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Context

This review is to describe the likely needs of this heterogeneous group of children on the basis of published studies and reviews, policies, guidance and statistics collected routinely by local Authorities. The likely underlying epidemiological need of the children and young people in the general population has previously been estimated by application of published morbidity rates of conditions to the populations of infants and school children. These have been presented as indicative numbers with a given condition in each of the operational areas of the HHSCP, as well as Argyll & Bute and can be accessed on NHS Highland intranet (Indicative Numbers). It is likely that looked after children have poorer health status and overall outcomes than their peers in the general population.

Aim of the review

The purpose of this review is to identify what is known in terms of the health needs of LACYP from the literature (and published statistics) and to highlight any recommendations that have been made to meet them.

The review is structured in the following sections:

Structure of the review

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Method

The literature on which this review was identified from amongst national publications of reviews, reports and policies. Other sources included evidence-based collections and grey literature. The majority of the statistics were from those published by the Scottish Government but a small sub-section was derived from bespoke data from Highland Councils Care First system.

Section 1: Definitions and characteristics of Looked after Children

Under the provisions of the Children (Scotland) Act 1995, 'looked after children' are defined as those in the care of their local authority. The majority will come into one of the following
two categories (1) *Looked After at home*-Where the child (or young person) has been through the Children’s Hearing system and is subject to a Supervision Requirement (regular contact with social services) with no condition of residence. The child then continues to live in their regular place of residence (i.e. the family home) (2) *Looked Away from home*-Where the child (or young person) has either: been through the Children’s Hearing system and is subject to a Supervision Requirement with a condition of residence; is subject to an order made or authorisation or warrant granted by virtue of Chapter 2, 3 or 4 of Part II of the 95 Act; is being provided with accommodation under Section 25 (a voluntary agreement); or is placed by a local authority which has made a permanence order under Section 80 of the Adoption and Children Act 2007. In these cases the child is cared for away from their normal place of residence, by foster or kinship carers, prospective adopters, in residential care homes, residential schools or secure units (Scottish Government, 2013). In Scotland a child reaches the age of legal capacity at 16 years but is entitled to be cared for and protected up to their 18th birthday. For the purposes of this report, young people up to the age of 21 years are included as this will also include the range of care to those with learning disabilities.

Also for the purpose of this report, the term Looked After Children and Young People (LACYP) is used and denotes the full spectrum of at home or away from home placements/settings and the full age range, potentially up to 21 years.

For the local populations of LACYP can be grouped according to what type of placement they are in, whether they are on the child protection register and/or assessed with special needs. A snapshot of this distribution pertaining to numbers in Highland Council as of May 2012 is depicted below (Figure 1).

**Figure 1: Groupings of children relevant to the needs assessment: Highland Council May 2012**
Therefore, looked after children and young people (LACYP) are of different ages (0-21 years), are in various settings e.g. Residential care or schools within and out with the Local Authority area, in own or foster homes with various carers, e.g. family members (kinship) or foster parents. They have also more often than not moved between settings and carers several times during their life in care. The needs of these children and young people therefore will vary on the basis of previous history and background, age and setting.

Services and responsibilities for looked after LACYP are underpinned by legislation, statutory guidance and good practice guidance which include:

**Figure 2: Legislation & guidance relating to Looked After and Accommodated children**

- Royal College of Paediatrics and Child Health and The Association of Police Surgeons (April 2002) Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse
- Statutory guidance on Promoting the Health & Wellbeing of looked after children (England, April 2013)
- Children (Scotland) Act 1995
- The Looked After Children (Scotland) Regulations 2009
- The Looked After Children (Scotland) Amendment Regulations 2013
- The Age of Legal Capacity (Scotland) Act 1991
- Getting it right for every child – Scottish Government, 2009
- These are our Bairns - a guide for community planning partnerships on being a good corporate parent – Scottish Government 2008a
- Looked after children and young people: We can and must do better – Scottish Government, 2007
- Scottish Executive, 2005 Health for all Children

Ref: Based on RCN & RCPCH Report May 2012 and additional resources as listed in appendix 2

Young people leaving care are also subject to legislation and statutory guidance in terms of aftercare:

**Figure 3: Legal framework for aftercare for care leavers in Scotland**

**Aftercare**

A young person is eligible to aftercare services if they are being compulsorily supported or if the person is being discretionarily supported, the definitions of which are:

**Compulsorily supported person:** a young person to whom the local authority has a duty to provide support and assistance under section 29(1) of the Children (Scotland) Act 1995, that is a young person who has ceased to be looked after over their minimum school leaving age but who is under 19 years of age.

**Discretionarily supported person:** a young person to whom a local authority has agreed to provide support and assistance to in terms of section 29(2) of the Children (Scotland) Act 1995, this is a prospective supported person the authority has agreed to support.

The main reason for children entering care has been stated to be as a result of abuse or neglect (58% of looked after children in England and Wales on 31 March 2010 became looked after because of abuse or neglect, RCN & RCPCH 2012).
In Scotland, over one quarter (27%) of children on the child protection register in July 2012 were also looked after children (Children’s Social Work Statistics Scotland, 2011-12). This represents 4.4% of all looked after children. If these rates also apply to the local cohorts, the number looked after and on the child protection register for Highland Council and Argyll & Bute may be in the order of 23 and 9 respectively.

Researchers using the results of a case study of LACYP from thirteen English Local Authorities during 2003/04 (on just under 7,500 children) have also described LACYP in terms of six distinct groups:

**Figure 4: Six Possible Distinct groups of LACYP**

- **Young entrants** (43%) These children were under the age of 11, and became looked after primarily due to abuse and neglect.
- **Adolescent graduates** (26%). These young people had first entered the system under 11 for similar reasons, but were now older. They tended to have more difficulties at home, at school and with behaviour.
- **Abused adolescents** (9%). These young people were first admitted over the age of 11 for reasons of abuse or neglect. On average their behaviour was significantly more challenging than that of the adolescent graduates and they were also doing much worse at school.
- **Adolescent entrants** (14%). Also first admitted over the age of 11, but usually because relationships at home had broken down. Their families had fewer problems in themselves than those of the previous groups, but the young people showed challenging behaviour and were often doing badly at school.
- **Children seeking asylum** (5%) were almost always over the age of 11, and became looked after because they had no families rather than because their families had problems. They tended to do comparatively well at school and displayed less challenging behaviour than any other group.
- **Disabled children** (3%) were recorded as looked after because of disability (social workers reported that a much higher proportion of looked after children, 16%, had a disability, but this had not been recorded as their primary ‘need code’). These children had comparatively high levels of challenging behaviour, were on average older than other groups and had been looked after for longer.


This study (described in Stein 2009) found that adoption was mainly restricted to those children coming into care aged under 5 years (9%) whilst only 0.5% of those first looked after at ages over 5 years, were adopted. Long-term placements including adoption were more likely in young entrants (60% of the 0-11 year group, in adolescent graduates and the disabled groups in contrast to the other three groups i.e. abused adolescent, children seeking asylum and the adolescent entrants in which shorter term placements were more likely.

The degree to which this profile applies to the local situation in NHS Highland HSCP is unknown but it does reflect the likely background and reasons for children and young people entering care and their relative probabilities in achieving stability.
Section 2: Profile of LACYP according to recorded national statistics

In relation to figure 1, there should be a drive to minimise the numbers of children who are placed in settings at the apex of the triangle. The Scottish Government publish annual statistics which in turn are based on returns received from individual Local Authorities (n = 32) in Scotland (so called CLAS returns). The most recently available numbers of children in care aged 0-21 years is for the year to July 31st 2012 with around 16,250 across Scotland. The majority are aged under twelve (60%) with just over one fifth under the age of five years and this profile is similar for the cohort of looked after children in Highland, (Table 1). There were just under 700 for the NHS Health Board area (507 by Highland Council and 190 for Argyll and Bute Council), (Children’s Social Work statistics 2011-2012; Scottish Government).

Table 1: Children & Young People looked after as at 31st July 2012 by age-band

<table>
<thead>
<tr>
<th>Age Band (yrs)</th>
<th>Highland Council(1)</th>
<th>Scotland(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Under 1</td>
<td>11</td>
<td>2.2%</td>
</tr>
<tr>
<td>1-4</td>
<td>106</td>
<td>21.1%</td>
</tr>
<tr>
<td>5-11</td>
<td>175</td>
<td>34.8%</td>
</tr>
<tr>
<td>12-15</td>
<td>165</td>
<td>32.8%</td>
</tr>
<tr>
<td>16-17</td>
<td>46</td>
<td>9.1%</td>
</tr>
<tr>
<td>18-21(3)</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>All</td>
<td>503</td>
<td>16,248</td>
</tr>
</tbody>
</table>

(1) Is fewer than the number (n=507) published by the Scottish Government
(2) Figures are provisional and may be revised in 2012-13.
(3) Includes a small number of looked after young people who were over 21yrs.
Sources: Scotland data: Childrens Social Work statistics 2011-2012; Scottish Government
Highland Council data: Care First data system from Highland Council

Since 2001, the rate of looked after children has increased but this increase has been “slowing” over the last five years as noted in figure 5. The latter also shows the trends in other UK countries but it should be noted that direct comparison is not possible due to the differences in the definition of looked after children across the countries. One difference is that Scotland includes children looked after at home whilst these are generally excluded in the numbers from England and Wales. However, even when the category of looked after children at home is excluded from the Scottish numbers, the rates are still higher than those of the other countries.
Using the Scottish Governments published data, the main characteristics of looked after children in the Council areas of NHS Highland can be compared with Scotland (table 2). The following differences are noted:

- The rate of LACYP was 1.1% (i.e. 1.1 per 100 population aged under 19 years) for both Argyll & Bute and Highland Local Authorities, compared to the higher national average of 1.5%.
- The proportion aged under 5 years was higher in Highland (23%) compared to Argyll & Bute and Scotland, 19% and 21% respectively.
- The proportion aged 16 years or over was lower in Argyll & Bute (5%) compared to Highland and Scotland, 9% and 10% respectively.
- The proportion of LACYP with additional support needs was over double the national average for the Highland Council at 24% compared to 11% nationally whilst the proportion in Argyll & Bute was similar (12%).
- The proportion of LACYP in Residential Care for Highland Council was almost double the national average, 16% versus 9% respectively with the proportion in A & B intermediate at 13%.

These differences should be seen in the context of the variation across all councils in Scotland, but the percentage with Additional Support Needs was also relatively high in the previous year for Highland Council (23% in 2010/11).
Table 2: Main characteristics of children & young people being looked after as at 31st July 2012 by age-band: Scotland and LAs in NHS Highland

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Number</th>
<th>Rate (2)</th>
<th>% aged under 5y (3)</th>
<th>% aged 16y or over (3)</th>
<th>% from MEGs (4)</th>
<th>% with ASN (5)</th>
<th>% in Community care</th>
<th>% in residential care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Bute</td>
<td>190</td>
<td>1.0%</td>
<td>19%</td>
<td>5%</td>
<td>3%</td>
<td>12%</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>Highland</td>
<td>507</td>
<td>1.1%</td>
<td>23%</td>
<td>9%</td>
<td>2%</td>
<td>24%</td>
<td>84%</td>
<td>16%</td>
</tr>
<tr>
<td>Scotland</td>
<td>16,248</td>
<td>1.5%</td>
<td>21%</td>
<td>10%</td>
<td>3%</td>
<td>11%</td>
<td>91%</td>
<td>9%</td>
</tr>
</tbody>
</table>

(1) Figures are provisional and may be revised in 2012/2013
(2) Calculated as the number per population aged 0-18 years of the mid 2011 population estimate (NRS)
(3) Proportion aged 0-4y or 16 y & over of the total number of LACYP number as at July 2012
(4) Minority Ethnic Group includes the ethnic groups Mixed Ethnicity, Black, Asian, and Other Ethnic Background.
(5) Until 2012 the additional support needs category was presented as ‘disability’. This has been amended because the information collected does not meet the definition of ‘disability’ outlined in the Equality Act 2010

Source: Children's Social Work statistics 2011-2012; Scottish Government

The number with additional support needs (ASN) by specific category of disability or problem is not obtainable from the national statistics at lower than national level. However, the national profile indicates that just under three-quarters are known not to have a disability, 15% are not recorded at all and the remaining 10% have social, emotional & behavioural difficulty, learning disabilities, vision impairment; autisms; multiple disabilities, physical disability and chronic illness. The numbers with ASN in Highland and Argyll & Bute as at July 2012 were 122 and 23 respectively i.e. 24% and 12% of the looked after cohorts.

