moreover, behavioural issues are reported to have the highest incidence rate in the population of looked after children, and this is observed across the different care settings (Ibid.).

Scott *et al.* (2013) again raise the concern that the research is not conclusive in understanding whether the mental ill-health of looked after children might relate to the child's reasons for being looked after (their pre-care experiences) or if it is as a consequence of being looked after (in terms of quality of placements, type of placement, number of moves, relationships and so forth). Equally, where research has considered the impact of different care settings on a child's mental health, the different ages and reasons for entry to care are not always taken into account. The lack of control of, or of reporting on, these different variables lead to difficulties in commenting

on a specific study's findings compared with another study. This can lead to conclusions that are not supported by other evidence.

Despite methodological concerns, the message from the extant body of research is that the mental health of looked after children is poorer than that of the general population. However, the reasons why this is the case are not as clear. A variety of interventions and services have been developed. Vostanis (2010), when considering the international literature on mental health services for children in care, suggests that although much is known about the factors which lead to mental health concerns, there is a lack of evidence about the effectiveness of different services, models and interventions. He identifies a number of gaps which need addressing. These include: (1) a lack of a common language between services and (2) the complexity of issues that looked after children can present, which often do not match the criteria for specialist services (such as Child and Adolescent Mental Health Services, CAMHS).

Minnis *et al.* (2006) suggest that the main gap in service provision relates to delivering effective interventions to children whose mental health problems are already identified, but which are persistent, disabling and hard to manage. In some later research (2013), Minnis suggests a new concept which she calls 'maltreatment associated psychiatric problems (MAPP)'. She describes this as 'a syndrome of overlapping complex neurodevelopmental problems in children who have experienced abuse or neglect in early life' (Ibid.:1). Minnis suggests that parents of this group of children, who experience extreme deprivation, abuse or neglect in their early years, may not access services. As such, these children are a 'hidden population' whose access to services, in their early years, to assess concerns about development and possibly neurodevelopmental clinical assessments may be very limited. Moreover, even if a child is referred, the complexity of the difficulties might prove overwhelming both in terms of description and response. However, Minnis (2013) concludes that children with complex neurodevelopmental problems are being denied interventions which 'could radically change their developmental trajectories for the better', and suggests that we need to develop new 'models of assertive outreach and preventative and intervention services' (Ibid.: 3). Other studies have suggested that the barriers to accessing services include limited capacity, long waiting times for CAMHS assessment, and reluctance of young people to become involved with services which add to their sense of stigmatisation and/or feelings of lack of control of their lives (Stanley, 2007).

Children who are looked after away from home can experience multiple placement moves. This has been linked to a greater likelihood of these looked after children having some form of psychiatric diagnosis compared with other looked after children (Beck, 2006). Alongside this, Beck (Ibid.) highlights the issue that young people who move placement frequently are less likely to access medical services.

A recent research report entitled, *What works in preventing poor mental health in looked after children* (Luke *et al.*, 2014), gave two caveats regarding what might be considered the 'best' type of intervention. Firstly, diversity in outcomes should be expected following maltreatment and neglect because of the many individual factors (biology, personal characteristics) and environmental factors (experiences before and in care, situational context) that contribute to each child's response. Secondly, it may be helpful to avoid thinking of the 'consequences of maltreatment simply in terms of 'damage' done to the child, as a response that may be adaptive or helpful in one context (e.g. detecting threat) can become 'problematic' in another'. Understanding likely reasons why 'problem' behaviours may have developed is key to finding effective interventions (Ibid.:1). In line with this, Rees' (2013) multidimensional Welsh study of 193 looked after children found that between 34% and 76% performed within the average to above average range on measures of mental health, emotional literacy, cognitive functioning, literacy and literacy achievement, despite the overall picture of their health appearing to be negative in comparison to norms.

These caveats chime with the calls to consider each child holistically, including the wider influences with which they interact. They also reflect the call to recognise and take into account the heterogeneity of looked after children, not just in terms of their lived care experiences but also their own biological factors and predispositions. Thus, if we are to respond effectively, we need to consider and encourage recognition of the individuality and strengths of looked after children.

2.3 Looked after children's health behaviours

Key messages from the literature:

- ***High rates of health-risk behaviours (for example, smoking and sexual relationships at a younger age) have been identified among the looked after population.***
- ***Transition points, such as into and out of care, may be particularly risky times when it comes to health-risk behaviours.***
- ***Rates of self-harm and attempted suicide are higher for looked after children and young people.***
- ***There is evidence that care leavers of all ages are over-represented in suicide statistics and other early deaths.***

The literature suggests that children and young people who are looked after may be more likely to smoke and use illicit drugs. Meltzer *et al.*'s Scottish study in 2004 found that in a sample of 128 11-15 year olds, 40% reported being current smokers⁷. This is a substantial figure,

⁷ 'Children were classed as current smokers if they said yes to the question; 'Do you smoke at all these days?' (Meltzer *et al.* 2004: 88).

especially when compared to the *Health Behaviour in School-Aged Children* (HBSC) report for the Scottish cohort (Currie *et al.*, 2011) where 1% of 11-year-olds, 7% of 13-year-olds and 18% of 15-year-olds reported being current smokers. Moreover, Meltzer's study found that, in the last month, 21% had used cannabis, compared with 9% of 15-year-olds in the HBSC report (2011). 31% of 11-15-year-old looked after children and young people in Meltzer's study reported to drink alcohol at least a few times a year or more regularly. Of these, 16% reported they drank alcohol once or twice a week and 3% reported to drink alcohol daily. 24% of the 11-15-year-old children and young people in this study reported that they did not drink alcohol anymore.

A report produced for Glasgow's Child Protection Committee in 2014 (Fuller *et al.*), considered the risk factors for suicide in looked after children, suggesting that there is 'a higher rate of suicide in looked after children than in the general population' (Ibid.: 9). Vincent and Petch's (2012: 92) audit and analysis of Serious Case Reviews (SCR) in Scotland found that nine cases, they considered in their study, related to teenagers.⁸ They suggest that cases 'involving teenagers are much more likely to be deaths'. They report that 'seven of these teenagers died: four from drug or alcohol intoxication; and three from suicide'. The reasons why these young people (all known to social work and seven of whom were or had been looked after and accommodated) died or were injured was not due to harm by their parents (as it might be for younger children) but 'they usually die through suicide or as a result of their own risk taking behaviour (Vincent, forthcoming)'.

Studies (Stanley *et al.*, 2004; Beck, 2006) of looked after children have shown that high rates of self-harm are particularly concerning. Furnivall (2013: 2) in her consideration of the evidence surrounding the issue of self-harm and suicide suggested that, 'because of difficult and in many cases traumatising backgrounds, children in care and care leavers are more at risk both of hurting themselves and completing suicide'. The SCR audit by Vincent and Petch (2012: 93) in their analysis of the deaths of the young people suggest that these young people's 'deaths are, therefore, not directly related to abuse or neglect but the abuse or neglect they experienced in their childhood, and agencies' response to this, undoubtedly played some part in contributing to these tragic outcomes'.

Meltzer *et al.* (2004) found that over 22% of looked after children surveyed had tried to hurt, harm or kill themselves; this rate was higher for children living in residential units (39%), compared to those with birth parents (18%) or foster carers (13%). These statistics, whilst helpful, need to be treated with caution. It would be a mistake to target services simply at residential establishments for the following reasons. Firstly, there is a difference in the age profiles of these children in the aforementioned care environments, with children living in

⁸ This report presents the findings from an audit and analysis of 56 Significant Case Reviews (SCRs) and 43 Initial Case Reviews (ICRs) conducted in Scotland since 2007.

residential care tending to be older.⁹ Understanding this difference in age profile may, in itself, account for the difference in reported statistics. Secondly, in terms of the relative numbers of children within these different care environments, there are many more children living at home with birth parents or in kinship and foster care than there are children living in residential care.¹⁰ This means that numerically there will be more children living at home or in kinship or foster care requiring, arguably, greater service provision.