The majority of LACYP are placed in the community (80-90%) most of whom are with foster carers or with friends and relatives. The remainder are in residential care which includes local authority or voluntary sector provided residential facilities and in residential schools, Crisis care or secure accommodation within or out with the Local Authority area. The proportion in residential care for LACYP in Highland Council in particular, is higher than the national average, 16% versus 9% respectively in 2012 (Table 3).

In terms of national trends over the last 10 years, there has been a reduction in the proportion of those being looked after at home (43% to 32%) and in those in residential care (14% to 9%) but a greater proportion placed in community settings away from home i.e. foster carers, prospective adopters and Kinship care and other community settings (Table 4). Similar detailed breakdown by accommodation type is not available from publications of earlier years for local authority data. However the data by the broader categories of residential care and community placement are available at LA level (table 5). Comparison between 2003 and 2012 (ten years) showed very little change in the proportions placed in the community and those in residential care for Highland Council. The change in Argyll & Bute was more similar to that nationally with the proportion in residential care decreasing from 20% to 13% (Table 5).
### Table 3: Children & young people looked after by type of accommodation and local authority, 31st July 2012 *(1) (2)*

<table>
<thead>
<tr>
<th>Type of accommodation</th>
<th>Highland Council</th>
<th>A &amp; B Council</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>In the Community (non-residential care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home with parents</td>
<td>139</td>
<td>27%</td>
<td>57</td>
</tr>
<tr>
<td>With friends / relatives</td>
<td>88</td>
<td>17%</td>
<td>55</td>
</tr>
<tr>
<td>With foster carers provided by LA</td>
<td>163</td>
<td>32%</td>
<td>49</td>
</tr>
<tr>
<td>With foster carers purchased by LA</td>
<td>9</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>In other community <em>(3)</em></td>
<td>25</td>
<td>5%</td>
<td>4</td>
</tr>
<tr>
<td>Total Not in Residential Care</td>
<td>424</td>
<td>84%</td>
<td>166</td>
</tr>
<tr>
<td>In Residential Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In local authority/voluntary home</td>
<td>24</td>
<td>5%</td>
<td>9</td>
</tr>
<tr>
<td>In other residential care <em>(4)</em></td>
<td>59</td>
<td>12%</td>
<td>15</td>
</tr>
<tr>
<td>Total In Residential Care</td>
<td>83</td>
<td>16%</td>
<td>24</td>
</tr>
<tr>
<td>Total Looked After</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>507</td>
<td>100%</td>
<td>190</td>
</tr>
</tbody>
</table>

*(1)* Table excludes children who are on a planned series of short term placements  
*(2)* Figures for 2011-12 are provisional and may be revised in 2012-13.  
*(3)* "Other community" includes with prospective adopters  
*(4)* "Other Residential Care" includes Crisis care and secure Accommodation and in residential school  
Source: Childrens Social Work statistics 2011-2012; Scottish Government

### Table 4: Number and proportions of children looked after by type of accommodation *(2)* in Scotland as in 2003 *(1)* and in 10 years later in 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>At Home</th>
<th>With foster carers or prospective adopters</th>
<th>With friends/relatives (Kinship care)</th>
<th>Other Community Placements</th>
<th>In Residential Care</th>
<th>Total Looked After <em>(3)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nos</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>2003</td>
<td>4,851</td>
<td>3,468</td>
<td>1,445</td>
<td>73</td>
<td>1,550</td>
<td>11,387</td>
</tr>
<tr>
<td>%</td>
<td>43%</td>
<td>30%</td>
<td>13%</td>
<td>1%</td>
<td>14%</td>
<td>100%</td>
</tr>
<tr>
<td>2012</td>
<td>5,153</td>
<td>5,541</td>
<td>4078</td>
<td>85</td>
<td>1,433</td>
<td>16,203</td>
</tr>
<tr>
<td>%</td>
<td>32%</td>
<td>34%</td>
<td>25%</td>
<td>9%</td>
<td>9%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*(1)* Prior to 2008, table includes estimates where local authorities were not able to provide information.  
*(2)* Table excludes planned series of short term placements. For those children on mixed placements (for example, a child attending a residential school and living with foster carers during the weekend) the child has been entered under the dominant placement, i.e. the place where the child spends the most time.  
*(3)* Some totals do not exactly equal the sum of their component parts due to the effects of rounding.  
Table 5: Number and proportions of children looked after by type of accommodation (1) in the Local Council areas as in 2003 (2) and in 10 years later in 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Community setting</th>
<th>Residential care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nos</td>
<td>%</td>
<td>Nos</td>
</tr>
<tr>
<td>Argyll &amp; Bute Council area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>175</td>
<td>80%</td>
<td>45</td>
</tr>
<tr>
<td>2012</td>
<td>166</td>
<td>87%</td>
<td>24</td>
</tr>
<tr>
<td>Highland Council area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>305</td>
<td>82%</td>
<td>65</td>
</tr>
<tr>
<td>2012</td>
<td>424</td>
<td>84%</td>
<td>83</td>
</tr>
</tbody>
</table>

(1) Table excludes children who are on a planned series of short term placements.
(2) Table includes rounded estimates for local authorities not able to provide information in 2003
(3) Some totals do not exactly equal the sum of their component parts due to the effects of rounding.

Data source: Children's Social Work Statistics, 2002-03 & 2011-12

The profile of children and young people starting to be looked after is also gathered by the social work statistical system. Nationally there is a trend of children to be taken into care at a younger age (Figure 6). It is not known whether this trend also applies to the local council areas in NHS Highland.

Figure 6: Children and young people starting to be looked after during a year (1) by age band: Scotland 2006 to 2012

(1) Those with a planned series of short stays are excluded.
A child may start to be looked after more than once in a year and so may be counted more than once. The 18-21 category in this table may include a small number of looked after young people who were over 21yrs

Data source: Based on data from Children's Social Work Statistics, 2011-12, Scottish Government statistics
The profile of LACYP by disability (now termed additional support needs, ASN) status is also collected and published nationally. This demonstrates that more than two thirds are recorded not having a disability, a quarter who are not known about, and the remaining 7% with a range of disabilities (table 6).

Table 6: Children starting to be looked after during 2011/12 in Scotland by Additional Needs Status: Percentage of a total number of 4,811

<table>
<thead>
<tr>
<th>Additional Needs</th>
<th>Percentage (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No disability</td>
<td>67%</td>
</tr>
<tr>
<td>Not known</td>
<td>26%</td>
</tr>
<tr>
<td>Multiple disabilities</td>
<td>2%</td>
</tr>
<tr>
<td>Social, emotional and behavioural difficulties</td>
<td>2%</td>
</tr>
<tr>
<td>Others (e.g. Learning difficulties; autistic spectrum disorders; Mental Health problems; sensory impairments; Language &amp; Communication disorders)</td>
<td>3%</td>
</tr>
<tr>
<td>All above</td>
<td>100%</td>
</tr>
</tbody>
</table>

(1) estimated from numbers out of a total of 4,811
Data source: Based on data from Children’s Social Work statistics 2011-12, Scottish Governments statistics

As well as a younger age at entry to care, the age at ceasing from care has also decreased over time nationally. In 2002/03 just over 40% of LACYP ceased were aged less than 12 years whereas in 2011/12 there were over 50% (figure 7). However, there seems also to be a trend of increased duration in care (figure 8).

Figure 7: Age profile of LACYP ceasing during the year: (1) Scotland for the period 2002/03 to 2011/12

(1) Those with a planned series of short stays are excluded. A child may leave care more than once during a year and will be counted for each episode ending. Figures for 2011/12 are provisional and may be revised in 2012/13. Further notes apply as shown in the publication
Data source: Based on data from Children’s Social Work statistics 2011-12, Scottish Governments statistics
Young people who are over the minimum school leaving age but are still in care are potentially entitled to aftercare services (see earlier definition). Local Authorities are required to undertake a “pathway assessment” for such young people. The numbers entitled to a pathway plan assessment and the proportion receiving it during the most recent two years for which data are available for the two local authorities show a very different profile with Highland recording 100% and Argyll & Bute recording below the national average for each of the two years (table 7).

Table 7: The number ceasing (1) during the years 2010/11 and 2011/12 who were above the minimum school leaving age and the percentage of these having a pathway plan

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>2010/11</th>
<th>2011/12(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number leaving care</td>
<td>% leaving with a pathway plan</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>31</td>
<td>52%</td>
</tr>
<tr>
<td>Highland</td>
<td>54</td>
<td>100%</td>
</tr>
<tr>
<td>Scotland</td>
<td>1,355</td>
<td>57%</td>
</tr>
</tbody>
</table>

(1) Figures include all episodes of ceasing to be looked after during the year where the age at leaving is above the minimum school leaving age (i.e. a child may be counted more than once).

(2) Figures for 2011-12 are provisional and may be revised in 2012-13.

Data source: Based on data from Children’s Social Work statistics 2011-12 and 2010/11, Scottish Governments statistics

The economic activity of those eligible for aftercare services is also recorded (table 8). Please note that the denominators in table 8 are higher than table 7 due to the fact that the
total number as at a point in time can represent LACYP who have left care in previous years. This shows that one third of care leavers in the Highland Council are in employment, education or training. The proportion in Argyll and Bute local authority is lower at 23% and similar to the national average.

Table 8: Young people eligible for aftercare services\(^{(1)}\), percentage receiving aftercare and percentage in employment, education or training as at 31\(^{st}\) July 2012 \(^{(2)}\)

<table>
<thead>
<tr>
<th>Local authority area</th>
<th>Young people eligible for aftercare services</th>
<th>Percentage receiving aftercare services</th>
<th>Percentage of those receiving aftercare services with unknown economic activity</th>
<th>In employment, education or training: As percentage of those receiving aftercare with known economic activity</th>
<th>As percentage of all eligible for aftercare services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Bute</td>
<td>44</td>
<td>100</td>
<td>30</td>
<td>32</td>
<td>23</td>
</tr>
<tr>
<td>Highland</td>
<td>104</td>
<td>100</td>
<td>9</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>Scotland</td>
<td>3,870</td>
<td>66</td>
<td>12</td>
<td>42</td>
<td>24</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Table excludes children who are on a planned series of short term placements.

\(^{(2)}\) These include all care leavers entitled to aftercare, at any time previous to and on the 31st July 2013 ie. may have left care prior to 2012/13

Data source: Children’s Social Work statistics 2011-12 additional tables, Scottish Governments statistics

The levelling of numbers looked after over recent years is reflected by a decrease in the difference between the numbers starting and the numbers leaving care (table 9). For Argyll and Bute, there have been more leavers than starters over the last two years. This is in keeping with the national trend (figure 9).

Table 9: Numbers of children and young people staring and leaving care by Local Authority areas for the years from 2003/04 to 2012/13

<table>
<thead>
<tr>
<th>FYE</th>
<th>Highland council</th>
<th>Argyll &amp; Bute</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Started</td>
<td>Ceased</td>
</tr>
<tr>
<td>2004</td>
<td>125</td>
<td>115</td>
</tr>
<tr>
<td>2005</td>
<td>161</td>
<td>132</td>
</tr>
<tr>
<td>2006</td>
<td>198</td>
<td>147</td>
</tr>
<tr>
<td>2007</td>
<td>211</td>
<td>154</td>
</tr>
<tr>
<td>2008</td>
<td>152</td>
<td>185</td>
</tr>
<tr>
<td>2009</td>
<td>219</td>
<td>233</td>
</tr>
<tr>
<td>2010</td>
<td>201</td>
<td>193</td>
</tr>
<tr>
<td>2011</td>
<td>196</td>
<td>170</td>
</tr>
<tr>
<td>2012</td>
<td>238</td>
<td>237</td>
</tr>
</tbody>
</table>

Data source: Children’s Social Work statistics for the specific years, Scottish Governments statistics
Section 3: The main types of health needs of LACYP

These can be grouped into needs arising from physical, mental or as a consequence of health related behaviour. Of course, all these are potentially interdependent and related to multiple factors including age, gender, type and duration of placements.