Looked after young people may also be more likely to engage in risky sexual behaviours (for example, engaging in sexual relationships at a younger age, having a higher number of casual partners or not using condoms). Three of the studies considered in Scott *et al.*'s (2013) review found that looked after young people may be at increased risk of engaging in risky sexual behaviours (see Lerpiniere *et al.* (2013) for further consideration of looked after children, risky behaviour and the link to CSE). The Jay report on Child Sexual Exploitation (CSE) in Rotherham (2014) identified the risk factors which were associated with children who are more likely to become victims of sexual exploitation. The report identified that 'almost 50% of children who were sexually exploited or at risk had misused alcohol or other substances' and that 'this was typically part of the grooming process'. In addition, in terms of personal health issues of the young people, 'a third had mental health problems (again, often as a result of abuse) and two thirds had emotional health difficulties'. In consideration of broader family and home influences, the Jay report suggested that, 'there were issues of parental addiction in 20% of cases and parental mental health issues in over a third of cases. Barriers to accessing specialist counselling and/or mental health services for children and young people *were a recurrent theme*' (Jay, 2014: 31-32).

Leaving care may be a particularly important time for young people in terms of their health. This is reflected in work by the National Children's Bureau (2008), which has found that young people leaving care are a particularly vulnerable group. A recent report in England suggests that young people with care experience are 'more likely to become young parents' (Centre for Social Justice, 2015: 4). This report suggested, using data gathered from 93 local authorities through a Freedom of Information request, that '22 per cent of female care leavers become teenage parents and that 'this is about three times the national average' (in England). These figures corresponded with an older study by Dixon (2008) in England which reported that a quarter of

⁹ The Age profile of Looked after children by accommodation type on 31st July 2014. In community based care (includes, birth, kin and foster care): Age (years) (5 -11) – 5674 children, (12-15) - 3853 children, (16-17) - 1,172 young people. In residential care: Age (years) (5-11) – 144 children, (12-15) – 776, (16-17) – 475. Available online at <http://www.gov.scot/Topics/Statistics/Browse/Children/PubChildrenSocialWork>

¹⁰ Total number of looked after children at 31 July 2014 was 15,580. The number of children looked after 'at home' was 4,144 (27% of the total looked after population). The number of children in foster care was 5,533 (36% of the total looked after population and represents 48% of the total 'accommodated' population). The number of children in kinship care was 4,181 (27% of the total looked after population). The number of children in residential care (including secure) was 1,470 (or 9% of total population). Available online at <http://www.gov.scot/Topics/Statistics/Browse/Children/PubChildrenSocialWork>

care leavers were pregnant or young parents within a year of leaving care (Dixon, 2008).¹¹ We do not have national data on how many looked after young people and care leavers are young parents in Scotland.

Dixon's (2008) study also highlighted that, compared to figures taken within three months of leaving care, this group of care leavers when interviewed a year later were more likely to report having problems with drugs and alcohol (increased from 18% to 32%) and to report mental health problems (12% to 24%). There was also increased reporting of 'other health problems' (28% to 44%) such as weight loss, asthma, flu, pregnancy and illnesses related to drug or alcohol misuse.

2.4 Summing up the literature so far

The literature relating to looked after children and young people suggests there are concerns with both physical and mental health issues and health behaviours. However, it seems that, due to the heterogeneity of the group, both the actual extent of these health issues and the implications for interventions and service models are not clear from what is known at present.

In terms of the holistic picture of a child's world and the acknowledged influences of the many different aspects of the environment which help shape a child's health, we need to take cognisance of the wider aspects of a child's life, and understand the presenting conditions and/or behaviours. Figure 1, at the start of this paper, provides the framework for some of these wider influences which are briefly discussed below.