3.1 Physical Health

3.1.1 Older children

During 2002/2003, the Office of National Statistics (ONS) undertook a survey of the mental health of young people looked after by local authorities in Scotland on behalf of the Scottish Executive, (Meltzer et al 2004). The survey covered a one in ten sample (n = 877) of looked after children aged 5 to 17 years. However, it was only possible to collect information from 355 of these children. In addition to mental well-being, measures of physical health and rates of health-related behaviour such as smoking were also collected. Around the same period of time, the ONS also surveyed children and young people looked after by local authorities in England. This survey was three times larger than the Scotland survey with 1,039 participants,(Department of Health, 2003).

The general health as rated by carers in Scotland in terms of being fair, bad or very bad was 13% (86% were rated as either very good or good) compared to the equivalent measure for LACYP in England of 8%. Among the LACYP in Scotland, those in foster care were more likely to have been rated as having very good health (70%) than children living in any other placement type, particularly those in residential care (38%). Better ratings of health also applied to those who had been in more secure placements as judged by a longer than two year duration (66% with very good health compared to 50% of those with less than two years of duration).
The most commonly reported physical complaints amongst the 355 children were: eye and/or sight problems (19%); bed wetting (14%); speech or language problems (12%); Asthma (12%) and difficulty with co-ordination (10%). Compared to a previous survey of children in private households in Great Britain, the prevalence rates of all complaints asked about were higher in looked after children with the exception of hay fever, asthma and eczema (Figure 10).

**Figure 10:** Percentage of young people with physical complaints among looked after and private household children


The prevalence of Asthma was twice that amongst children living with birth parents than with foster or residential placements but this was not statistically significant. This finding was also consistent with the survey across local authorities in England where the difference was three-fold and statistically significant in respect with the rate in residential care.

Oral health may be poorer in LACYP judged on the basis of a small survey (n = 96) of young people in Scotland in which only one half had visited a dentist in the last year, the majority of those (70%) being male (Scott, J. & Hill, M. 2006).

Some of these findings in relation to the physical health of LACYP are similar to those reported in the United States, for example, the prevalence of Asthma was also found to be lower than in the general population. Unlike the ONS surveys, the prevalence of dental problems was measured. At a rate of 22% this was the second highest to obesity at 35% (Steel, Buchi 2008)

### 3.1.2 Younger children

In terms of younger children entering care under the age of 5 years, a study (Chambers H 2010), based on facilitated discussion with looked after children services staff, care leaving managers and looked after children's nurses as part of the Yorkshire and the Humber Healthy Care Learning Network, suggested that the reasons for entering care in this younger group were from among the following:

- Mental health of parents – particularly mothers.
- Alcohol and substance using parents.
- Mother living with a violent or abusing partner so unable to provide safe care.
- High levels of domestic violence, especially during pregnancy and early years.
• Young people in and leaving care, especially those under 18 yrs are often thought not able to care adequately for their babies, because of their own lack of parenting and attachment, as well as grandparent support.
• Lengthy court processes for adoption; necessitating children remaining in foster care in pre- adoption placements for many months/years.
• Neglect, abuse and safeguarding from harm and abuse.
• Non-accidental injuries and contact with Accident and Emergency Depts.
• Youth offending by mother, with possible custodial sentence.

These can impact on the health and well-being of these children and possible actions to improve outcomes for children looked after in early years, through access to universal and targeted services are recommended.

3.2 Mental Health

3.2.1 Older Children

Using the review of survey questionnaires and interview results by Clinicians to identify mental health disorders on the basis of ICD 10 code criteria, the prevalence of mental disorders in LACYP as measured in the Scottish survey carried out by ONS demonstrated a similarly high overall rate of 45% amongst 5 to 17 year olds having one or more disorder to that measured in England. The prevalence of clinically significant conduct disorder was 38%, 16% with emotional disorder and 10% with hyperactivity. Compared to those not being looked after and living in private households, these rates were high (table 10).

Table 10: Prevalence of mental disorders among looked after and private household children in Scotland

<table>
<thead>
<tr>
<th>Mental disorder</th>
<th>Prevalence aged 5-10 years</th>
<th>Prevalence aged 11-15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LACYP In private households</td>
<td>LACYP In private households</td>
</tr>
<tr>
<td>Emotional</td>
<td>14% 4%</td>
<td>14% 5%</td>
</tr>
<tr>
<td>Conduct</td>
<td>44% 4%</td>
<td>35% 6%</td>
</tr>
<tr>
<td>Hyperkinetic</td>
<td>11% 1%</td>
<td>8% 1%</td>
</tr>
<tr>
<td>Any</td>
<td>52% 8%</td>
<td>41% 9%</td>
</tr>
</tbody>
</table>

Source: Data used from Meltzer H et al 2004

Overall, 22% of children or young people looked after by local authorities in Scotland had tried to harm, hurt or kill themselves. The rate of self-harm was more prevalent among older children, aged 11–17y (28%) than younger children (6%) and among those in residential care (39%) compared with children placed with their birth parents (18%) or in foster care (14%).

Within the emotional disorders category, two disorders had significantly higher rates among the 16- to 17-year-olds than younger children: 6% were assessed as having a depressive episode and 6% were suffering from separation anxiety.
Although there were no statistically significant differences among LACYP between children with a mental disorder and those without a mental disorder in terms of age, sex and placement characteristics, there was a greater odds of those with one or more mental disorders of being a boy rather than a girl, being in foster care than in residential care and to be aged 5 to 10 years than to be older. However from the equivalent survey amongst children and young people in Local Authority care in England, in general, children with a mental disorder, compared with other children, were more likely to be boys, aged 11–15, live in a residential care placement and to have been in their current placement for less than three years. The prevalence rate of any mental disorder was higher in those in residential care (68%) than in Foster care (39%). The inverse was reported in the Scotland survey with a higher rate in those in Foster care (50%) than in residential care (40%). However, the latter differences were not statistically significant, whilst the higher rates in residential care in England were.

Similarly in the same survey of Local Authorities in England but not in Scotland, over three-quarters of children with a mental disorder were reported to have one or more physical complaint compared with just over half of the children who were assessed as not having mental disorder.

A previous longitudinal study (Sempik J et al 2008) of 242 children who entered the care system for the first time and who had remained in care for at least a year in England, provided some insight as to the needs of children at the point of entry into care as opposed to those already in care in the ONS surveys (Melzer H et al 2004 and DoH 2004). Using the information from case files recorded by the social workers of the children with their subsequent review by Psychologists, the prevalence of emotional and behavioural problems was ascertained (this contrasts with the ONS surveys in which information from questionnaires and interviews were matched against diagnostic criteria for mental disorders). A higher prevalence of emotional and behavioural problems (72%) in looked after children was measured in this cohort than that measured in the ONS survey (46%) amongst 5 to 15 year olds. The higher rate was made up of higher rates of conduct disorders (particularly in boys) and in emotional disorders (especially among girls). Differences in methodology or the fact that only those who remained in care for the first time for at least 12 months (may be a more troubled group of children) may have contributed to this higher prevalence.

3.2.2 Younger children

An Expert paper as part of NICE Public Health Guidance (PH28; EP22 Sempik J 2010), suggested the prevalence of mental health problems is about 25% in looked after children under the age of 5 years. Conduct Disorders are reported to be the main problem and is also suggested that age at entering care is an important predictor of these problems. The latter is indicated from an Australian-based study of children aged 4-11 years (n =350) who had entered care due to court orders for foster care or kinship care (Tarren-Sweeney, M. (2008).

The strongest predictor of mental health was found to be the age at which children entered care, with earlier entry (i.e., < 7 months of age) being protective and later entry (i.e., > 7 months of age) relating to progressive declines in mental health. In addition, intellectual disability and reading difficulties predicted mental health problems independent of children's prior exposure to adversity. Sexual, physical, and emotional abuse was predictive of clinically significant problems related to social/emotional difficulties (e.g., sexual behaviour, social problems, attention problems, delinquent behaviour, anxious-depressed demeanour) and/or attachment problems as measured by the Child Behaviour Checklist (CBCL) and the Assessment Checklist for Children (ACC). Factors related to placement insecurity or a lack of permanence in placement (e.g., younger maternal age at birth, anticipated restoration of the child to birth parents’ care, exposure to a higher number of adverse life events in the preceding year) also predicted mental health problems’
3.3 Health-related behaviour

The ONS survey of Local Authorities in Scotland (Meltzer, H et al 2004) of looked after children also reported some aspects of social networking and lifestyle behaviours. The questions were restricted to those aged 11-17 years and therefore this was the age range to which the following results apply:

- Only the children in residential placements reported not spending time at all with their friends, probably because they are friends with people who do not live in the same home.
- Around a third of all children (34%) had sought help because they had felt unhappy or worried.
- The majority of children who had sought help, 64%, wanted a chance to talk things over, 8% required practical advice and just over a quarter (28%) were seeking both practical advice and a chance to talk things over.
- Compared to children in private households, the current smoking rate among looked after children aged 11–17y was four times higher. It was also higher than in England: 44% of the looked after young people in Scotland were smokers compared with 32% in England and 34% in Wales. (Figure 11)
- A quarter drank alcohol at least once a month and this was higher amongst the 11-15 year old looked after children (22%) than those living in private households (14%).
- A fifth of LAYP aged 11-17y had used cannabis within the last month and this was twice that found among LAYP in England (11%) and ten times more than young people living in private households in Scotland (2%).
- Although the prevalence rates of smoking, drinking and recent drug taking were higher in those in residential care, comparison was biased due to the higher proportion of older children in residential care.
- Almost one fifth had experienced rape or sexual abuse and two fifths reported having had sexual intercourse (excluding those who had been raped or sexually abused). The numbers were too low for any meaningful sub-analysis but the comparable and larger survey in England reported three times more children having had sexual intercourse in residential care than in foster care. However, the higher proportion of older children in residential care would bias this comparison. Children who had been in their placement for less than a year were more than twice as likely to have had sexual intercourse as children who had been in their placement for four or more years (39% compared with 16%).
A study undertaken in one Midlands local authority (Hadfield SC and Preece PM 2008) found looked after children to be more overweight and obese compared with their peers who were not looked after, and that the Body Mass Index (BMI) of a third of looked after children actually increased once they were in care. However, this study was relatively small (n=106) and restricted to those who had undertaken a health assessment. It did however highlight that children in care are not necessarily protected from obesity.

A number of studies have looked at the health and well-being of young people after leaving care. Two studies undertaken in the 1990’s in England reported that between 20% and 50% of young people aged 16-19 years became young parents compared to 5% of the same age in the general population. This higher prevalence also pertained to those in a more recent study in which 25% were either pregnant or young parents within one year of leaving care. The young people in this study stated that they considered the information they had received on safe sex before leaving care was enough (Dixon J 2008).

A population-based study followed up a birth cohort in Britain for 30 years (1970 to 2000) (Viner RM and Taylor B 2005). Children who had been in Public Care before aged 17 years, (n = 343) were separately identified and in general, their health and social outcomes were poorer than those who had not been in Public Care. Recent alcohol and drug misuse were amongst the outcomes measured with no difference for alcohol but a significantly higher prevalence for illegal drug use in males OR = 1.5 (1.0-2.1). Similar rates of pregnancy in those with a history of being in care between 10 to 16 years with those who had not been in care was found in contrast to the findings of other studies as described previously. The possible explanation for this was that there was a greater loss to follow-up in this birth cohort (47% compared to 28% in the non-care cohort) and that this may reflect a greater proportion of those pregnant being lost to follow-up.