3 Context of Child Health

3.1 Influences at the family level

Key messages from the literature:

- ***Positive relationships are key to providing quality care environments for children.***
- ***Exposure to adverse experiences in utero and during the early years of life can have substantial and lasting consequences for health.***
- ***A parent's capacity to care and parental health behaviours are critical to healthy child development.***

¹¹ Compare this to recent statistics produced by the Scottish Government (2014). Although not specifically about looked after children, they give an indication of the general population and the correlation between deprivation and teenage pregnancy. *There is a strong correlation between deprivation and teenage pregnancy. In the under 20 age group the most deprived areas have nearly 12 times the rate of delivery compared to the least deprived areas (53.8 compared to 4.6 per 1,000 population) and nearly twice the rate of abortion (21.9 compared to 11.8 per 1,000 population).* Available online at: <http://www.isdscotland.org/Health-Topics/sexual-health/Publications/2014-06-24/2014-06-24-TeenPreg-Report.pdf>

Every effort should be made to support the development and maintenance of positive relationships within the family, as these are extremely important to children and young people. In terms of the influences on the child in this holistic model, we see that parents/carers have a direct role in developing child health and health-related behaviours. Luke *et al.* (2014) emphasise the importance of 'ordinary care' in supporting children and young people's developing health and wellbeing. This conclusion that care is part of the ordinariness of everyday life has implications for the way we perceive interventions. It suggests that interventions might be working with parents/carers to develop strong, quality care environments for children.

There is a growing evidence base showing that exposure to early adverse life events affects the developing brain, exerting powerful and potentially long-term effects on neural structure and function. The impact on the brain is not constant throughout life, with early experiences exerting a particularly strong influence in shaping the functional properties of the immature brain (Nelson, 2012). Many looked after children are exposed to adverse experiences, including prenatal exposure to alcohol and/or other harmful drugs, neglect, sexual abuse, exposure to violence and parental instability (e.g. criminal behaviour, substance abuse, etc.). The *Adverse Childhood Experiences Study* looked at the impact of seven types of adverse events and subsequent outcomes. It found that a young person who has experienced four or more adverse events in early life is approximately seven times more likely to become an alcoholic and almost five times more likely to misuse drugs than a young person who has experienced no adverse experiences (Felitti *et al.*, 1998).

The influence on the child of the parents' capacity to care and the parents' own health behaviours can be seen as critical to healthy child development. Furnivall *et al.* (2012) review attachment theory and its impact on the life course. They describe how '[a]ttachment theory explores some of the earliest interactions between infants and their caregivers and seeks to explain how different responses from adult caregivers can affect infants' immediate wellbeing and indeed their developmental trajectory throughout childhood and into adulthood' (Ibid.: 10). Understanding the impact of poor parental health (for example, mental health problems), poor health behaviours (for example, drug misuse) and/or other environmental factors (for example, poverty) on the relationship between a child and their caregiver is crucial if we are going to promote and support healthy attachments.

An attachment-informed practice model would suggest that it is important to consider what support can be provided to parents and carers. A number of studies have looked at the effectiveness of behavioural and cognitive behavioural training to support foster carers in managing difficult behaviour, but there has been no measurable impact on outcomes for the children (NHS Health Scotland, 2012). Such results, however, need to be treated with caution. Furnivall (2011) points to a consistent theme in effective intervention for children looked after

away from home, namely, the caregiver's capacity to reflect on the child's behaviour in order to help them understand the child's thoughts, feelings and needs. Furnivall *et al.* (2012) argue that the 'most effective attachment based interventions target the caregiver and the relationship rather than the child directly' (Ibid.: 15). Luke *et al.* (2014) also point to the limitations of the research in this area, and in their report instead detail five principles of effective interventions which need further testing. Two of these principles focus on the caregiver and their relationship with the child (either directly or indirectly).

Children placed away from home need to have the support and opportunities to ensure that their health outcomes are not compromised by early childhood adversity. In this sense, then, we understand that the ways in which services are delivered and managed need to take cognisance of the influence of the many factors that might impinge on a looked after child's life.