Immunisation rates amongst Looked After Children have generally been reported as lower than the general population but these are based on rates measured in the 2000s. One study cited by Mooney A et al 2009, reported only half the rate of Meningococcal C Vaccination in looked after children. The reasons for the lower rates may be due to lower rates in children.
coming into care due to family circumstances and/or being less likely to be immunised when in care. The latter may be the result of poor record keeping as children move within the looked after sector. More recently, rates amongst Local Authorities in England are reported to have increased (Mooney A et al 2009) but there appears to be no publications now available to demonstrate this.

3.4 Security amongst looked after children and young people

A review covering deaths of LACYP between 1997 and 2001 (Scottish Government 2002) of children and young people who are looked after, highlighted the higher mortality rates amongst these children compared to that of the general child population citing those occurring during the year 2000 (no statistical tests were applied) as: 478 child deaths out of a total child population in Scotland of 1,062,140, equivalent to a mortality rate of 0.04%. In the same year 15 looked after children died out of a total population of 11,309, a mortality rate of 0.13%. In the same publication reference was also made to “Young people who are looked after have revealed to researchers that they do not always feel safe. They have revealed that they are at risk of physical, sexual or racial abuse, or at risk of misusing alcohol or drugs, self-harming behaviour or prostitution”. Concerns based on the findings of the review of thirty of the fifty deaths that were not health-related which had occurred during the five years, included medical practice and the lack of mental health services for children and young people with challenging behaviour who demonstrated high levels of reckless or self-harming behaviour. There were particular examples also where more could have been done to protect the children by the agencies concerned.

Since then, another review of deaths amongst looked after children, (Care Inspectorate 2013) has very recently been published. Legislation has been amended since the previous review whereby deaths of all children in care have to be notified to Scottish Ministers and also the Care Inspectorate within one working day by the Local Authority after which a full report must also be submitted within twenty eight days(Looked After Children (Scotland) regulations 2013 (SSI 2013/14). The findings of this more recent review were based on thirty deaths of LACYP who were aged from 1 year to 17 years for the three year period 2009 to 2011. These deaths had been reported from sixteen of the thirty two local authorities (no deaths had been reported from the other 16 LA’s). The equivalent crude death rate for 2009 was almost three times higher than that of the wider child population but only slightly higher for each of the two more recent years. As no statistical methods were applied and previous years mortality had not been considered, it cannot be concluded that the rate of deaths amongst LACYP is diminishing although this is suggested as such in the report. Half of the thirty deaths had occurred in those aged 15 to 17 years. The proportions by placement type were residential care (40%), home or kinship care (37%) and foster care (13%). The deaths in residential care are disproportionately high since in recent years, it accounts for less than 10% of all placements of LACYP (see section 2). Similar to the previous review, half of the deaths were not from health-related issues with the deaths by cause reported as Life-limiting conditions (n = 8); Other health issues (n=7); Suicide (n = 5); Accidental death (n = 5); Murder (n=1); Drug & alcohol related (n =3) and Unknown (n =1). The Inspectorate indicated that deaths from health-related issues other than life-limiting conditions, such as illness or a complex health condition has increased from previous years.

Section 4: Groups of looked after children with particular needs

The findings from surveys described in section 3 together with the conclusions of various published reviews, all suggest that generally LACYP are more at risk of poorer than average current and future health and well-being due to their backgrounds and previous experiences, for example from poor parenting, abuse and other factors. Relative differences have been found in relation to the type of care setting and the duration of the period of care. In this
respect the health of those in residential care as opposed to foster care and those whose period of care is under two years as opposed to those with over two years in a single place of care, are poorer, particularly in relation to mental health (Scott, J, and Hill, M. 2006).

However, it has been highlighted that much of the literature about looked after children focuses on those in foster or residential care with little being known about the needs of children looked after at home by their families under a care order, or looked after by friends and family, (Mooney A et al 2009; Scott J and Hill M 2006).

Looked after children originating from certain groups more marginalised in society, may be considered to have particular needs and be more at risk of having poorer outcomes. These children may come from the following groups (LACHE 2012):

- Disabled children
- Travellers’ children and those from minority ethnic groups
- Young people in the criminal justice system,
- Asylum seeking children who are separated, unaccompanied or with families
- Children whose educational needs are not being met
- Young people who are gay or lesbian
- Children and young people who are geographically isolated
- Children leaving care
- Children in poverty
- Young parents and their children

The particular needs of these groups may be educational (in the form of additional support needs) or health service requirement. Some of these are described below.

4.1 Additional Support Needs

These vulnerable groups may be more likely to have Additional Support Needs (ASN) and legally through the Education (additional support for learning) (Scotland) Act 2004 (and its amendment Act 2009), all LACYP should be deemed to have additional support needs unless the education authority determines that they do not require additional support in order to benefit from school education (ref. Supporting Children’s Code of Practice Revised edition 2010, Scottish Government). There is a wide range of factors which may lead to some children and young people having a need for additional support. These fall broadly into the four overlapping themes described below: (i) learning environment, (ii) family circumstances, (iii) disability or health need, and (iv) social and emotional factors.

(i) ASN may arise where the learning environment is a factor. This may take the form of barriers to learning or full participation in the life of the school as a result of a pupil’s special need. This might be through a learning problem such as reading or writing where the appropriate educational support is not being provided.

(ii) Family circumstances may give rise to additional support needs; for example where the pupil herself is a young mother or the child or young person may be being looked after by the local authority or have recently left care or be in need of measures to secure their care and protection. In these circumstances support from social work services may be needed to ensure that the child or young person is able to benefit from education.
(iii) Issues relating to a disability or health need may mean that additional support is required; for example, where a child or young person has a motor or sensory impairment, specific language impairment, autism spectrum disorder or has learning difficulties. Mental health problems such as attention deficit hyperactivity disorder and depression can disrupt learning and may lead to additional support being required from child and adolescent mental health services to ensure benefit from school education.

(iv) Social and emotional factors may also give rise to a need for additional support for example being bullied or bullying; experiencing racial discrimination; having behavioural difficulties. A child being bullied or bullying may need additional support.

In addition there are known health needs particularly more prevalent to these groups.

4.2 Health need requirements of particular groups

4.2.1 Black and Minority Ethnic groups

LACYP from Black & Minority Ethnic groups (BME) may experience additional adversity as a result of racism and this may impact on their health and health-related behaviours. In addition, some black and minority ethnic populations are vulnerable to certain hereditary illnesses such as sickle cell anaemia, thalassemia and predisposed to certain forms of diabetes. There is also evidence of high levels of depression among certain groups in the Asian community; African-Caribbean people have been significantly more likely to be diagnosed as schizophrenic than white adults and are more likely to be users of acute mental health services than preventative services. Less is known about access to CAMHS by children and young people from black and minority ethnic groups, but clearly there may be implications for the assessment of their emotional and behavioural development. Culture will also be an important factor informing the provision of services since there may be requirements concerning, for example, the gender of the doctor. Children and young people for whom English is not their first language may have difficulty in communicating their needs and experiences. Arrangements should be made to enable them to use the language they feel most confident in. Young people from black and minority ethnic groups, and those who are lesbian, gay or bisexual may also face multiple disadvantages or need additional support which may impact on their capacity to access services (LACHE 2012).

The immunisation status of migrant children arriving into care may be unknown and a course of primary immunisation may need to be undertaken (urgently). Children may have had no previous child health surveillance and may well not have undergone neonatal screening for congenital abnormalities or inborn errors of metabolism. Children may suffer from malnutrition, and depending on country of origin, conditions to consider include tuberculosis, hepatitis B and C, malaria, schistosomiasis and HIV/AIDS (LACHE 2012).

4.2.2 Looked after in secure settings

Children cared for in secure settings are another very vulnerable group whose placement in a secure establishment poses particular problems in meeting their health needs. The route by which children and young people enter secure settings will determine with whom responsibility for their welfare and care rests. In secure settings, children and young people in the same establishment will be cared for by the same staff but under different legal frameworks, e.g., welfare and criminal justice. This presents particular challenges for local authorities in respect of the children for whom they act as corporate parent and for secure establishments and staff within them which receive children and young people through different routes (LACHE 2012). It is therefore important that local authorities should ensure that the arrangements for providing health assessments and access to a comprehensive range of health services for children for
whom they are responsible are in place and are closely monitored. For individual children, as for other children placed outside the area, monitoring and reporting arrangements will be required. For establishments run by the local authority which care for children and young people placed through welfare and criminal justice routes, the local authority will need to pay particular attention to achieving coherence and consistency in securing the delivery of effective and high quality health services for all of them.

4.2.3 Individuals with specific conditions or complex health needs and looked after away from home

LACYP with particular individual conditions for example physical disability and those which are ‘hidden’ can be further disadvantaged if their condition is either misunderstood or overlooked when they become looked after away from home. Examples might include some genetic disorders, mild forms of autism and disorders which affect comprehension and learning, or conditions which are found in certain racial groups, e.g. sickle cell anaemia.

The number of children and young people with complex health needs who become Looked After is increasing, and they are likely to need a range of specialist or secondary health services. The most significant need is likely to be in relation to mental health services such as consultant child & adolescent psychiatrists who will diagnose and treat any tertiary mental illness, therapeutic nurses, art, play or occupational therapists, psychotherapists, child psychologists and this has been highlighted in the Governments report “These are our Bairns” (Scottish Government 2008a).

With respect to looked after children with specific needs as a consequence of particular individual conditions for example autism, NICE has developed a guideline focusing on the recognition, referral and diagnosis of children and young people on the autism spectrum (NICE 2011). This guideline specifies that additional support may also be required for looked after children and young people where a detailed developmental and medical history is difficult to obtain. If this expertise is not available to the autism team, referral is warranted. It is also acknowledged within this guideline that a child’s social circumstances (for instance, “looked after children) may also affect how quickly features of ASD are recognised.

Section 5: Access to general and specialist health services

As the above sections demonstrate, LACYP have a higher level of health, mental health and health promotion needs than their peers in the general population. Health issues will include psychological, behavioural, physical and risk-taking behaviours (such as alcohol & drug misuse). These needs are likely to be there at entry to public care for example, half of those in one study were found to have a diagnosable mental illness; other studies indicating greater rates of unprotected sexual activity, smoking, alcohol and drug misuse at entry to care (Dimigen G et al 1999; Steele JS and Buchi KF 2008; Sempik J et al 2008). Access to routine health care is also likely to have been relatively lacking before being taken into care as manifested in lower rates of immunisation cover and GP registrations (Rodrigues VC 2004). Longer term needs as a consequence of abuse and neglect are also indicated. Therefore, early and comprehensive health assessment is of primary importance. In Scotland there is a statutory requirement, (Scottish Government 2010) for a medical examination with a written health assessment to be carried out prior to or just after placement in care, but unlike the situation in England, (Department of Education 2013) there is no formal guidance on what these should constitute. The Scottish Government, through the Looked After Children Strategic Implementation Group (LACSIG), is developing guidance on undertaking health assessments of children entering care and is expected to be issued later in 2013. However there is no formal expectation that annual health checks
thereafter should be carried out and this misses any opportunity to provide compensatory (as a consequence of poorer than average health status) health care.

The physical health needs of LACYP may arise out of simple issues such as:

- incomplete immunisations,
- asthma,
- dental caries,
- refractive (visual) errors,
- scabies,
- head lice,
- conductive hearing loss

Or from more complex issues such as:

- foetal alcohol effects,
- vertically transmitted infections
- Undiagnosed disability;
- Diagnosed disability
- Consequences of neglect and abuse
- Special Educational Needs

In terms of mental health issues, these are commonly experienced in LACYP, particularly conduct disorders (see earlier section 3). Emotional and psychological needs as a consequence of abuse are quite often manifest as an obsessive need for eating (and drinking).

5.1 General Access to services

In terms of access to appropriate health care, published findings from various sources indicate that many children who are looked after and accommodated do not receive the health assessments and treatments they need from conventional health services and even when needs are identified, it is argued that there is a gap in the delivery of effective interventions to children and young people with mental health problems. (Scott, J & Hill, M 2006; Jones R et al 2012). Several factors may contribute to the gap between need and service access such as previous moves between placements, lack of effective information sharing, absence of advocates and lack of available services, particularly for Child and Adolescent Mental Health. A review of case notes of looked after children in East Surrey (n = 136) reported that only two thirds were registered with a GP and a smaller proportion had attended statutory medical examinations (Rodrigues VC 2004) Further findings included lack of background information to the medical practitioner carrying out the health assessment and barriers to uptake of CAMHS. The study was undertaken over a decade ago and it is unknown whether the situation has improved. This may not be the case as stated in These are Our Bairns report (Scottish Government 2008a), LAYP and care leavers are less likely to engage with universal health services such as GPs, dentists and opticians although the evidence on which this statement is based is not cited.

It has also been reported that children in public care also had lower immunisation rates overall and more incomplete schedules than the local population. (Mooney, A. et al 2009). Children on admission to care often have below average physical health and sometimes a poor record of immunisations and unmet dental needs. Frequent changes in contact with primary care services have sometimes led to inadequacies in health records. This also applies to those in residential care. One report (Hill M 2009) highlighted the different needs of young men and women in residential care and in particular the major support needs arising from early pregnancies for young mothers and their infants. In summary, it found that
children and young people in residential care have significant physical, mental and emotional health needs and therefore health service needs

A systematic review (Jones R et al 2012) of the evidence for the effectiveness of interventions to improve access to specialist or universal health services by LACYP (health and mental health services) also undertaken to support the recent NICE and SCIE public health guidance on LACYP in England and Wales, using both systematic review searching and supplementary searching resulted in the inclusion of only five studies, four of which were based in the US and one which was non-comparative in the UK. These provided the following evidence statements:

- There is limited evidence of reasonable quality, suggesting that multidisciplinary assessment at the point of entry into care, increases access to services in general. This however related to the short and medium term, but not in the longer term (i.e. at 12 months follow-up). As this was based on a US study carried out ten years ago, its applicability is doubtful.

- A comprehensive medical case management programme in the US increased access to psychiatric clinics services but slightly reduced access to mental health services. This is likely to be of moderate relevance to UK.

- General health service uptake is increased by provision of all ‘reasonably available medical records’ to the professional who is undertaking the initial assessment at initial point of access to care.

- There is limited evidence, of poor quality, suggesting that an agency caring for the LACYP with on-site mental health clinician, reduces the placement transfer rate compared to agencies without on-site mental health clinicians.

- There is very limited evidence suggesting that providing social services with information on current immunisation status does not lead to an increase in uptake of immunisation. However, this finding was derived from one poor-quality study.

In conclusion, evidence of effectiveness of interventions to improve access to services by LACYP is very limited. In particular, there is a lack of longitudinal evidence, or evidence focusing on specific groups of LACYP, including those from ethnic minority groups, from asylum-seeking backgrounds or among LACYP with disabilities. Evidence relating to the impact of placement type on access to services is also lacking, along with evidence across timeline of the care pathway. Also lacking was any intervention being delivered at a service level. The limited number of studies, the context of them and the quality of studies means that there is very little evidence for effectiveness of interventions to improve access to services for LACYP.

The report by Scott & Hill (2006) also referred to research on access to services of looked after and accommodated children. It made reference to a needs assessment that had identified a gap in the delivery of effective interventions to children whose mental health problems have already been identified. The assessment recommended that a more flexible approach to mental health issues by health professionals themselves should be employed and consideration made to providing training in mental health issues for those working directly with young people including carers.

The report also cites some specific initiatives in the provision of services to these children such as specialist looked after children’s nurses in schools and certain innovative approaches to mental health services. Some initiatives operated on an outreach basis which
obviated the requirement for attendance to clinics or surgeries some children consider to be stigmatising or daunting. Two of these involved supporting and training of those working directly with LACYP to better deal with difficult behaviours. These however were evaluated in the early part of the last decade. One of these was the Residential Care Health Project (RCHP) which was designed to help meet the health needs of LACYP in residential units in Edinburgh, East Lothian and Midlothian. It was funded by the Scottish Executive for two years and used a multi-agency and multidisciplinary team approach to assessing and providing care to these children in residential care to ensure universal access for children and young people to all health services. The project made recommendations within the three categories of (i) Staff & young people; (ii) Management (Social Work, Health and Education) and (iii) Policy (Grant, A. et al 2002).

The impact of the use of a specialist nursing service on the health care accessed by LACYP in residential care units in Renfrewshire, W. Dunbartonshire and Argyll and Bute was evaluated by a before and after study design (Hunter D et al 2008a). This involved the assessment of healthcare records of around 150 children after a project team comprising of a manager, three nurses (grade G) and administrative support officer had been implemented. The functions of the team were amongst others, to liaise with health and social care providers to meet the health needs of the children and to ensure that the standard health recommendations were adhered to including the completion of the relevant documentation. The team also provided health promotion advice and activities to children and residential home staff. It found that after the introduction of the service, the proportion of children with completed carer-held health records (BAAF health record booklets) increased from three per cent to 77 per cent; the proportion receiving a 'pre-admission medical' increased from 38 per cent to 48 per cent; the proportion adequately immunised increased from nine per cent to 56 per cent; the proportion with at least one outstanding medical referral decreased by at least four per cent; the number registered with a dentist increased from 14 per cent to 62 per cent and the proportion who received a 'comprehensive health assessment' increased from 17 per cent to 58 per cent. Thematic analysis of free text journals suggested that universal health services were much more accessible in Argyll & Bute due to well-developed interagency working, low numbers of children in residential care and low rates of staff turnover. In the more urban areas, the main advantage of the service was thought to be in the facilitation of interagency working. The main drawbacks were the short duration of the study (6 months), interpretation of the effect due to the study not using a control group and reliance on documentation as evidence of better outcomes i.e. process measure rather than outcome. However, it does suggest the importance of and it’s relative lack of, recording and sharing health information between agencies and different parts of the NHS.

LACYP miss more school days than those not looked after and the exclusion rate is much higher for example it was six times higher in Scotland in 2006/7, (Scottish Government 2008b, Count us in report). To address this, Birmingham City provides an educational system (Birmingham’s Virtual school and Looked After Children’s Education Service, LACES), which includes outreach teams offering peripatetic support & intervention and a split-site Pupil Referral Unit (PRU) providing onsite education options for LAC. It “oversees the education of children in care in the authority, and those children in the authority’s care who are placed out of the authority, as if they were in a single school”.

The National Institute for Health and Clinical Excellence (NICE) and Social Care Institute for Excellence (SCIE) issued recommendations (NICE PH28, 2013) from evidence based on research reviews, a practice survey, a consultation with young people who are or have been in care, fieldwork with practitioners and the testimony of expert witnesses. These were aimed to:

• promote stable placements and nurturing relationships
• support the full range of placements, including with family and friends
• encourage educational achievement
• support the transition to independent living
• meet the particular needs of looked-after children and young people, including those from black and minority ethnic backgrounds, unaccompanied asylum seekers, and those who have disabilities
• place looked-after children and young people at the heart of decision making

Service commissioning and delivery recommendations were included and the following specific guidance points made:

Commission services dedicated to looked-after children and young people that are integrated, preferably on the same site, and have expert resources to address physical and emotional health needs. These services should have links with universal services, be friendly, accessible and non-stigmatising and should include:

(i) Health promotion (see recommendations 37 and 46)
(ii) Early identification and prevention of physical and emotional health problems (see recommendations 8–11 and 20–23)
(iii) Access to specialist services, including child and adolescent mental health services (see recommendations 8–11)
(iv) Access to professional advice for the looked-after children and young people's care team (see recommendation 6).
(v) Encourage authorities to work together in local partnerships when commissioning services to offer greater choice and quality of services.

5.2 Access to specialist services

5.2.1 For those in Residential Care

In respect to LACYP in residential care, the National Residential Child Care Initiative (NRCCI) which was commissioned by the Scottish Government and COSLA via the Scottish Institute for Residential Child Care (SIRCC), has made recommendations in terms of the commissioning of services. Access to services for those in residential care has particular concerns in relation to the relationships between purchasers and providers due to:

- Distance from home base
- Issues around referral
- Placement disruption and instability (including end of placement transitions)
- Perceptions of cost and quality


The report recommends the development of three types of commissioning structures (1) Singleton: whereby a local authority may form a commissioning group to meet the needs for residential services in its own area, (2) Consortia: in which several local authorities may pool resources to deliver best value and manage risk (3) National: for a small population of children with complex needs and/or pose a significant risk of harm to themselves or to others who need a range of services:

- National schools for sensory impairment young people
- Specialist residential mental health services
- Secure care and education services
- Specialist residential treatment services for young people with a history of problematic sexual behaviour
A qualitative study as part of the evaluation of a specialist nursing service introduced to some of the residential care units in the West of Scotland (Hunter G et al 2008b) investigated what the barriers may be to health service uptake using structured interview methodology. From a total of twelve Residential Care Workers, the barriers were seen to be red tape (not being the parent means that some health information is not shared) waiting times, and flexibility in appointments. Long waiting times mean that for many children who are in residential care for short periods of time, they are often back home before the appointment comes. Often it is impossible to get appointments after school time and this is counter-productive as one of the important aspects of care for these children is to promote a good pattern of going to school.

5.2.2 Child & Adolescent Mental Health services

The high levels of mental health need amongst looked after children, particularly those in residential care (ScotPHN 2011) require the provision and access to the full range of child and adolescent mental health services (CAMHS), from promotion, advice and across the tiers from services in primary care / community setting to highly specialist provision (ref Mooney A et al 2009 and Hill, J. & Scott, M. 2006).

For example some children and young people will require referral to more specialist services from a multidisciplinary CAMHS team, including clinical psychologists and psychiatrists (CAMHS at tiers 2 and 3 – specialist community mental health teams). For those with high levels of mental health need, highly specialist provision will be required, which may be provided on a regional basis. This will include psychiatric in-patient units for children and adolescents and in some areas specialist outreach teams, which are able to support young people with mental illness in the community (Tier 4 CAMHS – in-patient provision). Children and young people in secure care are particularly vulnerable and often have the most complex difficulties. Many young people with high levels of mental health need also have complex social and educational difficulties. This further emphasises the need to adopt a holistic, whole-system approach to addressing the needs of looked after children.

Whilst the need for CAMHS is higher for LACYP, there seems to be no evidence to suggest that the barriers to access are any different to that experienced by the general child population in relation to long waiting lists and difficulties in obtaining appointments (Rodrigues, V.C. 2004).

5.2.3 Sexual health

It has been reported that teenagers who are in care are more likely to become pregnant (two and a half times) than those not in care (SCIE: Research briefing 9). According to Mooney A et al 2009, a study published in 1995 in England found one half of young women between 18 and 24 months of leaving care to be either pregnant or already mothers and also based in England, a more recent study (published in 2008), found a quarter of young people were either pregnant or young parents within a year of leaving care (both findings reported in Mooney A et al 2009). The SCIE report suggests this may reflect the greater exposure of LACYP to risk factors for teenage pregnancy such as experiencing social exclusion, low self-esteem, early age at first sexual intercourse, sexual abuse, socio-economic deprivation, limited involvement in education, low educational attainment; limited access to consistent positive adult support, being the child of a teenager, than many other groups. In contrast, access to good quality sex and relationship education has been demonstrated to reduce rates of teenage pregnancy. However, those in care have poorer access to good quality consistent sources of sex and relationship education and advice than many other children and young people. The recommendation given in the SCIE report is that additional services to the school-based programmes should be offered to LACYP due to the known limited
access of these (probably due to a greater rate of missing/moving between schools by this group of young women. In addition, Authorities that consult young people and develop specialist sexual health services for young people have greater success in reducing teenage pregnancy.