3.2 Influences at community level

Key messages from literature:

- ***There is a range of enabling legislation in Scotland which should facilitate better health-related outcomes for looked after children, young people and care leavers.***
- ***The enactment of Corporate Parenting by all publically funded organisations in Scotland should provide a range of opportunities to improve the health-related outcomes for looked after children, young people and care leavers.***

At the community level, service providers need to understand the lives of looked after children (in all their heterogeneity). Recent legislation in Scotland, *the Children and Young People (Scotland) Act 2014 (the Act)*, has provided an impetus to promote broader awareness and support for looked after children in their communities. The Act confers new statutory duties on a range of publicly funded organisations¹² that are now known as 'corporate parents'. Collectively, these duties are designed to ensure that the attention and resources of corporate parents are focused on the task of safeguarding and promoting the wellbeing of looked after children and care leavers. In particular, Section 58 of the Act states that every corporate must (a) be alert to matters which, or which might, adversely affect the wellbeing of an eligible young person; (b) assess the needs of eligible young people for any services or support provided;

¹² Corporate Parents in Scotland now include: Scottish Ministers (this refers to the Scottish government and its agencies), a local authority, National Convener of Children's Hearings Scotland, Children's Hearings Scotland, The Principal Reporter, Scottish Children's Reporter Administration, a health board, a board constituted under section 2(1)b of the National Health Service (Scotland) Act 1978, Healthcare Improvement Scotland, Scottish Qualifications Authority, Skills Development Scotland, Social Care and Social Work Improvement Scotland (also known as the 'Care Inspectorate'), Scottish Social Services Council (SSSC), Scottish Sports Council (also known as SportScotland), Chief Constable of the Police Service of Scotland, Scottish Police Authority, Scottish Fire and Rescue Service, Scottish Legal Aid Board, Commissioner for Children and Young People in Scotland (SCCYP), Mental Welfare Commission for Scotland, Scottish Housing Regulator, Bord na Gàidhlig, Creative Scotland.

(c) seek to provide eligible young people with opportunities to promote their wellbeing; and (d) take appropriate action to help eligible young people access those opportunities.¹³

This recent legislation is intended to help mitigate issues that looked after children face in their communities, and to provide opportunities in terms of, for example, access to play, music, leisure activities, sport, health, education and employment. Mooney *et al.* (2009) identify that, in the promotion of good health, looked after children and young people need access to positive activities, alongside educational opportunities, security and stability. Equally, Statham and Close (2010:6) indicate that there is a degree of consensus emerging regarding children and young people's wellbeing 'and most include domains which relate to their physical, psychological and social wellbeing in one form or another. They also incorporate, to varying degrees, measures of socio-economic and environmental wellbeing such as educational attainment, economic and material resources, housing and the local environment, quality of school life and access to leisure activities'. This suggests that the influence of their peer group and local cultural values and beliefs can impact on a child's wellbeing.

Another significant policy development in Scotland is the Public Services (Joint Working) (Scotland) Act 2014 (Scottish Government). The Act requires local authorities and the NHS to work together to provide integrated health and social care services to adults. Moreover, it also gives permission for the integration of children's services. Welch *et al.* (2014: 6), in reviewing the literature about the integration of services, suggest that 'the integration of adult health and social care is likely to impact on various groups of children and young people. In many cases collaborative approaches have been shown to be helpful; however, these benefits will only happen if children and young people's needs are considered and factored into decisions'. They conclude that the Act is 'a significant opportunity for children and young people in Scotland, providing that their needs are not overlooked given the substantive drivers and undisputed needs of adult service users'.

3.3 Influences at societal level

Key messages from literature:

- ***Marmot (2010) suggests that actions to reduce health inequalities must be universal, but with a scale and intensity proportionate to the level of disadvantage, something he terms 'proportionate universalism'.***
- ***A holistic approach to health and wellbeing takes account of the complexity of the issues faced by looked after children, young people and care leavers, as well as the impact of these issues on behaviours and outcomes across many areas of their lives.***

¹³ For full details on the corporate parenting duties, please see Part 9 of the Children and Young People (Scotland) Act 2014.