5.2.4 With complex needs

There is a range of programmes that have been or are being implemented in the UK which provide support in the community to children and young people in care or at risk of custody (Atkinson, M. 2012). The Multidimensional Treatment Foster Care (MTFC) programme is one such for looked after children and young people who have had many placement disruptions and who have high levels of need from social, health and education services and also for adolescents as an alternative to custody. The programme works with children and their carers from pre-school age (MTFC-P), school age (MTFC-C) and adolescence (MTFC-A) and provides intensive support to carers to maintain children in the community who might otherwise be placed in residential care or custody, based on social learning theory principles. The programme also works to improve children’s health, social and educational outcomes. There have been various pilot sites most of which are in England as Local Authorities have been funded by the Department of Education since 2003 but the programme for adolescents (MTFC-A) has included a site in Glasgow. The descriptions of the programmes and the results of the audit are available (MTFCE Annual Project Report 2011). However small numbers of LACYP had been involved in this last year’s programme but over the eight years, the outcome measures for all three age groups were positive and indicated appropriate recruitment to each of the programmes. For example, the MTFC-A recruited those with higher rates of Psychiatric disorder as measured by the Development and Well-Being Assessment (DAWB), of conduct disorders and difficulties scores (based on the Strengths and Difficulties Questionnaire (SDQ)) for both conduct and hyperactivity dimensions as well as total. After one year of the programme there was significantly decreased violent behaviour, self-harm and concerns over sexual behaviour but use of alcohol and substance use did not demonstrate significant reductions.

Another programme is KEEP (Keeping Foster and Kinship Parents Supported and trained) programme for mainstream foster carers and family and friends carers, is also being implemented in the UK and uses the same principles to work with mainstream foster carers to improve outcomes for looked after children as the MTFC programme. The audit results are available for the pilot KEEP for the carers of children aged 5 to 12 years (MTFCE Annual Project Report 2011)

Section 6: Preventative Health care (Health Improvement)

Young people who are looked after are recognised as being vulnerable to risk taking behaviour, including early and unprotected sexual activity, self-harming, misusing illegal and/or volatile substances and alcohol. These early risk-taking behaviours are very often indicators of poor emotional health and well-being and may be the forerunner of wider social exclusion such as homelessness and unemployment. Good health is dependent on a wide range of factors, many of which are interdependent i.e. health-related behaviour is influenced by physical and social environment, physical health, psychological, educational, access to health care and so on, and therefore a holistic approach to health improvement is a pre-requisite to promoting health. An opportunity to promote health is at the point of entry to care when assessment of needs occurs. It provides an opportunity for information to be gathered about the child’s state of health at a point in time but it can only be effective if it is part of a continuous process of monitoring and promoting the child’s health by committed carers and schools.
6.1 Health Assessments

Whilst it is statutory in Scotland to carry out a written assessment of the health and the health care needs of children or young people entering care by a registered medical practitioner or nurse, unlike the situation in England and as noted previously (section 5), the content of the assessment has not yet been specified, although it is under development by LACSIG. Statutory guidance to Local Authorities and the NHS in England by the Department of Education (Department of Education, 2013) includes some specific health promotion requirements (amongst other requirements such as immunisation etc) to be focussed on for the health assessments. These are listed for the three ages: (1) under 5’s; (2) ages 5-10 and (3) ages 11-18 (Adolescent and leaving care) and include:

- Diet (under 5’s)
- Exercise & diet and an understanding of a healthy lifestyle (ages 5-10)
- Provision of a healthy balanced diet (ages 5-10)
- Access to accurate simple information about sexual activity (ages 5-10)
- Lifestyle including diet and physical activity (ages 11-19)
- Understanding of issues relating to sexuality and sexual activity, including its role in relationships; contraception; sexually transmitted infection and the particular risks of early sexual activity (ages 11-19)
- Access to sources of information and advice about a range of health issues, including the risks of alcohol, tobacco and other substance use and access to sources of advice on modifying health risk behaviours. Assessment should be made of whether referral to specialist treatment for substance misuse is appropriate (ages 11-19)

Wales also has a practice guide for looked after children and young people (LACHE, 2012) and promotes holistic health assessments which would contain the following elements:

- Physical health needs
- Mental, emotional and environmental well being,
- Potential health risks to themselves and others,
- Appropriate health promotion suitable for the individual child
- Collect data for audit purposes.

These health assessments are then expected to be used to construct a holistic health plan for individual children. It also describes the roles of professionals and carers in relation to health promotion.

6.2 Strategies for specific risky health-related behaviour

The statutory guidance in England also describes a teenage pregnancy strategy that would support looked after children and care leavers to prevent early pregnancy and sexually transmitted infections (STIs), a smoking cessation training scheme for foster carers and LACYP, and for alcohol and substance misuse, that all professionals working with looked after children should understand the referral pathways for treatment and that the needs of LACYP should be included in the areas drug and alcohol plans.

In Wales, the Practice Guide (LACHE, 2012) states that many looked after young people use drugs for recreational reasons, just like many other young people amongst the non-care population. Yet there is also evidence that looked after young people may use drugs ‘to forget bad things’ reflecting their often traumatic personal histories. Although the research is limited, some studies illustrate that young people looked after are four times more likely than
those living in private households to smoke, drink and take drugs. When children and young people are abused through sexual exploitation, alcohol and other drugs are often involved in the grooming and enticement process. One study for example, found that 78 per cent of sex workers who were also problematic drug users had been in care (Cusick, L. et al, 2003). There is some evidence that looked after young people may ‘mature out’ of their drug use earlier than young people not in care. This seems to be associated with well-managed and supported transitions to independence.

An evidence briefing report (NHS Scotland, 2011), highlighted that healthy care for looked after children and young people should adopt the WHO settings-based, holistic approach to health improvement as established within health promoting schools and hospitals and that where children are not within mainstream education provision, access should be co-ordinated by educational establishments as recommended in the guidance, Health for All Children 4, (Scottish Executive, 2005) to make sure that children receive health promotion advice and child health checks and other health improvement activity.

6.3 Specific examples of health promotion and looked after children

The Residential Care Health Project (RCHP) involving local authority residential units for young people in Edinburgh, East Lothian and Midlothian, adopted a multi-agency approach to improving the situation for one group of children and young people. It used various methods of health promotion including drama, group work, individual work and work involving specialist agencies and recommended the value of positive role modelling in developing the idea of a health promoting unit in which staff and young people pull together to make their lifestyles as healthy and enjoyable as possible (Grant, A et al 2002).

Again in Scotland, one study evaluated Health promoting sessions delivered by a specialist nursing service working in residential care units in Renfrewshire, W. Dunbartonshire and Argyll and Bute (Hunter, D. et al 2008a). These sessions were positively received by the participating children, with the most helpful being rated for drug and alcohol, diet and exercise, giving up smoking and sexual health. The most effective element of the nursing service in terms of health improvement in this group was considered to be in the systematic monitoring of health progress by the nursing staff.

The second part of this study (Hunter, D. et al 2008b) was qualitative and on the basis of structured interviews of twelve Residential Care Workers, one of the main barriers to promoting health improvement was reported to be due to the conflict with undertaking the role of corporate parent: the need to protect the child from distress and the importance of maintaining a relationship with the child were suggested as important reasons for not promoting health improvement interventions.

The National Residential Child Care Initiative in its matching resources to needs report (Hill, M 2009) reported that young women in residential care have different needs from young men and these are often not acknowledged or else dealt with unhelpfully as a result of stereotypical reactions, especially with regard to sexual behaviour. Younger age pregnancies give rise to major support needs for young mothers and their infants. There is a widespread view that such young women are not being appropriately helped in their journey through care and that we need to find more effective ways of assisting them.

6.4 Potential for early health promotion activity

A study using routine UK Primary care data (the General Practice Research Database) and extracting health service uptake, compared the health status of children within the 12 month period before entering care with those of controls during the same period of time (Simkiss D.E. et al 2012). The comparison used mother and child pairs with the controls (538 pairs)
matched for age and sex with the cases (147 pairs). After controlling for maternal age and socio-economic status, the following were all associated statistically significantly with children entering care: maternal mental illness, maternal drug use, non-attendance at appointments, child mental illness and child admission to hospital. The researchers suggest that at risk populations for entering care can be identified on the basis of these factors and thus targeted for secondary prevention. They also highlight the probable under recording of risk factors in the clinical record by primary care practitioners.

Section 7: Leaving Care and the Transition period (child to adult)

7.1 Context of leaving care

Local authorities have a statutory duty to prepare young people for ceasing to be looked after ("Throughcare") and to provide advice, guidance and assistance for young people who have ceased to be looked after ("Aftercare") over school age up to 18 and a power to do so up to 21 years (Scottish Government 2004). The process for leaving is termed Pathways and the Local Authority is responsible by means of a Pathway Co-ordinator in ensuring that the views of the leaver are sought, an assessment is carried out that covers the seven areas of: Lifestyle; Family and Friends; Health and Well Being; Learning and Work; Where I Live; Money; and Rights and Legal Issues and a Pathway Plan is put in place which covers the same seven areas.

Even within this statutory framework, young people leaving care are vulnerable with their health and well-being poorer than that of young people who have never been in care (Department of Education, 2013). Generally, young people leaving care go to independent living at a younger age (majority at 16 to 18 years) than their peers who remain at home well into their 20s. In addition they have made this transition from restricted citizenship to full citizenship, irreversibly for the majority from various care placements. Often this is to a new area and both young men and women in and leaving care are more likely to be teenage parents than their peers (see section 5.2.3), for example one quarter has been reported to be within one year of leaving care (Dixon, J. 2008).

Scott & Hill (Scott, J, & Hill, M. 2006) refer to research in several countries showing 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. They also observe that “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”.

7.2 Outcomes of leaving care

A population-based study reported the results of a follow up of a birth cohort in Britain for 30 years from 1970 to 2000, (Viner R.M. and Taylor, B. 2005) in which those who had been in Public Care before aged 17 years, (n = 343) were separately identified. In general, their health and social outcomes were poorer than those who had not been in Public Care. This included statistically greater likelihood of being homeless, having a conviction, having psychological morbidity and be in poor general health. Recent alcohol and drug misuse were also amongst the outcomes measured with no difference for alcohol but a significant higher prevalence for illegal drug use in males OR = 1.5 (1.0-2.1).

Another study involving 106 care leavers from seven Local Authorities in England (Dixon, J. 2008), compared measures taken within 3 months of leaving care with those obtained from
interview approximately twelve months later. Amongst the findings were: problems with alcohol or drugs had increased two fold from 18% to 32%, reporting of other health problems (Asthma, weight loss, flu, illnesses related to alcohol or drug misuse and pregnancy) increased from 28% to 44% and mental health problems reported from 12% to 24%. In relation to mental health, the GHQ-12 change scores demonstrated an increase in symptoms amongst 44% of the care leavers, 30% in whom there was no change and 29% in whom the symptoms had lessened.

An earlier study involving leavers from residential care from three Local Authorities in Scotland (Dixon, J. and Stein, M. 2003) demonstrated similar outcomes in terms of increased mental health problems, health issues and emotional and behavioural difficulties.

A review of research studies on care leavers completed since the mid-1980’s suggests that the outcomes of leavers can be categorised into three groups (Stein, M. 2006):

- **Moving on:** Young people having good outcomes in terms of aftercare life and are likely to have had stability and continuity in their lives during care. Participating in higher education, having a job they liked or being a parent themselves, contributed to a feeling of being normal.

- **Survivors:** More likely to have experienced some disruption in their care and to have fewer educational attainments than the moving on group. They were more likely to have left care at a younger age and have had periods of disruption in aftercare such as homelessness, unemployment and others. Despite needing more assistance, those in this group feel more tough as they have had to grow up and be self-reliant.

- **Victims:** These were those who had the most damaging pre-care family experience which for most, the period of care could not compensate for. They were also likely to have entered care and left care earlier, with a higher degree of discontinuity in placements. After leaving care, they are most likely to be homeless, unemployed, lonely and have mental health problems. Aftercare is the least likely to help this group but it’s important to them that somebody was there for them.

### 7.3 Effectiveness of Transitional (Throughcare) Support Services

This has been a review topic commissioned by NICE (Everson-Hock, E. et al 2010). Similar to the effectiveness of interventions to improve access to health services of LACYP, there was insufficient evidence of high quality and relevance (most were from U.S. studies). The following summarises its findings in relation to the outcomes reviewed—the outcomes selected in relation to the type of Transitional Support Service (TSS) area:

- **Education:** There is moderate evidence of a mixed effect in relation to the likelihood of completion of compulsory education with formal qualifications compared to those who did not receive TSS.

- **Current employment:** There is moderate evidence of a positive effect of TSS

- **Employment history:** There is moderate evidence of a mixed effect; one prospective UK study showed less likelihood with TSS whilst two retrospective US studies demonstrated a greater likelihood with TSS.

- **Employment at case-closing:** There is moderate evidence of a mixed effect; Two US studies reported an increased likelihood whilst one other US study, a decreased likelihood with TSS.

- **Crime/offending behaviour:** There is moderate evidence of a mixed effect with three US studies showing an increased likelihood, a decreased likelihood and one in which there was no difference.

- **Parenthood:** There is moderate evidence for a positive effect from three US studies in terms of reduced likelihood to become parents.
• **Housing/living independently:** There is moderate evidence for a positive effect from five US studies and one UK prospective study in terms of increased likelihood to have a place to live and live independently.  

• **Homelessness:** There is moderate evidence for a mixed effect from four US studies, half of which demonstrated a reduced likelihood of being homeless and the other two did not demonstrate any difference.  

• **Mental Health:** Evidence of mixed quality to suggest little evidence of effect of TSS’s on mental health outcomes.

Interestingly despite the paucity of evidence regarding TSS concerned with supporting employment (as above), a parallel economic modelling study to the one above, has demonstrated the cost-effectiveness of TSS’s that are concerned with skills to assist employment compared to no TSS. The authors conclude that employment may have an indirect positive effect on other outcomes including crime and mental health, (Duenas, A. et al 2010).

An evidence summary (NHS Scotland 2012) in relation to health-related behaviour, stated “there is evidence of good quality (one cohort study rated +) for an association between transitional planning and drug and alcohol misuse as an adult (evidence statement 2.8). Also within the same statement, “there is evidence of mixed quality (2 cohort studies rated – and 1 review rated +) for an association between transitional planning and education and employment as an adult (medium effect size)”.

### 7.4 Care leavers views on health

#### 7.4.1 Overall

Studies of young people leaving care typically report that their health concerns are similar to those of young people outside the care system (such as smoking, sexual health and STIs) (Mooney, A. et al 2009). However, concerns about traditional health issues such as healthy eating are not considered first when young people are asked about health. They are consistent in listing the wider determinants of health as being the most important such as housing, depression, care experience, close personal relationships, feelings about life (National Children’s Bureau, 2008). This briefing also states that small-scale local studies about health services, have identified that young care leavers value supportive and friendly health professionals; would like to keep the same GP if possible and like the idea of young people’s clinics although not all were sure of what these are. They also appear not to know how to make dental appointments and some liked Accident & Emergency departments because they didn’t need to make appointments.

Peer research carried out by young care leavers themselves tends to reveal a more positive picture than most other research studies. The *What Makes the Difference* (WMTD) project trained care leavers to undertake 265 interviews with other care leavers aged between 15 and 23 years, from 15 local authorities. The majority of these young people said they were registered with health professionals and felt confident about accessing advice, and more than three quarters felt that leaving care services showed interest in their health (Mooney, A. et al 2009).

#### 7.4.2 Views of young parents

Mooney, A. et al 2009 also cite research that indicates many young mothers fearing involvement with services that could help them to look after their child’s health as well as their own, in case it leads to their child being taken into care. In addition, young parents also...
report a wide variation in the support available to them across England including access to sexual health services before they became pregnant.

7.5 Recommendations

The statutory guidance issued in England (Department of Education, 2013) highlights the following four points in relation to leaving care:

1. All should be mindful that the responsibilities of local authorities and the health needs of young people cease when looked after young people enter adulthood. They are more vulnerable as they do not have the same family support as other young people and thus more likely to fall through gaps in children and adult services.

2. Due to the higher rate of pregnancy amongst young care leavers, it is likely that they need additional support in access to specialist advice on contraception and sexual health. Several guidance publications are recommended, one for local Authorities and Primary care Trusts.

3. In order for care leavers to continue to be able to access health services, personal advisors (Pathway Co-ordinator in Scotland) should work closely with doctors and nurses involved in health assessments and would benefit from training on how to promote both physical and mental health. Leaving care services should ensure that health and access to positive activities is included in the pathway plan and if needed, they should provide health services on their premises. CAMHS transition should be planned at least six months in advance of the 18th birthday.

4. Care leavers with complex needs that may include disabilities should have their transition between children and adult services supported so that it is as seamless as possible through pathway planning. This may involve using support from the voluntary sector which should be identified and facilitated through the personal advisor (pathway co-ordinator).

Section 8: Differences between Looked after children (LAC) and looked after and accommodated children (LAAC); [Using the definition of LAC as those in home or kinship placement and LAAC as those in Foster or Residential care]

The majority of LACYP will have had several changes of placements and placement types during their time in care. Although there are particular reasons for a child or young person to be in a residential care setting, usually due to complex needs and/or specific learning needs, the difference between the type of needs or outcomes of children cared for under a home supervision order distinct from those who are placed away from their normal residence, is less well known.

Based on the results of the ONS survey in England carried out on over 1,000 children aged 5 to 17 years, the reported differences between children in different types of care were: less common disorders, particularly those on the autistic spectrum, were far more common among children in residential care than in other placements (11% compared to 2%); and children living under a care order with their natural parents were over four times as likely as those placed in foster care to have depression, 9% compared to 2%, (Mooney, A. et al 2009).

A very recent Health Needs Assessment of looked After Children in Scotland (ScotPHN, 2013) analysed a specifically requested data sample (n = 12,600) of looked after children in Scotland as at 30th June 2012. The data from the Scottish Children’s Reporter Administration
(SCRA) which holds records for children with supervision requirements and can be cross-linked via the Scottish Candidate number (SCN) to the Governments collected Social Care and Education data, was analysed by sub-placement category. It included profiling by age, parental socio-economic status, grounds for supervision requirement and some educational measures.

The following related to Home as the care setting for those with a supervision requirement:

- Were slightly older on average (9.8 years) than those in Kinship or Foster care (8.6 years).
- There were more males than females (54%) being in care at Home compared to other placements which had a more even gender balance with the exception of Residential care where it was 60% male.
- Although the socio-economic profile of parents current place of residence (on the basis of SIMD quintiles) was not the most deprived among the placement types, (highest was for Kinship care where 61% of parents were in the most deprived quintile and the lowest for those in Residential care at 48%), it was still more deprived than that of the general population with over 50% living in the most deprived quintile.
- Compared to Foster or Kinship care placements, there was a greater proportion of behaviour problems as being a ground for supervision requirement (19% as opposed to 3-4% in Foster or Kinship Care).
- The average school attendance rate of 79% was the lowest across all placement settings although the overall average of 87% for LAYCP (across all placements) was in turn lower than that of the general population of 93%.
- Educational attainment on the basis of Universities and Colleges Admission Service (UCAS) award points was the lowest (35 UCAS) of all the placement types and decreased with the number of placements
- School exclusion rate was highest amongst community placements (at 409/1000 pupils looked after in a single placement throughout 2010/11, it was twice that of those in Kinship care and three times that in Foster care, although lower than those in residential care, Scottish Governments Education Statistics).

On the basis of the social health outcome measures relating to education, the HNA report under the section on Social Health (section 6) stated “Children looked after at home have the poorest outcomes on a number of measures” as one of its summary points.

It seems that on the basis of some socio-economic determinants of health measures and some social health outcome measures, that the 30% of LACYP in care at home with parents (approx. 200 in NHS Highland, 140 in Highland and 60 in A & B council areas as at July 2012) are at greater risk of poorer health and well-being than other community placed LACYP.
### Section 9: Summaries & Key Messages from sections 1 to 8

#### From Section 1: Definitions & Characteristics of LACYP

- Different definitions of LACYP with four main placement settings: Home; Kinship; Foster; Residential
- Effective prevention would reduce the need for secure and residential care
- Age range is from 0 up to 18 years but potentially to 21 years as LAs are legally bound to provide aftercare to those who require it
- Over one quarter of those on the child protection register are also looked after
- The main reason for entering care is as a result of abuse or neglect
- The younger the age at entry to care, the more likely long-term placements (including adoption) can be attained

#### From Section 2: Statistical profile of LACYP

- As at July 31st 2012, there were approximately 700 children in care in NHS Highland (200 in A & B and 500 in Highland). These equate to rates of 1.0% and 1.1% of the overall populations of children & young people aged 0 to 18 years respectively compared to a national average rate of 1.5%. The Scottish rate is higher than that of other UK countries but similar to them, the rate of increase year on year is slowing.
- Nationally and in Highland Council, 20% to 25% were aged under five years and 10% aged 16 years and over with the majority (two thirds) aged 5 to 15 years.
- The proportion of those with Additional Support Needs in Highland Council (24%) was over twice the national average (11%).
- Locally and nationally, the majority were in community settings (80-90%) but relative to the national average, the percentage in residential care was higher, particularly in Highland Council (16% versus 9% in Scotland). Over one third were in foster care, another third at home with parents and one quarter in kinship care.
- The ten year national trend from 2003 to 2012, was a reduction in the proportion looked after at home or in residential care and an increase in those with foster parents, prospective adopters and in kinship care. The trend in A & B was broadly similar to the national trend with increased placement in community settings and decreased placement in residential care but in Highland, there was little change in the proportions of these two types of placements over the ten years.
- Nationally, over two thirds of those entering care do not have additional need (disability), one quarter who are unknown about and less than 10% with a recorded disability
- The age at both entering care and leaving care has been decreasing nationally over the ten year period (2003 to 2012)
- Nationally, the difference in the numbers entering and leaving care has diminished over the last ten years resulting in more stable numbers in care.
- In 2010/11 and 2011/12, the proportion of care leavers above the minimum school leaving age (entitled to aftercare) who had received a pathway plan was consistently high in Highland (100%) and lower in A & B approx. (50%) which compared to national averages of 57% and 73% for these two years
- As at July 31st 2012, one third of care leavers in Highland eligible for aftercare were in employment, education or training as opposed to less than one quarter for A & B and Scotland as a whole.
From section 3: The main types of health need of LACYP

For younger children
- Most of the knowledge about this age group is derived from studies looking into the circumstances of children entering care and the impact of these on the health of the child. The prevalence of mental health problems estimated at 25% in those under the age of 5 years was mainly conduct disorders. Predictors of poorer health, particularly mental health was older age at entry (over 7 months), intellectual disability, reading difficulty, previous sexual, physical and emotional abuse and Parental factors (mainly maternal such as mental health, drug and alcohol misuse, young age, previous criminal offending.

For older children (5 to 17 years)
- Most of our knowledge on the health (physical and mental) status of looked after children in this age group is derived from two (ONS) surveys across the UK undertaken ten years ago.
- The general health status as rated by carers was slightly worse in Scotland than England with 13% rated as fair, bad or very bad compared to 8% in England.
- Those in Foster care were rated as having better health than those in other care settings particularly residential care.
- With the exception of asthma, hay fever and eczema, the prevalence of all conditions asked about were higher in LACYP than those in private households; Eye/sight; bed wetting and speech & language were the three most common problems.
- The prevalence of mental health disorders was 45% overall, with conduct disorders as the highest. These rates are much higher than private household children in Scotland. In England, higher rates were in boys aged 11 to 15 years, in residential care as opposed to foster care and to have been in a current placement for less than three years. A higher prevalence rate (72%) was measured in children who had entered care for the first time and who were still in care at least 12 months later may reflect a more troubled cohort than the cross-section of LACYP in the ONS surveys. Over one fifth of LACYP self-harmed in Scotland, mainly in older children and in residential care.
- Amongst 11 to 17 year olds, the prevalence of smoking, alcohol use and recent drug taking were all higher in LACYP and in the case of smoking and drug use, higher in Scotland than the LACYP in England. It appears that being in care also does not prevent obesity.
- Amongst 11 to 17 year olds, one fifth had experienced rape or sexual abuse and excluding these, two fifths had experience of sexual intercourse.

For care leavers
- There is some evidence that care leavers have worse health and social outcomes relative to those not being in care and a greater proportion becoming young parents, (20-50% aged 16-19 years compared with 5% in general population).