Health inequalities (Marmot, 2010) are recognised as an issue for service provision. Reflecting on 'health improvement' and 'health inequalities', a number of studies refer to the 'inverse care law', whereby the benefits of policies accrue more to advantaged groups in society, and overall improvements in health mask continuing inequalities.¹⁴ Preventing or reducing health inequalities for looked after children may, therefore, require investment in targeted services and general population-focused programmes. For instance, McIntyre (2007) suggests that information-based approaches (such as pamphlets in GP surgeries, media campaigns or those requiring individuals to 'opt in') may be less effective amongst disadvantaged groups. Marmot (2010) suggests that to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity proportionate to the level of disadvantage, something he terms 'proportionate universalism'. His report concluded that reducing health inequalities requires concerted action to 'give every child the best start in life', crucial to reducing health inequalities across the life course.

Kelly *et al.* (2013), in their consideration of looked after disabled children, suggest that a holistic approach to children helps us understand the complexity of concerns, of which health and wellbeing are fundamental. They propose, as expressed in Figure 1, that the interwoven nature of health, education, social and environmental factors leads to an understanding that 'deficits in one area are likely to impact on child outcomes in another area' (Ibid.: 87).

¹⁴ A report by CordisBright (2013) for All Wales Heads of Children's Services entitled *Research on difference in the looked after population* noted 'the higher the level of deprivation, the higher the number of children per 10,000 who are looked after' (Ibid.: 28). They suggest this is consistent with previous research and with the English context. This suggests that looked after children are generally from less affluent groups. Report available online at www.wlga.gov.uk/download.php?id=5542&l=1

IV Implications for policy and practice

This review of the health of looked after children and young people has highlighted that, in general, this group of children have poor health outcomes. However, it has also illustrated how an individual's health needs to be contextualised. In adopting a holistic approach to health, we can mitigate slippage towards 'service drift' (where a discussion of the social determinants of health gives way to a consideration of health services alone) (Scottish Parliament, 2015). The implications for policy and practice that emerge have a common component in that they require an attendance to the diversity and individuality of looked after children. This is reflected in the four points below which call for more effective data collection, robustness of research, review of the effectiveness of current interventions and consistent evaluation:

1. The effectiveness of the data collected about looked after children's health and health outcomes at national and local levels should be reviewed to ensure that it is sufficient and fit for purpose, taking into account the heterogeneity of looked after children.
2. The limitations of the research described in this paper suggest that more work needs to be done in the design and implementation of research to study effectively what works for looked after children in a number of different areas including physical health, mental health and health behaviours. These need to indicate and describe the target population, addressing and reporting on all the known variables.
3. The effectiveness of interventions and services developed to attend to the mental health needs of looked after children and care leavers should be reviewed. These interventions should take into account the additional barriers that looked after children may face in accessing services, for example, multiple placement moves. Services need to be flexible at the point of contact and in their delivery, and interventions need to be integrated into the wider aspects of the child's life. This should take into consideration the importance of relationships in children's lives and how the consistency and quality of 'ordinary care' can be strengthened and supported.
4. It is important that interventions and services that are developed in response to the health needs of looked after children and young people are evaluated effectively. Research monitoring the effectiveness of these interventions would provide information about what works. It makes little sense to invest in services which are not effective. This increasing knowledge bank would then inform future service developments.

This paper illustrates the fact that there is much evidence and discussion about the health of looked after children. It suggests that investment in looked after children and young people's health should be driven by an understanding of what works and needs to be addressed using an intentionally holistic approach.

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About the authors:

Dr Andrea Priestley is Policy Implementation Lead at the Evidence and Policy Implementation Hub, CELCIS, University of Strathclyde.

Dr Lisa Ann Kennedy is Policy Implementation Associate at the Evidence and Policy Implementation Hub, CELCIS, University of Strathclyde.

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Contact details:

CELSIS

University of Strathclyde

Lord Hope Building, Level 3

141 St James Road

Glasgow G4 0LT

t: +44 141 444 8500

e: celcis@strath.ac.uk

International Public Policy Institute (IPPI)

McCance Building, Room 4.26

University of Strathclyde

16 Richmond Street

Glasgow G1 1XQ

t: +44 (0) 141 548 3865

e: ippi-info@strath.ac.uk

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