Security
- Reviews of deaths of LACYP suggest that the rates are decreasing and that health-related deaths as opposed to suicides and accidents are making up a greater proportion of them. However, there is statistical uncertainty as to whether the mortality is any higher than in the general children & young person’s population and whether it is decreasing.
From section 4: Health need by groups of looked after children

- Certain groups of children coming into care are more at risk of poorer outcomes. These include those from minority groups ((travellers, ethnic); in the criminal justice system, asylum seekers; gay or lesbian; geographically isolated, leaving care, educational unmet needs and others.

- More vulnerable groups are more likely to have ASN due to factors relating to: (i) barriers to learning e.g. a learning problem not being met (ii) family circumstances e.g. being a young mother (iii) disability or health need e.g. sensory impairment, autism spectrum disorder (iv) social and emotional factors such bullying, racial discrimination.

- LACYP in secure establishments are at risk of not having their health needs met, mainly due to the challenges to communication and coordination in situations where the responsible LA is different to the setting LA and the setting staff receive children from a variety of different routes.

- Children looked after away from home with specific conditions or complex health needs, may not have their needs met due to their problems not being identified or being misunderstood. The guideline on Autism issued by NICE specifically refers to LACYP as being at greater risk of being missed due to the likelihood of incomplete medical and developmental history. Those with complex needs make up an increasing proportion of LACYP and access to specialist or secondary care services, particularly those for mental health is required.
Section 5: Access to general and specialist health services

- LACYP have greater needs for health services and health improvement both during care and prior to being taken into care reflected by lower rates of immunisation and registration with General Practitioners. Also longer term needs as a result of abuse and neglect are indicated. Physical health needs can vary from simple (e.g. incomplete immunisations, scabies) to more complex (e.g. foetal alcohol effects and various disabilities). Mental health needs include conduct disorders, and emotional and psychological needs as a consequence of abuse.

- Health assessment at entry to care (which is statutory) and future regular monitoring of health needs are therefore important. There is no formal expectation that annual health checks take place. In Scotland, formal (statutory) guidance on what these health assessments should constitute is awaited.

- There is very little good quality evidence for the effectiveness of various interventions to improve access to specialist or universal health services and is almost entirely from studies based in the United States. One such demonstrated short and medium but not in the longer term (over 12 months) improvement in access to general health care after multidisciplinary health assessment at entry to care.

- Lack of studies to assess effectiveness of any interventions delivered at a service level

- A before and after study of the impact of a specialist nursing service on access to health care of children in residential care in Scotland improved several outcomes including immunisations, dentist registrations, medical referrals and completed health care records. It also found that access to general health care was better in more rural areas most likely due to a number of factors.

- Recommendations to improve access to specialist health care for those in residential care have been issued by the Scottish Government and by COSLA via the SIRCC on the basis of three types of commissioning strategies.

- Barriers to the uptake of specialist health services for those in residential care include red tape (not being a parent), long waiting times when children are often in residential care for short periods) and unavailability of out of school hour appointments.

- LACYP have a greater need for CAMHS including Tier 4 services. Those in secure care are likely to be most at risk of not accessing these services due to the complexity of their needs i.e. often includes social and educational needs.

- LACYP have a greater need for sexual health services but are less likely to have access to good quality and consistent sources of sex and relationship education due to greater absenteeism from school and from movements between schools.

- There are examples in the UK of programmes (KEEP and MTFC) aimed at improving health outcomes for LACYP cared for in community settings by supporting and training carers.
Section 6: Preventative Health care

- LACYP are vulnerable to early risk-taking behaviour
- Entry to care should provide the opportunity to promote healthier behaviour via the health assessments. The NHS in England has provided statutory guidance for these and it includes several specific health promotion requirements for three age groups.
- There have been various initiatives in Scotland to promote the health outcomes by health promotion methods of LACYP which includes one for those in residential care (RCHP)
- Possible barriers to promoting health by residential Care staff is the conflict between the role of reducing distress and maintaining a relationship with the child/young person and the role of promoting health via changing health-related behaviour.

Section 7: Leaving care

- There is a statutory requirement for LA to provide Throughcare which will prepare young people for ceasing care
- Young people leaving care generally go to independent living (16 to 18 years) at a younger age than the general population
- Both the shorter (within 3 months of leaving care) and the longer term health outcomes have been found to be worse than that of the general population at the same age. These included drug and alcohol abuse, mental health, emotional and behaviour difficulties as well as various other health issues, homelessness and unemployment.
- Similar to the interventions to improve access to health services, there is little evidence for the effectiveness of throughcare support services
- The views of care leavers on health have indicated a lack of knowledge in relation to making appointments and a preference for A & E as a consequence but are consistent in knowledge about the wider determinants of health such as employment and housing.
- Peer research (undertaken by care leavers) about care leavers provided a more positive aspect to care leavers views of health
- The statutory guidance issued by the NHS in England includes four issues in relation to care-leavers: (i) Duty to provide on-going services and likelihood of falling through the gap due to lack of family support (ii) Additional support to access specialist advice on contraception and sexual health (iii) Various strategies to be adopted by Personal advisors (equivalent to Pathway Co-ordinators in Scotland) including training on physical and mental health promotion and to ensure appropriate access to health care. (iv) Care leavers with complex needs-ensure seamless transition from children to adult services using pathway planning and possible support from the voluntary sector.
Section 8: Differences between LAC and LAAC

- Comparison between care settings needs to be considered within the context of the multiplicity of placements that most LACYP experience during their time in care.

- The particular needs or outcomes of those cared for at home distinct from those placed away from their normal residence is relatively unknown but some research shows:
  1. Less common disorders particularly on the autistic spectrum are more prevalent in those in residential care compared to other placements (11% versus 2%).
  2. Those living at home under a care order with their natural parents are four times more likely to be depressed compared to those in foster care (9% versus 2%).

- The recent Health Needs Assessment published by ScotPHN reported the following characteristics of those looked after at home:
  1. Slightly older than in foster or kinship care (9.8 years compared to 8.6 years)
  2. More males than females (54%) whilst more even in other settings with the exception of residential care (60%)
  3. Higher proportion of behaviour problems as the ground for supervision requirement compared to those in kinship or foster care (19% versus 3-4%)
  4. Half of the current place of residents of parents were in the most deprived quintile (this however was lower than the proportion for Kinship care (61%) but much higher than that of the general population
  5. Lowest school attendance rate of all care settings (79% versus overall LACYP average of 87%)
  6. Lowest educational attainment of all care settings
  7. High school exclusion rate: twice that of Kinship care and three times that of Foster care

- Conclusion is that the 30% of LACYP who are in care at home with parents (n = 200 in NHS Highland) are at greater risk of poorer health and well-being than other community (i.e. Kinship or Foster care) placed LACYP.
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**Appendix 1: Abbreviations / acronyms used**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A &amp; B</td>
<td>Argyll &amp; Bute Council area or CHP</td>
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<td>ACC</td>
<td>Assessment Checklist for Children</td>
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<td>ASN</td>
<td>Additional Support Needs</td>
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<tr>
<td>BAAF</td>
<td>British Association for Adoption and Fostering</td>
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<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
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<tr>
<td>CBCC</td>
<td>Child Behaviour Checklist</td>
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<td>CSF</td>
<td>Department of Children, Schools and Families</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<tr>
<td>CLAS</td>
<td>Children LOOKED AFTER Statistics</td>
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<tr>
<td>HHSCP</td>
<td>Highland Health and Social Care Partnership</td>
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<tr>
<td>KEEP</td>
<td>Keeping Foster &amp; Kinship Parents Supported and Trained</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>LAC</td>
<td>LOOKED AFTER Children</td>
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<td>LAAC</td>
<td>LOOKED AFTER and ACCOMMODATED Children</td>
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<td>LACSIG</td>
<td>LOOKED AFTER Children Strategic Implementation Group</td>
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<td>LACYP</td>
<td>LOOKED AFTER Children and Young People</td>
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<tr>
<td>MFTC</td>
<td>Multidimensional Treatment Foster Care</td>
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<td>NRCCI</td>
<td>National Residential Child Care Initiative</td>
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<td>ONS</td>
<td>Office of National Statistics</td>
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<td>RCHP</td>
<td>Residential Care Health Project</td>
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<td>SCIE</td>
<td>Social Care Institute for Excellence</td>
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<td>ScotPHN</td>
<td>Scottish Public Health Network</td>
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<td>SIRCC</td>
<td>Scottish Institute for Residential Child Care</td>
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Appendix 2: Policies

The Scottish Government’s *Getting it right for every child* (GIRFEC) programme began in 2005 and aims to promote a more child-centred system and an effective integrated approach across agencies and to give children and young people the best possible start in life and improve their life opportunities. However, there are identified gaps in the knowledge-base namely: the needs of young people in residential care and in particular of how particular placements in care should address these; and the needs and progress of children with disabilities in residential care. It also aims to ensure that all parents, carers and professionals work together effectively. The approach is designed to help those facing the greatest social or health inequalities, encouraging earlier intervention by professionals to avoid crises at a later date.

*For Scotland’s Children* sets out a vision for all children and young people in Scotland in general (not specifically to LAC), 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.

In terms of NHS Board policy and practice and in recognising that children and young people in residential care are among the most vulnerable members of our society often having very complex and challenging needs which require specialised services, the *Getting it Right for the Health of Looked After Children: Practice Guidance* specifies that “Each NHS Board is to assess the physical, emotional and mental health of ALL Looked After Children (including those at home and in kinship care)”

During 2009, the Scottish Government also established the National Residential Child Care Initiative (NRCCI) to undertake a strategic review of residential child care services. Its aim was to develop a ‘blueprint’ to shape the future direction of services, ensuring the needs of children and young people are being met. The report’s recommendations include improvements in assessment and care planning, better management information, effective collaboration and equipping and supporting the workforce.

The importance of adopting a partnership approach across agencies and with carers to provide solutions to health concerns and enable access to health services when they need them has been highlighted *The Children (Scotland) Act 1995; Looked After Children (Scotland) Regulations 1996 and 2009* indicated that every looked after child must have an assessment of their needs and a care plan to address these needs.

*Looked After Children & Young People: We Can and Must Do Better* was published in January 2007. This report identified what was required to improve educational and other outcomes for Looked After children and young people and care leavers. Action 15 of this report was of particular relevance in terms of health whereby:

“Each NHS Board will assess the physical, mental and emotional health needs of all Looked After children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments. They will ensure that all health service providers will work to make their services more accessible to Looked After and accommodated children and young people, and to those in the transition from care to independence.”
To implement this action the next steps required were described as: “Joint assessment and planning which takes into account the views of the young person and includes details of their particular health needs, including registration with a GP, dentist, regular health and dental checks, advice on sexual health, mental health and emotional wellbeing and access to any mental health services required”

For example the Residential Care Health Project (RCHP) was set up in 2000 in recognition that the health of looked after children is the responsibility of a number of agencies. Their report *Forgotten Children* (2004) concluded that: “From past research and from information gathered in the course of the RCHP it is clear that the primary cause of poor health outcomes for this group of young people is not the state of the child’s health on the day they enter the care system. It is rather the history of unmet need prior to being accommodated ... These are compounded by the lack of our current health care systems to adapt to the needs of a mobile population, by difficulties of tracking children and young people, and of communication between and within agencies. These issues can only be addressed by a coordinated approach to tracking and intervention, in which all areas of health service provision have a role to play”.

National care standards (2002) set out what each individual child or young person can expect from the service provider in meeting their needs. The standards include eating well, keeping well – life style, and keeping well – medication. They promote healthy activity and a good diet. The Care Commission inspects all residential homes for children against these standards.

The underpinning theme of the Scottish Government’s report, *These are Our Bairns* is working together which is also one of the key themes identified in *Looked After Children and Young People – We Can and Must Do Better* (Scottish Executive, January 2007). Both reports highlight the importance of recognising that each child is an individual and that early intervention, prevention, flexibility and personalisation will recognise their needs and make sure that they are able to be all they can be in the future.
As part of the Directorate of Public Health & Health Policy of NHS Highland, the Epidemiology & Health Science team provide specialist skills in the areas of:

Epidemiology, Evaluation, Literature Review, Health Economics and Database design for Public Health functions

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